Australasian Faculty of Rehabilitation Medicine

Draft Discussion paper

The Rehabilitation Trainee of the Future

Executive Summary

5 pages

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Background

Rehabilitation Medicine is that branch of medicine involved with the: prevention and reduction of functional loss, activity limitation and participation restriction arising from impairments; management of disability in physical, psychosocial and vocational dimensions; and improvement of lost function. Specialists in Rehabilitation Medicine are Rehabilitation Physicians. The Royal Australasian College of Physicians (RACP) provides training to Australasian Medical Practitioners specialising in Rehabilitation Medicine via the Australasian Faculty of Rehabilitation Medicine (AFRM).

In just 40 years, Rehabilitation Medicine has evolved from a mere concept to a thriving speciality in Australasia, fulfilling an essential role in healthcare in Australia and New Zealand. The last decade has seen the development of rapid change in the speciality. Rehabilitation now extends beyond its traditional subacute setting and Rehabilitation Physicians now work alongside acute clinicians providing early Rehabilitation. Earlier transfer to Rehabilitation results in a greater patient acuity and the management of patients who frequently continue to have active acute issues, and there is also a progressive focus on integrative models of care, with community based Rehabilitation care for those with chronic disability and health conditions.

AFRM's mission is "to train, accredit and support medical practitioners in the management of functional loss, activity limitation or participation restriction arising out of illness and injury". To achieve this aim as the speciality continues to advance, the specialist training program must be reviewed and contemporised to guarantee a supply of specialists who are suitably equipped for the evolving needs of the speciality within the landscape of modern Australasian health care.

Aims

- To evaluate the current Adult Rehabilitation Medicine training program
- To identify options to ensure the training program meets the future needs of the speciality.
- To review the option of restructuring the existing training program to RACP Basic Training with Advanced Training in Rehabilitation Medicine via the Adult Medicine Division (the "FRACP option").

An AFRM Coordinator of Education was appointed for 12 months from July 2013 to carry out this work.

Methods

AFRM members (Fellows and Trainees) were invited to provide feedback regarding the Training program to the Coordinator of Education via a range of formal and informal options, including face to face meetings, telephone, email, discussion at the 2013 and 2014 AFRM member Meetings and via a Member Survey. Evaluation of the Training program was conducted using the SWOT Analysis format

In response to the SWOT analysis, potential options and actions were identified to address the speciality's future needs.

The option of restructuring the current adult Rehabilitation Medicine training program to RACP Basic training with Advanced Training in Rehabilitation Medicine via the Adult Medicine Division was considered in greater detail. The practicalities and implications of implementing such a change were reviewed, particularly they relate to the aforementioned analysis of the current training program. A Competency mapping analysis between the Adult Basic Training Curriculum and the Adult Rehabilitation Medicine Curriculum was undertaken by an educationalist, and curriculum specifications for Advanced Training in adult Rehabilitation Medicine under this model were delineated.

Results

Extensive input into evaluation of the training program was provided by AFRM members. In addition to vigorous discussion at the Annual Members' meeting, a third of Members responded to an electronic survey. The demographics of the electronic survey respondents were consistent with known AFRM member demographics, enhancing confidence in the generalizability of the responses. The key issues facing Rehabilitation Medicine in the coming two decades identified by respondents relate directly to the training program – its quality and content, and the importance of equipping trainees with the knowledge and skills for managing chronic disability, ageing with a disability, and Rehabilitation of the older person.

SWOT analysis summary

Feedback received regarding the training program was formulated into a SWOT analysis, as shown below.

	Helpful	Unhelpful
Internal	Strengths 1. Quality of the Rehabilitation Medicine Training program 2. Increasing adequacy of trainee numbers 3. Strong engagement of Rehabilitation Medicine community in the training program 4. Effectiveness and responsiveness of the AFRM and benefits of being a Faculty of the RACP	Weaknesses 1. Entry to training - too early, standards ill-defined 2. Difficulty completing training requirements within existing timeframes 3. Rehabilitation Medicine Clinical Curriculum update needed 4. Modules 1 and 2 - lack of syllabus, timing, expected standard, 5. Fellowship examinations - fluctuating results, timing, content mismatched to clinical experience, removal of essays 6. Breadth and oversight of individual clinical experience 7. Utility of some aspects of external training modules, formal long case assessments, Learning Needs Analysis and Trainee Term evaluations 8. Quality of and access to consistent teaching and learning opportunities 9. Issues with some training settings - accreditation, suitability 10. Supervision issues - dealing with trainees in difficulty,

		inadequate supervision in some settings
External	Opportunities 1. Future workforce demands for Rehabilitation Medicine Fellows 2. Expansion of the role of Rehabilitation Medicine - acute setting, higher patient acuity in subacute setting, greater focus on "re-conditioning" rehabilitation, focus on continuum of management including ambulatory care programs, older person Rehabilitation, and managing chronic disability and aging with disability	Threats 1. Institutions other than RACP offering Specialist training in Rehabilitation Medicine 2. Adequacy of geographic distribution of Rehabilitation Medicine trainees and Fellows 3. Rehabilitation Medicine Fellows inadequately equipped to meet the evolving trends of the speciality with the potential for: Suboptimal patient care, clinicians working on the margins of clinical practice, restricted involvement in certain models of clinical care, negative impact on image and credibility of Rehabilitation Medicine, Rehabilitation Medicine roles taken on by other specialities

Key Recommendations to address identified issues

In response to each of the factors identified in the SWOT analysis, actions were identified with the purpose of reinforcing and capitalising on the positive internal and external factors, and addressing the negative factors both in the short term and in the medium to long term. A summary and discussion of the key recommendations is presented below.

Entry to training

Many of the concerns identified regarding the training program will be mitigated by addressing the entry to training criteria for the Rehabilitation Medicine Training Program.

Fundamentally, greater clarity is needed to define the characteristics of a trainee suitable for a career in Rehabilitation Medicine, including personal qualities, commitment to the speciality and baseline knowledge and skills. This will inform and guide the entry to training processes.

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

Workforce

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

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

Syllabus and teaching

In the context of recent and projected developments within the speciality, a gap analysis of existing and predicted knowledge and skills for future specialists is needed. It is likely that Rehabilitation Physicians of the future will need greater foundational knowledge and skills in

internal medicine. While Rehabilitation Physicians are not the primary physicians responsible for complex medical conditions, comorbidities and complications, there is an increasing need for Rehabilitation Physicians to have an understanding of the impact of conditions on the Rehabilitation process, and indeed of the impact of the Rehabilitation process on medical conditions.

Moving to the "FRACP option" would provide trainees with the foundation knowledge and skills necessary for future Rehabilitation Medicine practice. Approximately one quarter of the content of the current clinical syllabus is duplicated in the Basic Training curriculum and could be removed from the existing Rehabilitation Medicine syllabus.

Independent of the potential move to the "FRACP option", the existing syllabus needs updating, with the addition of content; review of the structure and weighting of content, and to consider moving some content from core to non-core.

A strategic review of the existing teaching and learning program will complement the syllabus review to ensure that trainees have consistent and equitable opportunities to address the updated syllabus. This includes allocation of adequate resources for a contemporary approach to teaching and learning, including appraisal and enhancement of existing teaching programs and the development of innovative approaches to teaching and learning. .

Breadth of clinical experience

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

Training program elements

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

Overview of FRACP option for adult Rehabilitation Medicine training

The potential move of adult Rehabilitation Medicine training to the "FRACP option" would address several, but not all domains identified in the analysis of the Rehabilitation Medicine training program. There was mixed support for this model in the member survey, with 41% of respondents in favour of this change and 49% not in favour.

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

Basic Training focuses on developing core medical skills and knowledge, introducing the specialty disciplines and providing a foundation for consolidation and further study within Advanced Training. The current Basic Training Syllabus in Adult Internal Medicine includes limited reference to Rehabilitation Medicine. An extensive College-wide curriculum review is currently underway, providing a natural opportunity for redressing the Rehabilitation Medicine content in the Basic Training curriculum. Some current Rehabilitation Advanced Training terms would change to Basic Training terms.

In this model, Advanced Training in Rehabilitation Medicine would likely be three years in duration. Other than removal of Modules 1 and 2, no other significant alteration to the current

training program components would be necessary. The Advanced Training curriculum would be updated, with removal of approximately 25% of content already addressed in the Basic Training Syllabus.

As with other Advanced Training programs undertaken via Divisional Training, governance of Advanced Training in Rehabilitation Medicine would sit with an Advanced Training Committee reporting to the Adult Medicine Division Education Committee. A change to this model of training would be dependent on support from the Adult Medicine Division of the College. The formation of a Specialist Society in Rehabilitation Medicine would not be essential for this model, though this eventuality could provide input into the Advanced Training Committee.

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

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

Next Steps

Decision-making regarding the future of the Australasian Rehabilitation Medicine training program must be preceded by purposeful and meaningful discussion by relevant stakeholders, and informed by contemporary data and analysis of the industry (see "The Horizons" report). The Executive Summary was presented at the Annual Members Meeting on September 10 2014, and has been made available for review by the members since that time via the website with an open invitation for comment and feedback. The full discussion paper will be made available to the members.

It is anticipated that AFRM members will be invited to participate in a facilitated workshop in the first half of 2015 to further delineate the future directions of RM training in Australasia in response to the feedback received from the AFRM members.

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