RACGP

Rural General Fellowship (FRACGP-RG)

Additional Rural Skills Training (ARST) Curriculum for Palliative Care

Rural Generalist Fellowship (FRACGP-RG): Additional Rural Skills Training (ARST) Curriculum for Palliative Care

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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

Introduction

The Rural Generalist Fellowship (FRACGP-RG) is a qualification awarded by The Royal Australian College of General Practitioners (RACGP) in addition to the vocational Fellowship (FRACGP). Completion of a minimum 12 months of Additional Rural Skills Training (ARST) in an accredited training post is an essential component of training towards FRACGP-RG. This additional training is designed to augment core general practice training by providing an opportunity for rural general practitioners (GPs) to develop additional skills and expertise in a particular area and enhance their capability to provide secondary-level care to their community.

This curriculum sets out the competencies that candidates are required to develop to complete ARST in Palliative Care. It is also designed to provide a framework for the teaching and learning of the critical knowledge, skills and attitudes that rural generalists require to effectively deliver end-of-life care in rural and remote environments, where specialist support is often limited.

Objectives

The provision of palliative care services is a significant challenge for the health sector and will become increasingly important as the Australian population ages and demand for these services increase. Rural generalists play an important role in this area, delivering palliative medicine across a number of care settings and coordinating the broad range of service responses required to meet diverse patient need in rural settings.

Stage of illness, care setting and patient preferences all add to the complexity of palliative care, and it is important that rural generalists have access to the training and support they need to meet patient needs in this challenging context. By undertaking ARST in Palliative Care, candidates will build their capacity to address these rural challenges and deliver high-quality palliative care services to their community. A long-term outcome of this will be improved equity of access to skilled practitioners and quality care for rural Australians.

Prerequisites

ARST in Palliative Care can only be undertaken after the Hospital Training Time component of FRACGP has been completed. To give candidates a rural general practice context to the learning, and provide a better understanding of where their additional skills will be practised, it is strongly recommended (but not mandatory) that they have completed at least 12 months full-time equivalent (FTE) of community rural general practice terms before starting the ARST. However, the RACGP recommends that candidates work closely with their training team to plan the best training pathway for their individual circumstances.

Duration

This ARST in Palliative Care requires a minimum of 12 months (FTE) in an accredited training post, in accordance with the vocational standards and requirements published by the RACGP. Candidates must demonstrate satisfactory achievement of outcomes as per the curriculum.

Context for the FRACGP-RG ARST Curriculum for Palliative Care

ARST in Palliative Care must be completed with an accredited specialist palliative care unit. This may be in a metropolitan, regional or rural setting. The ARST may be undertaken across one or more posts; however, at least six months (FTE) must be completed in a hospital/hospice setting. Remaining training time may be spent working in:

- hospice or specialist inpatient palliative care unit
- community palliative care service
- general hospital consultative service
- specialist oncology (medical and radiation) unit.

The emphasis of this ARST in Palliative Care is on the acquisition of relevant clinical skills and experience. Candidates will engage in self-directed learning under the supervision of a palliative medicine physician who is a Fellow of the Royal Australasian College of Physicians (RACP) or a Fellow of the RACP's Australasian Chapter of Palliative Medicine. Registrar candidates will be supported by a GP medical educator. A rural GP mentor is recommended as an additional source of advice on training in the broader context of rural general practice, as well as a professional role model and support person.

The role of the GP mentor includes:

- act as a professional role model and support person
- observe the candidate's performance and provide regular feedback and assistance in general practice settings, where appropriate
- contribute to formative assessment of the candidate, where appropriate.

The GP medical educator provides a link back to the training team to inform the candidate about educational activities and overall training requirements. Their role is to:

- provide advice and assistance regarding training needs, learning activities and completion of training requirements
- assist in the development, implementation and evaluation of learning materials
- assist in access to learning opportunities
- contribute to formative assessment of the candidate and monitor progress.
- contextualise learning to rural general practice

The palliative medicine physician provides the candidate with a source of clinical expertise, advice and educational support. Their role is to:

- provide supervision in the clinical setting
- facilitate access to clinical learning opportunities
- demonstrate clinical skills and procedures
- observe the candidate's performance and provide regular feedback and assistance
- conduct regular teaching sessions

- monitor candidate progress and contribute to formative assessments
- report on progress in completing assessment requirements.

An alternate or independent assessor is someone with similar qualifications as the supervisor who will contribute to formative assessment of the candidate. They should be a palliative medicine physician who is a Fellow of the RACP, or a Fellow of the RACP's Australasian Chapter of Palliative Medicine, or a Fellow of the RACGP or ACRRM with additional skills in palliative care.

A combination of teaching methods is used, taking into account the specific clinical context and learning environment. Teaching and supervision methods strongly emphasise the acquisition of knowledge and skills in practice settings. Through demonstration, observation and interactive teaching methods, candidates are challenged to perform, reflect upon and assess their competence in applying the clinical knowledge and skills described in the curriculum.

Teaching methods may include:

- practice-based demonstration by supervisors
- practice-based observation and feedback on candidate performance
- group discussion, activities, case studies and presentations
- role-play or simulated scenarios illustrating challenging clinical situations
- online learning modules
- simulation of clinical presentations
- specific courses and workshops
- audio-visual and web-based presentations
- research projects
- regular meetings with supervisors
- access to continuing professional development workshops
- presentation of educational sessions to other staff or community groups
- journal articles and web-based resources
- development of teaching skills through teaching of junior medical staff and medical students.

Candidates are expected to determine the depth and extent of education and training required in consultation with their supervisors and document this as part of their training plan.

Content of the FRACGP-RG ARST Curriculum for Palliative Care

The following content list provides guidelines for the candidate and the supervisors regarding topics to be covered during training. This is a non-exhaustive list of desirable knowledge and skills to meet the palliative care needs of rural communities. It is anticipated that this list may be adapted to address the particular learning goals of candidates and the particular context in which the training is conducted.

The content is organised under the following headings:

1. The nature of palliative care work
2. Palliative assessment and intervention
3. Legal and ethical issues in palliative care
4. Self-care

1. The nature of palliative care work

- Common barriers to communication (eg language difficulties, deafness, confusion and dementia) and how they can be overcome
- Common impacts of illness, uncertainty and the threat of death on people with life-limiting illnesses
- Professionally and sensitively discussing prognosis and end-of-life issues
- Providing palliative care as part of a multidisciplinary team
- Techniques for forming therapeutic and supportive relationships with people with life-limiting illnesses, their family and carers
- The bio-psycho-social-spiritual model of care
- The role of palliative care and the principles of maximising quality of life, relieving suffering and providing support

2. Palliative assessment and intervention

- Assisting patients to establish advance care directives
- Clinical management of common conditions and complications within the palliative care setting
- Common psychological concerns of patients as disease progresses and therapeutic interventions for minimising psychological distress
- Indicators of approaching death and the management of symptoms that occur at the end of life
- Management of emergencies that occur in the palliative care setting
- Pain assessment and management, including pharmacological and non-pharmacological pain management strategies
- Principles and processes for the safe and appropriate prescribing of medication within the palliative care setting
- Principles and practices of patient-centred management planning
- Processes for managing patient care in various contexts (homes, hospitals, hospices and residential care facilities)

3. Legal and ethical issues in palliative care

- Common ethical issues relating to end-of-life care, including patients declining treatment, the withdrawal of ‘active’ treatments, the withdrawal or withholding of invasive feeding and fluids, managing requests for euthanasia, the provision of terminal care at end of life, and the ‘doctrine of double effect’
- Legal requirements for the certification of death, including burial, cremation and reporting of death to the coroner
- Local legal status of voluntary assisted dying (differs between states/territories)
- Processes for ethical decision making in the context of palliative care
- The meaning and use of legal documentation such as power of attorney, enduring guardian, advance care directives, ‘not for resuscitation’ orders, and consent for body or tissue donation

4. Self-care

- Common psychological impacts of working in palliative care and strategies for managing the personal challenges of dealing with death and grief on a daily basis
- Identifying own personal culture and beliefs, and the impact these have on the ability to deal with death and dying of others
- Strategies for personal and professional support and debriefing

Learning outcomes and performance criteria

The **RACGP curriculum for Australian General Practice 2022** bases lifelong teaching and learning on the five domains of general practice. The domains represent the critical areas of knowledge, skills and attitudes necessary for competent, unsupervised general practice. They are relevant to every general practice patient consultation and form the foundation of the skills of rural GPs. Candidates undertake this ARST in Palliative Care in conjunction with the **RACGP Curriculum for Australian General Practice 2022**. Subsequently, this curriculum is designed to detail the additional knowledge and skills that GPs completing their ARST in Palliative Care are required to develop in order to provide comprehensive palliative care in rural and remote communities. The five domains are:

1. Communication and the patient–doctor relationship
2. Applied professional knowledge and skills
3. Population health and the context of general practice
4. Professional and ethical role
5. Organisational and legal dimensions

By the end of this ARST in Palliative Care, the candidate will have expanded upon the assumed level of knowledge of the vocational registrar in these areas.

Note: Italicised terms in the following tables are defined in the next section, titled ‘Range statements’.

1. Communication skills and the patient–doctor relationship

Learning outcomes	Performance criteria
1.1 Communicate with patients, relatives and carers effectively and appropriately in the context of palliative care	1.1.1 Establish a *therapeutic and supportive relationship* with patients and their families based on trust, empathy and confidentiality, with an understanding of the importance of family and carer relationships in the context of palliative care 1.1.2 Sensitively explore palliative patients' concerns across the various *domains of health* 1.1.3 Demonstrate focused, flexible and appropriate communication with patients, their families and carers in discussing palliative, prognostic and end-of-life issues, including *advance care directives/ planning* 1.1.4 Communicate medication issues clearly and concisely to patients, their families and carers 1.1.5 Modify communication with palliative patients and their families who are from *culturally and linguistically diverse and/or Aboriginal and Torres Strait Islander* backgrounds 1.1.6 Respond sensitively to, and work effectively with, strong emotional reactions and appropriately manage *challenging circumstances* 1.1.7 Identify and overcome common barriers to communication in *palliative care*
1.2 Effectively communicate within a *multidisciplinary team* to provide high-quality, holistic palliative care	1.2.1 Communicate clearly and professionally with other members of a *multidisciplinary team* 1.2.2 Clearly communicate advance care directives and end-of-life issues with other professionals as required

2. Applied professional knowledge and skills

Learning outcomes	**Performance criteria**
2.1 Use a holistic approach to palliative care assessment and planning	2.1.1 Describe the experience of *life-limiting illness* from the perspective of the patient and their family, and the meaning and consequences of illness to them 2.1.2 Use evidence-based pathophysiology and symptom management to address the range of physical, psychosocial, and spiritual issues relating to life-limiting illness and terminal decline 2.1.3 Assist patients to negotiate the common impacts of illness, uncertainty and the threat of death on interpersonal relationships, family functioning, body image, sexuality and personal and social role functioning 2.1.4 Practise culturally appropriate palliative care, with consideration for spiritual, cultural, ethnic and societal issues around death and dying, which impact on the practice of palliative medicine 2.1.5 Assess the patient and their situation to manage symptoms, as well as concurrent and new medical diagnoses 2.1.6 Demonstrate clinical management that is appropriate for the patient, their symptoms and their context 2.17 Assess risk factors for terminal decline
2.2 Appropriately use a range of palliative therapies	2.2.1 Manage concomitant clinical problems and *comorbidities* 2.2.2 Describe the benefits, precautions and common adverse effects of a range of different evidence-based therapies 2.2.3 Manage pain effectively, utilising both *non-pharmacological and pharmacological* means 2.2.4 Prescribe medication *safely and appropriately* based on the known pharmacology and best available evidence within the palliative care setting 2.2.5 Prioritise appropriate investigations and management 2.2.6 Assess risk factors for terminal decline

2.3 Appropriately use a range of management strategies	2.3.1 Use a model of care that focuses on managing symptoms and optimising *quality of life* 2.3.2 Employ pharmacotherapy for the full spectrum of palliative medicine issues 2.3.3 Provide *supportive counselling* to patients and their families and carers 2.3.4 Recognise and manage *emergencies* as they arise in the context of palliative and end-of-life care 2.3.5 Manage patients within the context of *their life*, based on the principles and practices of maximising quality of life, relieving suffering and providing support 2.3.6 Make a plan for managing deterioration and for crisis intervention that falls outside the expected clinical course of the life-limiting illness 2.3.7 Demonstrate continuity of care for the longer-term health of the patient to ensure optimum quality of life 2.3.8 Outline the criteria for transfer of palliative patients to and from hospital 2.3.9 Apply disease-specific treatments in the management of progressive life-limiting illness 2.3.10 Manage common psychological concerns of patients as disease progresses
2.4 Work effectively as part of a multidisciplinary team in the provision of safe palliative healthcare to patients with a terminal illness	2.4.1 Organise and implement a treatment plan through collaboration with team members and other colleagues 2.4.2 Involve team members in interdisciplinary meetings to maximise relevant contributions 2.4.3 Manage complex palliative health issues as part of a multidisciplinary team 2.4.4 Educate health professionals involved in the patient's care on palliative and end-of-life care and other associated topics, as appropriate 2.4.5 Develop a *comprehensive professional referral network* 2.4.6 Collaborate effectively with relevant organisations involved in the area of palliative care

3. Population health and the context of general practice

Learning outcomes	Performance criteria
3.1 Advocate for appropriate, timely and best practice palliative care services for the community	3.1.1 *Advocate* for equity of access to multidisciplinary palliative care services 3.1.2 Advocate for access for those from disadvantaged groups and their families/carers 3.1.3 Advocate to address the determinants of the experience of illness, dying and bereavement
3.2 Provide direction and leadership to address palliative care needs in the community	3.2.1 Promote palliative care services within the health system and community 3.2.2 Provide information to the community and other health professionals about palliative care and associated concepts as a means of contributing to a 'healthy' and normalising experience of dying and bereavement for patients, families and communities 3.2.3 Identify local palliative care resources, and budgetary and human resource limitations, to help determine efficient and effective service delivery for the community 3.2.4 Negotiate *prudent* use of palliative resources 3.2.5 Identify, and where needed, develop, local *policies and standards* for palliative care 3.2.6 Involve consumers and consumer groups, and carers and carer groups, in developments and initiatives in health service provision 3.2.7 Provide ongoing professional development sessions to other health professionals, staff, consumers and members of the community

4. Professional and ethical role

Learning outcomes	Performance criteria
4.1 Work within all relevant professional and ethical guidelines when providing palliative care	4.1.1 Maintain *professional standards of behaviour* when managing palliative patients 4.1.2 Recognise, analyse and address *ethical issues* and conflicts in patient care and clinical practice
4.2 Apply self-reflection in improving clinical care	4.2.1 Identify, and use, strategies for establishing, maintaining and improving self-awareness when interacting with patients with palliative care issues 4.2.2 Identify own personal beliefs, and the influence of culture and society, on the ability to deal with death and dying of others 4.2.3 Explain how the losses and grief of patients and their families can influence a doctor's ability to deal with their own losses, and vice versa
4.3 Apply strategies for managing the personal challenges of dealing with death and grief on a daily basis	4.3.1 Identify personal stressors and common psychological impacts of caring for dying patients and their families and the need for self-care 4.3.2 Identify, and use, *self-care strategies* that protect and minimise potential personal impacts involved in working in a palliative care setting 4.3.3 Identify indicators of the need to seek personal support for dealing with the emotional and existential issues that inevitably arise when providing palliative care 4.3.4 Develop a network of supports and strategies that are individually tailored to own unique needs and use as needed 4.3.5 Access opportunities for debriefing
4.4 Demonstrate a commitment to continuing self-directed learning and professional development sufficient to provide quality care	4.4.1 Undertake professional development activities regularly 4.4.2 Access opportunities for professional supervision and peer review

5. Organisational and legal dimensions

Learning outcomes	Performance criteria
5.1 Work within relevant organisational, statutory and regulatory requirements and guidelines associated with end-of-life care	5.1.1 Apply *relevant state/territory-based legislative and administrative requirements* 5.1.2 Define and describe the use of power of attorney, enduring guardian and *advance care directives* and negotiate these appropriately 5.1.3 Demonstrate *professionally acceptable standards* of documentation and report writing in delivering palliative care, including advance care directives, ‘not for resuscitation’ orders and consent for body or tissue donation
5.2 Monitor and improve the delivery of palliative care	5.2.1 Develop and use *resources and effective processes* to ensure continuity of care for patients with palliative care issues 5.2.2 *Structure* the clinic/practice to accommodate patients with palliative care issues 5.2.3 Undertake regular audits of management practices in dealing with patients needing palliative care and their families/carers

Range statements

The following statements and definitions are offered to improve the understanding of key terms used throughout the learning outcomes and performance criteria. These terms are not definitive and need to be considered in local contexts. They are grouped according to the five domains of general practice.

Communication skills and the patient–doctor relationship

Therapeutic and supportive relationship – This refers to a respectful, professional and collaborative relationship between a healthcare professional and patient (and their family) in which they can effectively engage with each other.

Domains of health – These are the factors that together comprise a person's general health and wellbeing, including physical, psychological, emotional, social, cultural and spiritual factors.

Advance care directives/planning – This refers to the process of exploring a patient's (and others they consider significant) values and goals of care in certain circumstances. The outcome of this is typically the development of an advance care directive, which may be specific (eg not for intubation) or more general in nature.

Culturally and linguistically diverse – This can include refugees, visa holders, migrants, people from English and non-English-speaking backgrounds, and people with diverse cultural and religious beliefs and practices that include unfamiliar/unconventional/challenging medical beliefs and practices regarding the roles of children, women, men and others in the community. People who are intellectually or hearing impaired should also be considered.

Aboriginal and Torres Strait Islander peoples – This includes people who are of Aboriginal and Torres Strait Islander descent, who identify as Aboriginal and/or Torres Strait Islander, and who are accepted as such by the community within which they associate.

Challenging circumstances – These are situations that can make demands on one's abilities, endurance, patience and tolerance. Such patient behaviours may include anger, aggression, violence, agitation and psychiatric symptoms.

Common barriers to communication in palliative care – This refers to common barriers to communication in the palliative care context, such as language difficulties, deafness, confusion and dementia.

Multidisciplinary team – This may include oncologists, surgeons, GPs, palliative care nurses, allied health professionals and other specialists (eg occupational therapists, psychologists, social workers).

Applied professional knowledge and skills

Life-limiting illness – This means any irreversible disease process or illness where it is expected that death will be a direct consequence of the disease or illness.

Manage symptoms – This means to control symptoms, manage concurrent symptoms and new medical diagnoses through non-pharmacological and pharmacological means such that the patient can enjoy a good quality of life without suffering.

Comorbidity – Comorbidity has implications for aetiology, diagnosis, management and prognosis of palliative conditions. Patients in the terminal phase of their lives often experience pain and develop palliative care problems, as well as other medical conditions.

Non-pharmacological means – This refers to managing someone's pain without the use of medication, such as by using heat, ice, massage, physical therapy or psychological therapies.

Pharmacological means – This refers to the use of medications and the various medication delivery methods, including oral analgesia, transdermal patches, 24-hour infusion pumps and intravenous therapies.

Safely and appropriately – This refers to prescribing only medications that may benefit the patient in managing their symptoms, to allow them to have a good quality of life in a manner that does not put them at harm.

Phenomenology – This is the appropriate description of a patient's medical signs and symptoms in the palliative care context.

Quality of life – This is tied to the perception of 'meaning' and is a broad, multidimensional concept of overall wellbeing that reflects the difference between a person's hopes and expectations and their ability to experience and enjoy life.

Supportive counselling – This refers to providing patients and families counselling that collaboratively and appropriately sets realistic management goals for their concerns.

Emergencies – These may include, but are not limited to, airway obstruction and severe shortness of breath, pain crises, hypercalcaemia, superior vena cava obstruction, spinal cord compression, fractures, haemorrhage, seizures and acute anxiety and depression.

Context of their life – This refers to the life of the patient outside the context of healthcare, whether this be in their own home, at a medical practice, in hospital, in a hospice or in a residential care facility.

Comprehensive professional referral network – This is a network of the local services, healthcare professionals and specialists, who can be accessed throughout the care of the patient.

Population health and the context of general practice

Advocate – This refers to the process of supporting or recommending a course of action. This may involve advocating for patient needs, including accessing best-practice resources, or advocating for the needs of social groups and cultures within the community who have specific palliative care needs or do not have effective access to palliative care services.

Prudent use – This means using good judgement in the use of palliative resources, for example, the use of in-home services / house calls for patients who are too unwell to attend your practice, and the use of infusion pumps for pain and symptom control.

Policies and standards – This includes, for example, the standards for providing quality palliative care for all Australians, as well as the policies specific for health districts and hospitals.

Professional and ethical role

Professional standards of behaviour – This can include negotiating and agreeing on treatment modalities, priorities and goals of treatment in partnership with the patient, family or carers; resource allocation to best serve the health needs of the population on the basis of need and equity of access to care and support; recognition of personal emotional stress and seeking assistance appropriately; understanding patient and community perspectives on a 'good death'; the need to complete 'unfinished business'; and the issues surrounding relief of suffering versus euthanasia.

Ethical issues – These include the core ethical principles of autonomy of the patient; non-maleficence, which is the doctor's duty to avoid inflicting physical or emotional harm on the patient; beneficence, which is to prevent or remove harm and promote wellbeing; and justice, which does not operate in a vacuum, but responds to the ever-changing social, political, religious and legal mores of the moment. May include advance medical planning, family involvement in medical planning, treatment of concurrent medical problems with limited life expectancy, and balancing symptom management with adverse drug events. Doctors must recognise, analyse and address issues relating to truth-telling, informed consent, advance care directives, confidentiality, end-of-life care, conflicts of interest, resource allocation and research ethics.

Self-care strategies – These are activities that ensure the doctor remains well physically, spiritually and emotionally.

Organisational and legal dimensions

Relevant state/territory based legislative and administrative requirements – These can include death certificates, advance care directives, medical powers of attorney, enduring guardianship requirements, carer's allowance applications, Will preparation and testamentary capacity.

Advance care directive – This is a statement derived from discussion with a patient and others they consider significant, outlining their values and goals of care in certain circumstances. It may be specific (eg not for intubation) or more general in nature.

Professionally acceptable standards – Medical records are not accessible by doctors alone, but also by regulatory agencies, by court-ordered subpoena, in malpractice litigation and by patients under the *Freedom of Information Act 1982* (Cth).

Resources and effective processes – These can include written and recorded notes, copies of referrals and the involvement of appropriate professionals.

Structure – This can include accommodating home visits for patients needing palliative care, when appropriate, arranging adequate clinical handover to partners or preferred after-hours providers to ensure continuity of care at all hours for patients requiring palliative care and their families.

Assessment

Satisfactory completion of the ARST in Palliative Care will be assessed by a combination of workplace-based assessment (WBA) approaches during the candidate's 12-month (FTE) placement in an accredited training post.

WBA is a recognised approach to assessing medical practitioners in training in the actual workplace, and WBA assists with training, as well as assessment. To achieve this requirement, WBAs assess a diverse range of attributes, including clinical competencies, domains and skills. Further details about WBA and how it is applied in ARST assessment can be found in the **AGPT Registrar Training Handbook** and the **Rural Generalist Training Handbook**.

The following WBA assessment tools will be used to assess the candidate's competency in this ARST in Palliative Care:

- logbook
- three random case note analysis sessions reviewing a minimum of three cases per session
- two supervisor reports, one completed at six months and one at completion of 12 months of training (FTE)
- two Mini-Clinical Evaluation Exercise (Mini-CEX) sessions, with a minimum of three cases per session
- two case-based discussion sessions (candidate submits four cases and is assessed on two each session).

Each task is described in more detail below.

Logbook

Candidates will be required to maintain a logbook throughout their training. A component of maintaining this logbook involves reflecting on self-identified learning needs. The range of skills that are logged, and any proposed professional development in this area, should take into consideration the community requirements.

This logbook will need to be regularly reviewed by the supervisor and reviewed by the medical educator at each medical educator meeting.

Random case notes analysis

Candidates will be required to undertake three random case note analysis sessions in which a minimum of three cases are reviewed per session. Using patient notes that are randomly selected, the assessor will review the quality of case notes as well as explore the candidate's clinical decision making, management and therapeutic reasoning.

The first of these random case notes analysis sessions should be completed by the supervisor in months two to four (FTE) of the training. The second session should be completed by an alternative assessor in months four to six (FTE). The third session should be completed in months seven to eight (FTE) by the supervisor.

Supervisor reports

The candidate and their supervisor will meet half-way through the training (eg at six months for full-time training) and at the end of the training period (eg at 12 months for full-time training) to complete a supervisor report.

These reports should provide a global assessment of performance against the outcomes outlined in this curriculum. The candidate and supervisor will meet to discuss the candidate's performance, identify areas for further learning and development, and ensure that the candidate is progressing adequately in their training. Progression, or lack thereof, should be documented and discussed, with the intent of formulating a plan to remediate any gaps identified either through additional learning, or experiences, or a combination of both.

Mini-CEX

Candidates will be required to undertake two Mini-CEX sessions in which a minimum of three cases are observed per session. The assessor will observe the candidate conducting a consultation with real patients and provide feedback about their performance.

The first of these Mini-CEX sessions should be completed by the supervisor in months two to four (FTE) of the training. The second session should be completed by an alternative assessor in months seven to eight (FTE).

Case-based discussions

Candidates will be required to undertake two case-based discussion sessions. The candidate will be required to submit four cases and will be assessed on two cases for each session. The assessor will explore the candidate's case management and clinical reasoning alongside their medical knowledge.

The first of these case-based discussion sessions should be completed by an independent assessor in months four to six (FTE) of the training. The second session should be completed by an independent assessor in months nine to 11 (FTE).

Recommended learning resources

- Australian and New Zealand College of Anaesthetists (ANZCA) and Faculty of Pain Medicine. Acute pain management: Scientific evidence. 4th edn. Melbourne: ANZCA and FPM, 2015.
- Australian & New Zealand Society of Palliative Medicine. Draft Clinical indicators for end of life care and palliative care. Available at **https://www.anzspm.org.au/c/anzspm?a=sendfile&ft=p&fid=1543214649&sid=**
- 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). Available at **https://pubmed.ncbi.nlm.nih.gov/10964998/**
- CareSearch: Palliative care knowledge network. Available at **https://www.caresearch.com.au/**
- Department of Health: Palliative care resources. Available at **http://www.health.gov.au/palliativecare**
- National Pain Strategy: **Pain management for all Australians**. Pain Australia, 2011. Available at **https://www.painaustralia.org.au/static/uploads/files/national-pain-strategy-2011-exec-summary-with-stakeholders-wftfjtpbdaij.pdf**
- NSW Therapeutic Advisory Group. Practical guidance on the use of opioids in pain management. Darlinghurst, NSW: NSWTAG, 2021. Available at **https://www.nswtag.org.au/practical-guidance/**
- Therapeutic guidelines: Palliative Care. Version 4. Melbourne: Therapeutic Guidelines Limited, 2017.
- Watson M, Campbell R, Vallath N, Ward S & Wells J. Oxford handbook of palliative care. 3rd edn. Oxford: Oxford University Press. 2019.

RACGP resources

- The Royal Australian College of General Practitioners (RACGP) Advance care planning. Available at **https://www.racgp.org.au/running-a-practice/practice-resources/practice-tools/advance-care-planning**
- The Royal Australian College of General Practitioners (RACGP), gplearning, activities including: Effective pain management in general practice; Making an effective pain diagnosis: A whole person approach; Management of moderate acute pain and the role of combination analgesia. Available at **https://www.racgp.org.au/education/professional-development/online-learning/gplearning**

Journal

- Journal of Pain and Symptom Management. Available at **https://www.jpsmjournal.com/**
- Journal of Palliative Care. Available at **https://journals.sagepub.com/home/pal**
- Pain. Available at **https://journals.lww.com/pain/pages/default.aspx**
- Palliative Medicine. Available at **https://journals.sagepub.com/home/pmj**

List of acronyms and initialisms

ARST	Additional Rural Skills Training
FRACGP	Fellow of the Royal Australian College of General Practitioners
FRACGP-RG	Royal Australian College of General Practitioners Rural Generalist Fellowship
FTE	full-time equivalent
GP	general practitioner
Mini-CEX	Mini-Clinical Evaluation Exercise
RACGP	Royal Australian College of General Practitioners
RACP	Royal Australian College of Physicians
WBA	workplace-based assessment

Healthy Profession.
Healthy Australia.

RACGP