



Australasian Faculty of  
Rehabilitation Medicine

Draft Discussion paper

# **The Rehabilitation Trainee of the Future Executive Summary**

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## **1. Background**

Rehabilitation Medicine is that part of the science 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<sup>1</sup>.

In just 40 years, Rehabilitation Medicine has progressed from a mere concept to a thriving speciality in Australasia, occupying an essential role in healthcare in Australia and New Zealand. 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). Background information regarding Rehabilitation Medicine in Australasia is presented in Chapter 2, along with a detailed explanation of the current training program in Chapter 3.

A strategic goal of the Faculty is to ensure members are equipped with the skills and knowledge to provide best practice Rehabilitation Medicine services now and into the future.

AFRM members have raised concerns regarding the Adult Rehabilitation Medicine training program's future fitness for purpose in the context of recent and projected changes in the speciality, and the potential need for stronger medical knowledge and skill base, which are traditionally offered through training in Adult Medicine.

A Coordinator of Education for AFRM was appointed in June 2013 with the goals of reviewing the AFRM training program in the context of the context of Rehabilitation Medicine's current and projected developments with a view to identifying gaps in the training processes, and opportunities for addressing them, including the option of restructuring to RACP Basic Training followed by Advanced training in Rehabilitation Medicine via the Adult Medicine Division.

A training program which has the capacity to train adequate number of specialists in Rehabilitation Medicine, who are suitably equipped for the evolving needs of the speciality, and which adheres to the highest academic and procedural standards will be essential for the ongoing role of Rehabilitation Medicine in the healthcare landscape of Australasia.

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<sup>1</sup>. AFRM (2009). About AFRM. <http://www.racp.edu.au/index.cfm?objectid=E4B0BC8E-9A48-7593-DC18C6755E5182DD>

## **2. Methods**

### **1. Review the Adult Rehabilitation Medicine training program to determine its suitability for addressing the future training needs of the speciality.**

This review was conducted with formal and informal AFRM member input, including discussion at the 2013 AFRM annual members meeting and a member survey (Chapter 4).

### **2. Formulate the review of Rehabilitation Medicine training in “SWOT Analysis” format<sup>2</sup>**

Strengths, weaknesses, opportunities and threats related to the adult Rehabilitation Medicine training program and its positioning to address the future training needs of the speciality were identified (Chapters 5 to 8).

### **3. Identify options to equip the adult Rehabilitation Medicine training program to meet the future needs of the speciality**

Options and actions in response to the SWOT analysis were identified to address the speciality’s future needs, input into some of which had also been sought during the AFRM member consultation process (Chapter 9).

### **4. Detailed review of option to restructure current adult Rehabilitation Medicine training program to RACP Basic training with Advanced Training in Rehabilitation Medicine via the Adult Medicine Division**

This option was considered in further detail, specifically how it addresses issues identified in the SWOT analysis (Chapter 10). A competency mapping analysis between the Basic Training program and the AFRM adult Rehabilitation Medicine was carried out (Chapter 11) and curriculum specifications for Advanced Training in adult Rehabilitation Medicine was determined (Chapter 11).

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<sup>2</sup> The Origin of the SWOT analysis technique is credited to Albert Humphrey in the 1960s and 1970s<sup>1</sup> as a tool used in strategically analysing a business, often at a time where structural or procedural changes are being considered. It facilitates an understanding of the positive and negative aspects of an organisation’s internal and external environments. The acronym stands for: Strengths – internal positive factors to be maintained, built on or leveraged; Weaknesses – internal negative aspects to be remedied, changed or stopped; Opportunities – external positive factors to be prioritised, captured and built on; Threats – external negative factors to be countered, minimised or managed. Humphrey, Albert (December 2005). "SWOT Analysis for Management Consulting". SRI Alumni Newsletter (SRI International).

### 3. Member Survey summary findings

A survey was prepared to seek input from AFRM members regarding the training program in Rehabilitation Medicine and potential changes. It was prepared via the “Survey Monkey” platform, and was open from 10th March 2014 to 2nd June 2014. 211 responses were received, representing 29% of the 737 individuals to whom the survey was sent.

Demographics of the respondents are presented in the table below. 93.5% of respondents currently work in Australia, 68% were Adult Rehabilitation Medicine Fellows, and 24.3% Adult Rehabilitation Medicine Trainees, with 2.2% and 0.45% being Paediatric Rehabilitation Medicine Fellows and Trainees respectively. 45.4% of respondents were female and 52.7% male. 81.1% had completed their primary medical degree in Australia. The average period since completion of the primary medical degree was 21.2 years (Appendix 1), and the average time elapsed since entering specialist training was 14.5 years (Appendix 2).

It is noted that the demographics of survey respondents closely matched known College AFRM membership parameters, as shown in Table 1 below. As at 21/8/2014, there were 757 AFRM Members of the College. Of these 67.9% were Adult RM Fellows, 25.5% were Adult RM trainees, with 4.5% being Paediatric RM Fellows and 2.1% Paediatric RM trainees. 45.6% of AFRM members were female and 54.4% male. No comparative data is available on the proportion of AFRM members who have completed their primary medical degree in Australia or the proportion who currently work in Australia.

**Table 1 - Comparative data - Training survey respondents and AFRM members**

	Respondents number (survey)	Respondents %	RACP Number <sup>2</sup>	RACP %
Adult RM Fellows <sup>1</sup>	129	68%	514	67.9%
Paed RM Fellows <sup>1</sup>	4	2.2%	34	4.5%
Adult RM trainees	45	24.3%	193	25.5%
Paed RM Trainees	1	0.5%	16	2.1%
Other	8	3.8%	-	-
Skipped question	25	11.8%	-	-
<b>Total</b>	<b>212</b>		<b>757</b>	
Male (total)	112	45.4%	412	54.4%
Female (total)	95	52.7%	345	45.6%
No gender specified	5	2.36%	-	
<b>Total</b>	<b>212</b>	<b>100%</b>	<b>757<sup>3</sup></b>	<b>100%</b>

1. Number of Fellows surveyed (757) include active and retired Fellows as at 10/3/2014.

2. Total RACP Fellow and trainee figures are from RACP database as at 21/8/2014.

3. Total RACP AFRM figure (757) may be higher than surveyed recipient number (737) due to some Fellows electing not to receive survey emails from the College.

Factors identified as being the most important in self-selection into Rehabilitation Medicine related specifically to the nature of the speciality itself, along with personal experience with Rehabilitation Medicine. Strongest negative influences on a decision to specialise in Rehabilitation Medicine were the image of, and professional respect for Rehabilitation Medicine. These factors must be addressed and mitigated to ensure the future workforce supply.

The most important issues facing Rehabilitation Medicine in the coming two decades identified by respondents relate directly to the training program – the quality and content of the training program, 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 (Appendix 3).

Of the options for change surveyed in the questionnaire, the strongest support was for introduction of a log book / portfolio (57% support), review of the Rehabilitation Physician Scope of practice (55% support), and re-introduction of the Fellowship long case examination (53% support). 41% supported changing adult Rehabilitation Medicine training to RACP Basic Training with Advanced Training in Rehabilitation Medicine via the Adult Medicine Division, with 49% opposed to this option (Appendix 4).

#### **4. *Questions for discussion***

The following questions are proposed here to prompt and direct purposeful consideration regarding the future direction of RM training in Australasia as you review the analysis of the training program and the potential actions and options, and as these issues are discussed more broadly within the RM community.

1. What is the relative importance and urgency of the various issues identified in the SWOT analysis of the RM Training program?
2. In what way are the components of the Rehabilitation Medicine SWOT analysis impacted by issues raised from the Rehabilitation Medicine Horizons Paper, and discussion regarding the Rehabilitation Medicine Speciality Society?
3. What are the preferred options for addressing the future educational needs for RM in Australasia?
  - a. Modify components of the current RM training program via options indicated in the proposed options / actions table
  - b. Change structure of Rehabilitation Medicine Training program to FRACP as outlined +/- incorporate other changes to training program
  - c. Promote option of dual / joint training +/- incorporate other changes into training program
- What would be the impact on capacity to train for each of these options?

## **5. Summary of SWOT analysis of Adult Rehabilitation Medicine Training Program**

### **Strengths**

1. Quality of the Rehabilitation Medicine Training program
2. Increasing adequacy of trainee numbers
3. 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 criteria
  - a. Entry to training too early
  - b. Lack of clear standards for entry to training
  - c. Limited competition for registrar positions in some settings
  - d. Experience and knowledge of some International Medical Graduates entering training
  - e. Non recognition of prior learning for training and qualifications from other Colleges
2. Challenges of fulfilling current training requirements within existing timeframes
3. Need for review of Rehabilitation Medicine Clinical Curriculum
4. Timing and Content of Modules 1 and 2
  - a. No syllabus for either assessment
  - b. Limited support in preparation
  - c. Rate of repeat questions in Module 1
  - d. Module 2 pass standard too low
  - e. Timing of Modules 1 and 2 too late
5. Fluctuations in adult Rehabilitation Medicine Fellowship examination results
  - a. Timing – too early
  - b. Mismatch between content and clinical experience
  - c. Removal of essay questions from Fellowship written examination
  - d. Fellowship written examination MCQ database
6. Utility of some aspects of External Training Modules
  - a. Timing
  - b. Adequacy of supporting course material
  - c. Lack of individualised feedback
7. Lack of coordination of the individual's training program
  - a. Lack of oversight of the breadth of clinical exposure throughout training
  - b. Limited number of available positions in high demand rotations
  - c. No provision of casemix information for training terms
  - d. Limited use of mentors / professional development advisors
8. Usefulness of long case assessments
9. Quality of and variations in teaching and learning opportunities
  - a. Variations in access
  - b. Access to protected teaching time
  - c. Lack of appropriately skilled clinicians and educators to develop and deliver the teaching and learning program
  - d. Variability in individual teaching quality
  - e. Availability of relevant teaching courses

- f. Variable trainee enthusiasm for teaching and learning
- 10. Utility of Learning Needs Analysis and Trainee Term Evaluations
- 11. Issues with some training settings
  - a. Accreditation process
  - b. Suitability of some training settings
- 12. Supervision issues
  - a. Difficulties with giving negative feedback and dealing with trainees in difficulty
  - b. Training program specific knowledge
  - c. Lack of feedback for supervisors
  - d. Inadequate supervision in some settings

### **Opportunities**

- 1. Future workforce demands for Rehabilitation Medicine Fellows
- 2. Expansion of the role of Rehabilitation Medicine
  - a. More RM in the acute setting
  - b. Greater patient acuity in the subacute setting
  - c. More “re-conditioning “ Rehabilitation
  - d. Focus on continuum of management, ambulatory care programs, Rehabilitation of the older person, and managing chronic disability and aging with disability

### **Threats**

- 1. Institutions other than RACP offering Specialist training in RM
- 2. Adequacy of geographic distribution of RM trainees
- 3. Rehabilitation Medicine Fellows not equipped to meet the evolving trends of the speciality
  - a. Suboptimal patient care
  - b. Clinicians working on the margins of clinical practice
  - c. Limitations to involvement in models of clinical care
  - d. Detrimental impact on image and credibility of Rehabilitation Medicine
  - e. Rehabilitation Medicine roles being taken on by other specialities

## 6. Proposed options and actions arising from SWOT analysis

In response to the SWOT analysis the Rehabilitation Medicine Training program, potential options and actions to address each aspect were identified. These are outlined in the Table 2.

Table 2 – Proposed options and actions in response to AFRM training program SWOT analysis

Strengths	Options / Actions
1. Quality of the RM Training program	1. Conduct regular structured review of training program at predetermined time-points
2. Increasing adequacy of trainee numbers	2. Model impact of proposed changes to training program on potential trainee numbers through consultation with current and potential trainees 3. Enhance awareness of RM as a potential career option amongst potential trainees <ol style="list-style-type: none"> <li>Update current RM career marketing strategy</li> <li>Encourage RM fellows to advocate for RM inclusion in medical school curricula / clinical rotations<sup>3</sup></li> <li>Increase JMO RM rotations, consider changing some registrar rotations to JMO positions</li> </ol>
3. Engagement of RM community in the training program	4. Welcome input by AFRM fellows into the moulding of the training program. 5. Acknowledge importance of role of AFRM members into the success of the training program 6. Identify and mitigate factors with the potential to erode ongoing engagement of AFRM Fellows in training
4. Effectiveness and responsiveness of the AFRM and educational benefits of being a Faculty of the RACP	7. Review standards regarding timeliness of responding to correspondence, and communicate with members. 8. Review, and communicate with trainees the standards pertaining to timeframe for educational decisions.

<sup>3</sup> The Academic Rehabilitation Medicine Subcommittee of the AFRM notes that there is extreme variability regarding the inclusion of RM in Primary Medical Degree programs. This committee has developed Core Curriculum Learning Objectives in RM for Medical Students after extensive consultation in the Faculty<sup>3</sup>. These are advisory and are not officially endorsed by the Faculty or the College, but serve as a guide to assist with enhancing undergraduate experience with RM.

Core Curriculum Learning Objectives in Rehabilitation Medicine for Medical Students

<http://www.racp.edu.au/index.cfm?objectid=8DE7DD88-C214-BDE8-A06F6CEB61C702D5>

Weaknesses	Options / Actions
<p>1. Entry to training criteria</p> <ol style="list-style-type: none"> <li>a. Entry to training too early</li> <li>b. Lack of clear standards for entry to training</li> <li>c. Limited competition for registrar positions in some settings</li> <li>d. Experience and knowledge of some International Medical Graduates entering training</li> <li>e. Non recognition of prior learning for training and qualifications from other Colleges</li> </ol>	<ol style="list-style-type: none"> <li>9. Increase collaboration within and between states for annual RM trainee recruitment in current format</li> <li>10. Develop industry specific consensus regarding ideal characteristics of potential RM trainee by consultation within the RM community. Preliminary discussion with AFRM members suggests the following characteristics are felt to be of particular relevance: <ul style="list-style-type: none"> <li>- Personal maturity</li> <li>- High standard of communication skills – verbal, non-verbal and written</li> <li>- Baseline knowledge about RM</li> <li>- Commitment to the training program</li> <li>- Entry level knowledge and skills in the management of commonly encountered medical and surgical issues</li> <li>- Relevant experience to allow the trainee to have developed entry level knowledge and skills in the management of commonly encountered medical and surgical issues</li> <li>- Entry level knowledge of anatomy and physiology relevant to training in RM</li> <li>- Demonstrated Professionalism</li> <li>- Potential to develop Leadership skills</li> <li>- Commitment to collaboration and team work</li> </ul> </li> <li>11. Develop entry to training standards with regards to experience and skills. For example: <ol style="list-style-type: none"> <li>a. Pre-requisite acute skills at entry, for example, having completed the ATLS (Advanced Trauma Life Support) or ACLS (Advanced Cardiovascular life support) prior to entry – though it is noted that these courses are in high demand and there may be access block to them.</li> <li>b. Pre-requisite recent acute care experience, For example, Intensive Care Unit term or Emergency Department term during the year prior to entry.</li> <li>c. Pre-requisite relevant clinical experience, For example: <ul style="list-style-type: none"> <li>- Completion of one year of Basic Training or</li> <li>- Within the last two years, trainee has completed at least one surgical and medical term from a list of relevant terms within an Australasian Health care setting For example: <ul style="list-style-type: none"> <li>▪ Medicine, eg neurology, geriatrics, rheumatology, general medicine, cardiology, respiratory</li> <li>▪ Surgery eg orthopaedics, neurosurgery, Vascular surgery, General surgery.</li> </ul> </li> </ul> </li> </ol> </li> <li>12. Increase time from completions of medical school to entry to training to three years (though this would bring RM further out of alignment from other training programs).</li> <li>13. Develop standardised methodologies for the implementation of entry to training criteria. <ol style="list-style-type: none"> <li>a. Interviews – either independent from employment interviews (conducted by AFRM / RACP) or combined with employment interviews (with RACP / AFRM representative on interview panel for positions at onset of training)</li> <li>b. Reference checks by AFRM prior to entry to training to review specific qualities of suitable trainee</li> <li>c. Other options such as Multiple mini interviews (a variant of OSCEs), Situational Judgement tests, Personal statements, Portfolios</li> </ol> </li> <li>14. Consider other options for entry to training. For example:</li> </ol>

	<ul style="list-style-type: none"> <li>a. Successful completion of Module 1 and 2 prior to entering training</li> <li>b. Basic Training (adult) – see later</li> </ul> <p>15. Reintroduce training exemptions for individuals who have completed relevant qualifications within a recent time period (eg General practice)</p>
<p>2. Challenges of fulfilling current training requirements within existing timeframes</p>	<p>16. Reduce curriculum content, change some content from core to non-core</p> <p>17. Reduce training program requirements</p> <p>18. Increase duration of training and / or introduce fellowship year, focusing on subspecialty area or research.</p> <p>19. Change timing of assessments (Modules 1 and 2 earlier, Fellowship examinations later – see later)</p> <p>20. Improve efficiency of current training program</p> <ul style="list-style-type: none"> <li>a. Improve coordination of individual training programs (see later)</li> <li>b. Enhance coordination of teaching and learning opportunities (see later)</li> <li>c. Improve efficiency of other elements of training program (see following sections)</li> </ul>
<p>3. Need for review of Rehabilitation Medicine Clinical Curriculum</p>	<p>21. Inclusion of additional curriculum content</p> <ul style="list-style-type: none"> <li>a. Topic areas, for example: Rehabilitation management in the patient with higher medical acuity, General medical topics, pulmonary Rehabilitation, Burns Rehabilitation, Cancer Rehabilitation</li> <li>b. Skills in techniques such as musculoskeletal sonography, and botulinum toxin injection, orthotics prescription.</li> </ul> <p>22. \Modify structure of curriculum to include general Rehabilitation topics separate form subspecialty areas</p> <p>23. Include topic weightings within the curriculum - informed by suggested data from Training Survey (Appendix 5)</p> <p>24. Change some more detailed curriculum content from “core” to “non-core”</p> <p>25. Introduce options for addressing such “non-core” elements of the curriculum, for example: compulsory but self-selected external training modules, fellowship year, Graduate Advanced Diploma</p>
<p>4. Timing and Content of Modules 1 and 2</p> <ul style="list-style-type: none"> <li>a. No syllabus for either assessment</li> <li>b. Limited support in preparation</li> <li>c. Rate of repeat questions in Module 1</li> <li>d. Module 2 pass standard too low</li> <li>e. Timing of Modules 1 and 2 too late</li> </ul> <p>Recent results for Module 1 and 2 examinations are shown in Appendix 6</p>	<p>26. Decide whether Modules 1 and 2 should remain part of the training program or whether they should change to be prerequisites for training</p> <p>27. Review options for enhancing content of Modules 1 and 2. For example:</p> <ul style="list-style-type: none"> <li>- Expand Module 1 question bank question bank for Module 1. Explore options for accessing other question databases (for example, other colleges, universities), and continue to encourage fellows to set questions</li> <li>- For Module 2 – give a greater focus to evaluation of communication skills – verbal, non-verbal and written</li> <li>- Invite acute care colleagues to be involved in setting the questions (including physicians and surgeons)</li> <li>- Expand the range of sources from which MCQs are obtained, continue to encourage fellows to prepare questions and explore alternative options for sourcing questions, for example, access to other MCQ databases</li> </ul> <p>28. If Modules 1 and 2 are to remain part of the training program, develop curriculum and supporting training program</p> <p>29. If Modules 1 and 2 remain as part of training program, change to barriers to progression to second year of training</p> <p>30. Obviate need for Modules 1 and 2 by changing training structure to Basic Physician training with Advanced Training in Rehabilitation Medicine via Adult Medicine Division.</p>
<p>5. Fluctuations in adult</p>	<p>31. Enable Fellowship examinations to be attempted from final year of</p>

<p>Rehabilitation Medicine Fellowship examination results (See Appendix 7)</p> <ol style="list-style-type: none"> <li>a. Timing</li> <li>b. Mismatch between content and clinical experience</li> <li>c. Removal of essay questions from Fellowship written examination</li> <li>d. MCQ database</li> </ol>	<p>training</p> <ol style="list-style-type: none"> <li>32. Change calendar timing of Fellowship clinical examination.</li> <li>33. Increase range of Fellows involved with fellowship examinations to enhance consistency between examinations and routine clinical experience</li> <li>34. Re-introduce essays into the Fellowship Written Examination,</li> <li>35. Broaden Fellowship written examination MCQ database<sup>4</sup></li> <li>36. Increase number of stations in FCE</li> <li>37. Introduce examination of “live patients” in the FCE</li> <li>38. Permit FCE examiners to repeat the question</li> <li>39. Review evidence supporting exit fellowship examinations</li> </ol>
<p>6. Utility of some aspects of External Training Modules</p> <ol style="list-style-type: none"> <li>a. Timing</li> <li>b. Adequacy of supporting course material</li> <li>c. Lack of individualised feedback</li> </ol>	<ol style="list-style-type: none"> <li>40. Map external modules against the curriculum to ensure that they are continuing to provide relevant educational value for trainees.</li> <li>41. Review need for provision of additional course material and teaching for External Training Modules to augment their educational value</li> <li>42. Provide specific individualised feedback to trainees to enhance the educational value of External Training Modules</li> <li>43. Investigate innovative and evidence based approaches for augmenting the delivery of External Training Modules, for example: courses, workshops, online modules and Webinars.</li> <li>44. Require completion of Behavioural sciences and Neuropsychology External Modules during second year of training</li> <li>45. Research module:             <ol style="list-style-type: none"> <li>a. Option for later completion of Research Module (encourage focused dedicated periods of research)</li> <li>b. Presentation of research at a scientific meeting is an additional required component for Research Module</li> <li>c. Accept university short course on statistics / research in lieu of the Research External Module.</li> <li>d. Establish and enhance national / International RM research networks to facilitate research collaboration to assist trainees with the Research Module (has more general advantages for the speciality)</li> </ol> </li> <li>46. Health Services Evaluation and Administration Module             <ol style="list-style-type: none"> <li>a. Develop a Rehabilitation Medicine specific course for Health Services Evaluation and Administration Module</li> <li>b. Include element of self-reflection / assessment for trainees who attend a course for Health Services Evaluation and Administration Module</li> </ol> </li> <li>47. Enhance Behavioural sciences Module by incorporating components addressing high level communication skills.</li> <li>48. Consider expansion of the range of External Training Modules for trainees to address “non-core” elements of clinical curriculum<sup>5</sup></li> </ol>
<p>7. Lack of coordination of the individual’s training program</p> <ol style="list-style-type: none"> <li>a. Lack of oversight of the breadth of clinical exposure throughout training</li> <li>b. Limited number of available positions in high demand rotations</li> <li>c. No provision of casemix information for training terms</li> <li>d. Limited use of mentors / professional development advisors</li> </ol>	<ol style="list-style-type: none"> <li>49. Enhance TLC authority for not approving proposed training programs where significant imbalances are identified regarding clinical setting, experience</li> <li>50. Centralised term allocation at the national or state level, taking consideration of preferences, seniority and stage of training, and previous clinical experience</li> <li>51. Introduce a compulsory non-metropolitan term during Advanced training</li> <li>52. Shorten duration of terms (to three or four months), especially for high-demand rotations</li> <li>53. Develop options for modular short-term clinical placements, could be allocated through a centralised online booking system. For example, week long placements in spinal unit, specialist ambulatory clinics, private settings. Would require consideration of insurance / accreditation implications</li> </ol>

4. Continue to encourage fellows to write questions, explore option of accessing other MCQ databases.

5. For example, musculoskeletal ultrasound, spasticity management, counselling, Rehabilitation in acutely unwell patients

	<p>54. Introduce logbooks / portfolios</p> <p>55. Make allocation of PDA compulsory for trainees and provide necessary support for PDAs.</p>
8. Usefulness of long case assessments	<p>56. Conduct all Formal Long Case Assessments during a specified time period in particular designated settings, or re-introduce into Fellowship Examination process</p> <p>57. Introduce maximum number of attempts for Formal Long Case</p>
9. Quality of and variations in teaching and learning opportunities <ul style="list-style-type: none"> <li>a. Variations in access</li> <li>b. Access to protected teaching time</li> <li>c. Lack of appropriately skilled clinicians and educators to develop and deliver the teaching and learning program</li> <li>d. Variability in individual teaching quality</li> <li>e. Availability of relevant teaching courses</li> <li>f. Variable trainee enthusiasm for teaching and learning</li> </ul>	<p>58. Review and update bi-national and state based teaching and learning strategies and programs so that they map to the curriculum and consistently and equitably deliver a contemporary program.</p> <p>59. Enhance delivery of bi-national training program through increased session frequency or by delivery in different formats that would enhance equity of access (for example, eLearning online modules, Webinars)</p> <p>60. Promote development and integration of learning networks at regional, state, national and international levels</p> <p>61. Review outcomes from and successful components of Sydney Fellowship examination preparation course and Victorian Rehabilitation Directorate for trainees as possible blueprints for other areas across Australasia.</p> <p>62. Develop AFRM courses on specific components of RM, for example, short course on a core component of the curriculum, or Graduate Diploma courses if some components of the RM curriculum were changed to ‘;non-core”</p>
10. Utility of Learning Needs Analysis and Trainee Term Evaluations	<p>63. Provide additional training regarding LNAs for trainees and supervisors to address identified gaps.</p> <p>64. Develop LNA templates for individual training sites and for stages of training which can then be individualised.</p> <p>65. Periodically provide de-identified trainee feedback to supervisors to assist with performance appraisal and supervisor accreditation</p>
11. Issues with some training settings <ul style="list-style-type: none"> <li>a. Accreditation process</li> <li>b. Suitability of some training settings</li> </ul>	<p>66. Provision of adequate resources to allow for more on-site accreditation visits to ensure suitability of training positions, particularly for new training sites, or for sites where specific concerns have been raised.</p> <p>67. Downgrade to JMO positions those which do not offer sufficient educational value, enhancing exposure to RM for JMOs.</p>
12. Supervision issues <ul style="list-style-type: none"> <li>a. Difficulties with giving negative feedback and dealing with trainees in difficulty</li> <li>b. Training program specific knowledge</li> <li>c. Lack of feedback for supervisors</li> <li>d. Inadequate supervision in some settings</li> </ul>	<p>68. Develop online support networks for RM supervisors</p> <p>69. Provide supervisors with past supervisor reports for current trainees</p> <p>70. Incorporate training and standard setting regarding other elements of the training program during long case calibration sessions</p> <p>71. Periodically provide de-identified trainee feedback to supervisors to assist with performance appraisal and supervisor accreditation</p>

Opportunities	Options / Actions
<p>1. Future workforce demands for Rehabilitation Medicine Fellows</p>	<p>72. Conduct RM workforce review (distribution, employment rate, settings, nature of work)                      73. Predict future workforce need (Fellows and trainees) .                      74. Predict future need for trainee inputs into RM training in Australasia                      75. Being informed by a RM workforce review and predicted future workforce needs, develop strategic plan to address future RM workforce needs across Australasia (with specific reference to regional; / state-based variations</p>
<p>2. Expansion of the role of RM:</p> <ul style="list-style-type: none"> <li>a) More RM in the acute setting</li> <li>b) Greater patient acuity in the subacute setting</li> <li>c) More “re-conditioning “ Rehabilitation</li> <li>d) Focus on continuum of management, ambulatory care programs, Rehabilitation of the older person, and managing chronic disability and aging with disability</li> </ul>	<p>76. Clarify future direction and scope of practice for RM via review of projections and consultation with RM community                      77. Define the knowledge and skills, and educational requirements for clinicians working in RM in the coming years                      78. Perform a gap analysis between existing and predicted training needs for RM                      79. Address gaps in predicted RM training needs:</p> <ul style="list-style-type: none"> <li>a. Curriculum update</li> <li>b. Change entry to training prerequisites (see previous section)</li> <li>c. Change structure of training program, for example, change to Basic Adult Physician Training followed by Advanced Training in RM. This option will be considered in greater detail in the main discussion paper, including curriculum mapping analysis of adult RM curriculum against Basic Training curriculum, development of a potential curriculum for Advanced Training under this model. This option is outlined further in the following section with review of how it would address components of the SWOT analysis</li> <li>d. Promote dual training, where trainees complete Basic Adult Physician training, followed by dual training in RM plus another adult speciality</li> <li>e. Promote joint training option, where trainees enrol in two programs, Basic Training and Rehabilitation Medicine</li> </ul>

Threats	Options / Actions
1. Institutions other than RACP offering Specialist training in RM	80. Conduct regular structured review of training program at predetermined time-points 81. Maintain engagement of RM community in training program as previously discussed
2. Adequacy of geographic distribution of RM trainees	82. Enhance RM workforce non-metropolitan settings: <ul style="list-style-type: none"> <li>a. Developing STP training positions</li> <li>b. Introduce compulsory non-metropolitan training period into training requirements</li> <li>c. Link more popular metropolitan terms to regional terms</li> <li>d. Develop short-term modular training options in non-metropolitan settings</li> <li>e. Enhance access to subsidised accommodation</li> <li>f. Training salary supplements.</li> </ul>
3. Rehabilitation Medicine Fellows not equipped to meet the evolving trends of the speciality <ul style="list-style-type: none"> <li>a. Suboptimal patient care</li> <li>b. Clinicians working on the margins of clinical practice</li> <li>c. Limitations to involvement in models of clinical care</li> <li>d. Detrimental impact on image and credibility of Rehabilitation Medicine</li> <li>e. Rehabilitation Medicine roles being taken on by other specialities</li> </ul>	83. Ensure training program equips Fellows in the expansion of the role of Rehabilitation Medicine 84. Promote understanding of RM by other clinicians, external bodies and patients

## **7. Overview of FRACP option for adult Rehabilitation Medicine training**

The potential move of adult Rehabilitation Medicine training to a training program with the post-nominal qualification of Fellow of the Royal Australasian College of Physicians (FRACP) 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 (BT) would precede Advanced Training (AT) in Rehabilitation Medicine (RM) via the Adult Division of Medicine resulting in the qualification of FRACP. The FAFRM qualification would no longer be offered.

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

AT in RM would probably be three years in duration. Other than removal of Modules 1 and 2, no other significant alternation to the current training program components would be necessary. The AT curriculum would be updated, with removal of approximately 25% of content already addressed in the BT curriculum.

As with other AT programs undertaken via Divisional Training, governance of AT in RM would be the responsibility of an Advanced Training Committee reporting to the Adult Medicine Division Education Committee. A change to this model of training would not be dependent on support from the Adult Medicine Division of the College and the formation of a Specialist Society in RM, though if one were to exist, it 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 BT for current AFRM Fellows could be explored, though the requirements for completing the BT written and clinical examinations would remain.

To give greater clarity on the potential impact of this model of training, it is mapped against aspects of the RM training program identified in the SWOT analysis in the Table 3.

Table 3 - Review of FRACP option with reference to SWOT analysis of AFRM Training program

Strengths	Advantage	Disadvantage	Neutral
5. Quality of the RM Training program	Quality of BT augments overall training program		AT in RM unaffected
6. Increasing adequacy of trainee numbers	Enhancement to trainee numbers: <ol style="list-style-type: none"> <li>1. Greater exposure to RM by BTs</li> <li>2. Stronger employment opportunities for graduating fellows</li> </ol>	Risk to trainee numbers <ol style="list-style-type: none"> <li>1. Perception of unpredictability of the BT examinations (not borne out by actual trends (Appendix 8))</li> <li>2. Disinterest in acute medicine</li> <li>3. Longer duration and cost of training</li> <li>4. Lifestyle factors associated with BT (for example, on-call, secondments)</li> <li>5. Dissuade those with surgical interest</li> <li>6. Additional assessment burden with requirements for BT and AT examinations</li> <li>7. Having completed BT, trainees unlikely to do AT in RM, instead choose area with higher profile, more lucrative areas</li> </ol>	
7. Engagement of RM community in the training program			Provided adequate member consultation
8. Effectiveness and responsiveness of the AFRM and educational benefits of being a Faculty of the RACP			AFRM roles taken on by other college areas
Weaknesses	Advantage	Disadvantage	Neutral
13. Entry to training criteria			
a. Entry to training too early	Trainees enter RM training 4 years post-graduation		
b. Lack of clear standards for entry to training	Medical knowledge and skills on entry to RM training improved	BT screens for medical knowledge / skills not necessarily attributes for success in RM	

c. Limited competition for registrar positions in some settings		Risk of less competition if insufficient AT in RM.	
d. Experience and knowledge of some International Medical Graduates entering training			Unaffected
e. Non recognition of prior learning for training and qualifications from other Colleges			Unaffected
14. Challenges of fulfilling current training requirements within existing timeframes			Probably unaffected – while curriculum content reduced by 25% and removal of Modules 1 and 2, training duration shorter (3 years).
15. Need for review of Rehabilitation Medicine Clinical Curriculum	RM curriculum would undergo extensive review		
16. Timing and Content of Modules 1 and 2 a. No syllabus for either assessment b. Limited support in preparation c. Rate of repeat questions in Module 1 d. Module 2 pass standard too low e. Timing of Modules 1 and 2 too late	Modules 1 and 2 no longer exist	Modules 1 and 2 screen for RM specific knowledge prerequisites (for example, surgery, anatomy, physiology) though these could be added to AT curriculum	
17. Fluctuations in adult Rehabilitation Medicine Fellowship examination results a. Timing b. Mismatch between content and clinical experience c. Removal of essay questions from Fellowship written examination d. MCQ database			Unaffected – though if retained, RM would be inconsistent with other AT programs.
18. Utility of some aspects of External Training Modules			Unaffected
19. Lack of coordination of the individual's training program			Unaffected
20. Usefulness of long case assessments			Unaffected
21. Quality of and variations in teaching and learning opportunities			Unaffected
22. Utility of Learning Needs Analysis and Trainee Term Evaluations			Unaffected
23. Issues with some training settings a. Accreditation process			Unaffected

b. Suitability of some training settings	Terms offering less advanced RM training opportunities may change to BT terms		
24. Supervision issues			Unaffected
<b>Opportunities</b>	<b>Advantage</b>	<b>Disadvantage</b>	<b>Neutral</b>
3. Future workforce demands for Rehabilitation Medicine Fellows	Enhances employability of Rehabilitation Physicians	Could threaten certainty of future RM workforce if inadequate trainee numbers	
4. Expansion of the role of RM	BT equips trainees with relevant knowledge and skills		
<b>Threats</b>	<b>Advantage</b>	<b>Disadvantage</b>	<b>Neutral</b>
1. Institutions other than RACP offering Specialist training in RM			Unaffected
2. Adequacy of geographic distribution of RM trainees		Risk to trainee numbers	
3. Rehabilitation Medicine Fellows not equipped to meet the evolving trends of the speciality	BT equips trainees with relevant knowledge and skills, mitigating these risks. FAFRM enhances image / credibility of RM		
<b>Other considerations</b>	<ul style="list-style-type: none"> <li>- Inclusion of additional RM material in BT would enhance RM knowledge for all physicians</li> <li>- Contributes to simplification to training pathways within College</li> </ul>	<ul style="list-style-type: none"> <li>- RM hierarchy – FAFRM versus FRACP resulting in employment inequity between FAFRM / FRACP (more significant issue for those with recent Fellowship).</li> <li>- RM is a speciality that lies outside the “medical model” of patient care, RM role is not to be an expert in the management of medical issues other than at a basic level</li> <li>- May result in dual fellowship not being available for paediatric trainees</li> </ul>	

## **8. *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.

This Executive Summary is provided to stimulate initial discussion amongst AFRM members whether at the AFRM Annual Members meeting on September 10th 2014 or not.

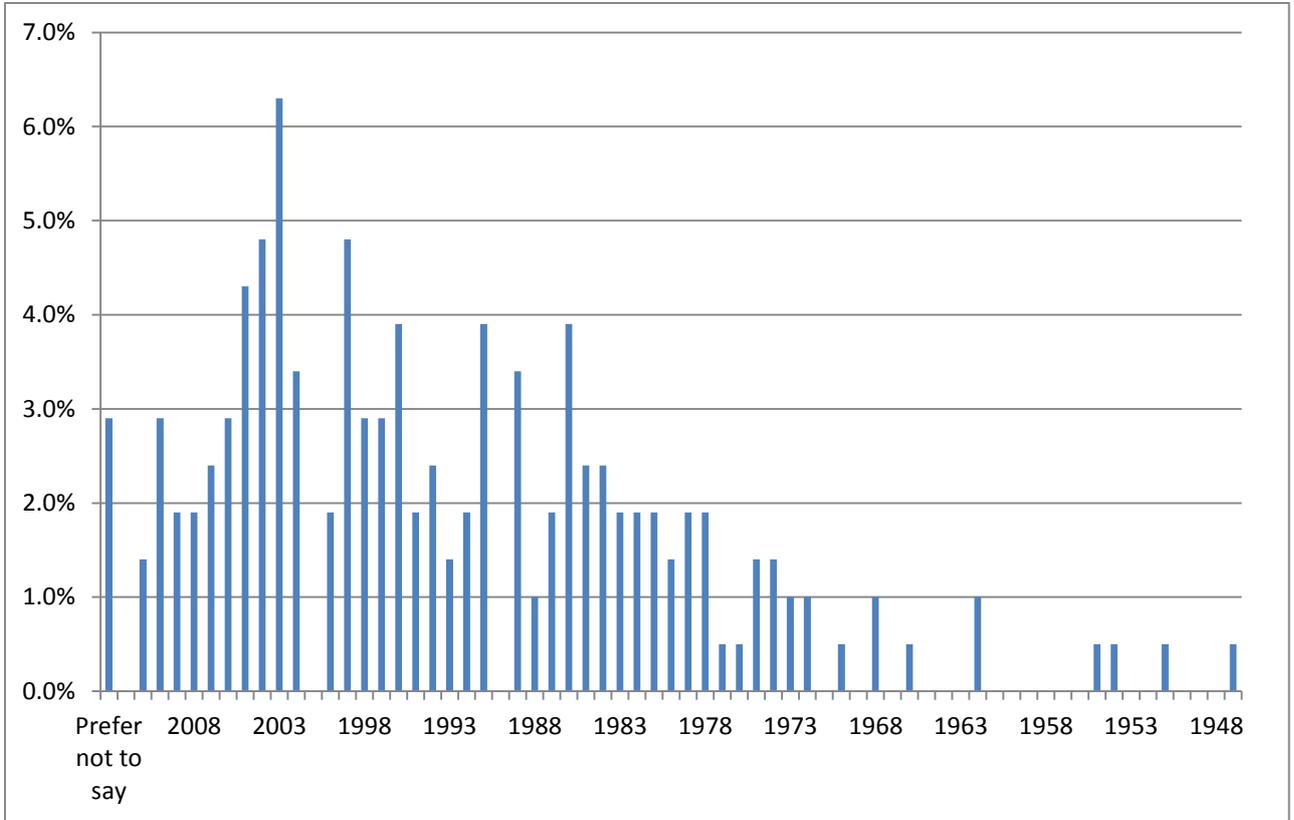
The full discussion paper will be sent to members by the end of November 2014

Feedback regarding the Executive summary and Discussion paper will be invited by email by the end of February 2015.

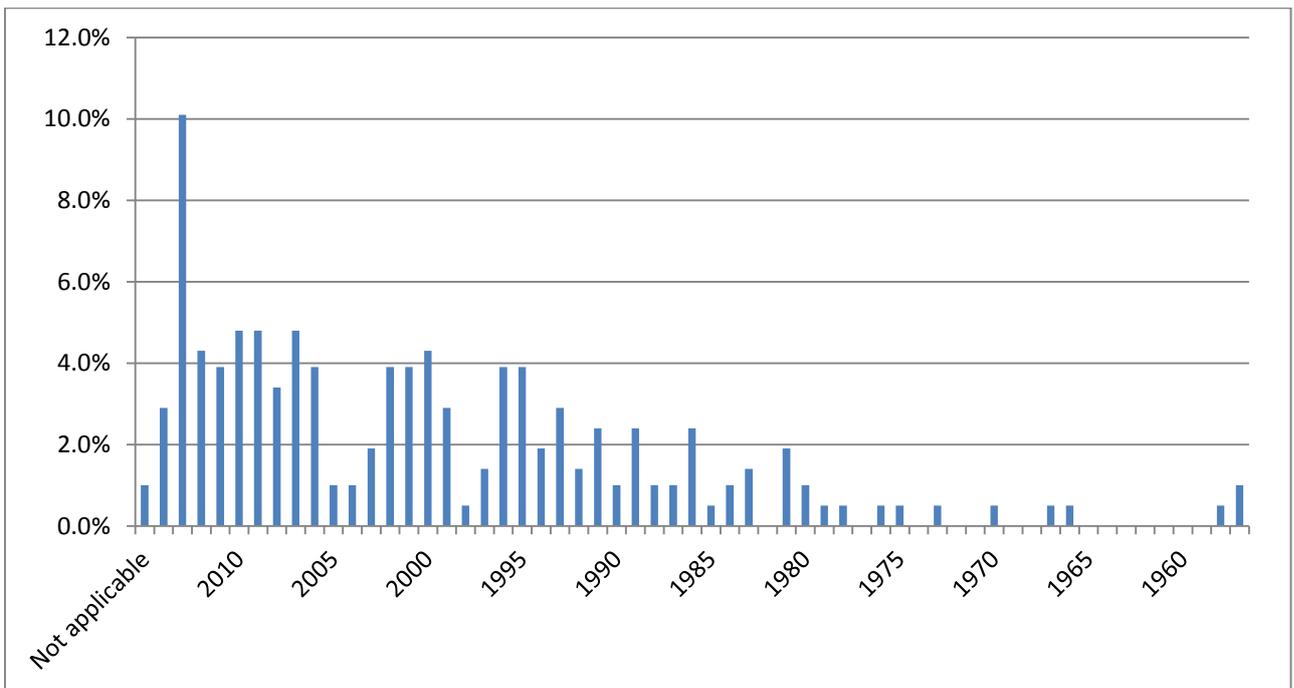
AFRM members will be invited to participate in a facilitated workshop in the first half of 2015 to further delineate the future directions of RM training in Australasia.

## Appendices

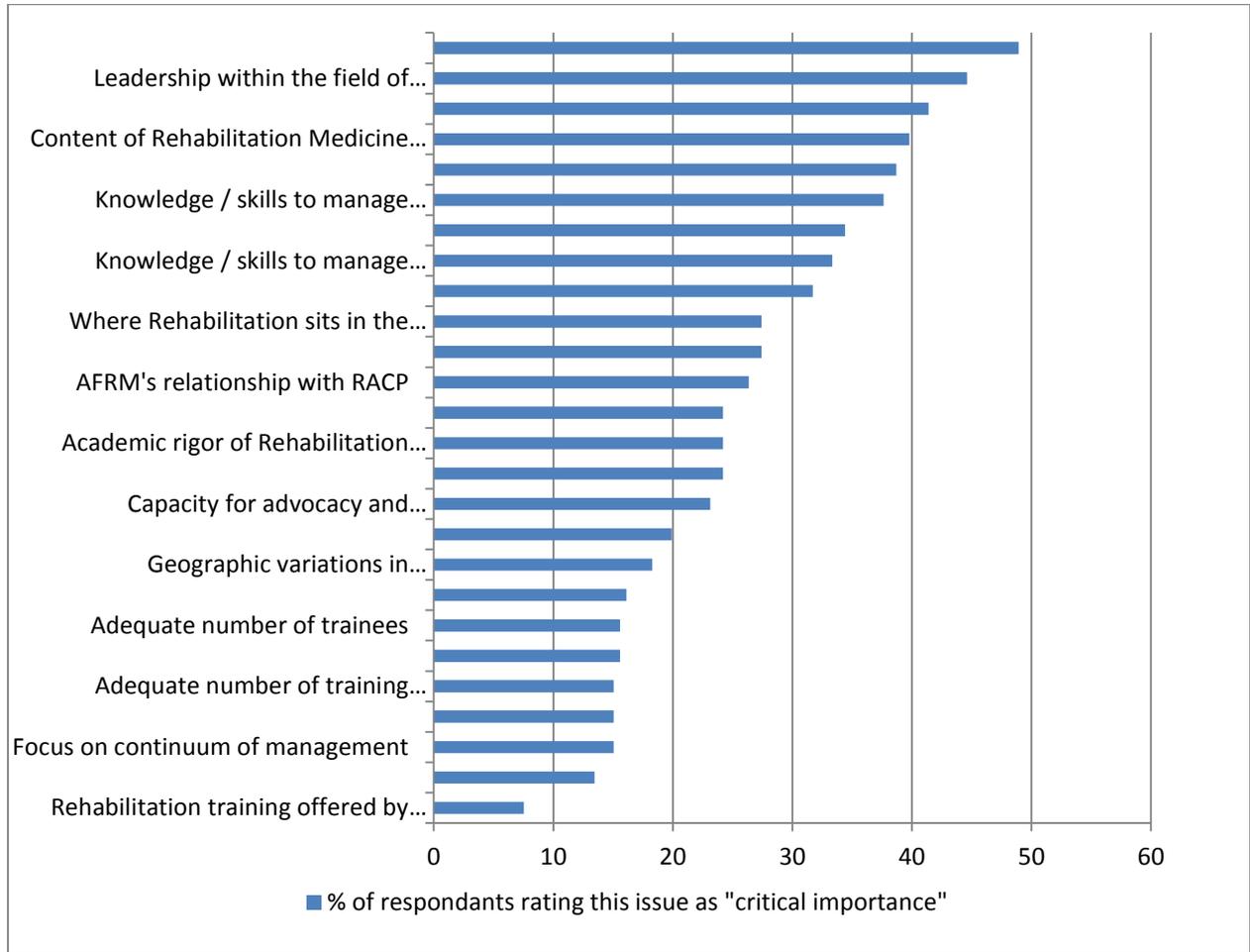
Appendix 1 – Results for question from Training Survey “In what year did you complete your primary medical degree?”



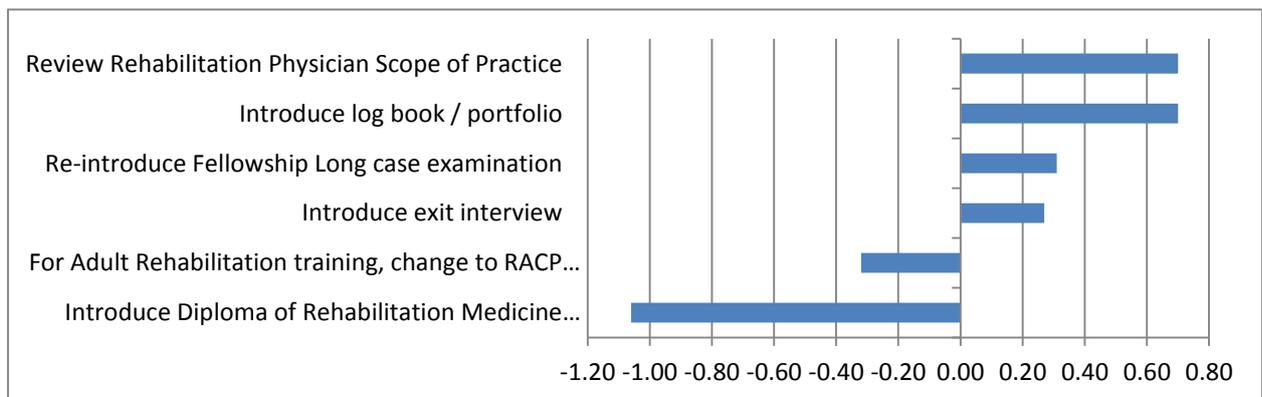
Appendix 2 – Results for question “In what year did you enter specialist training?” from Training Survey



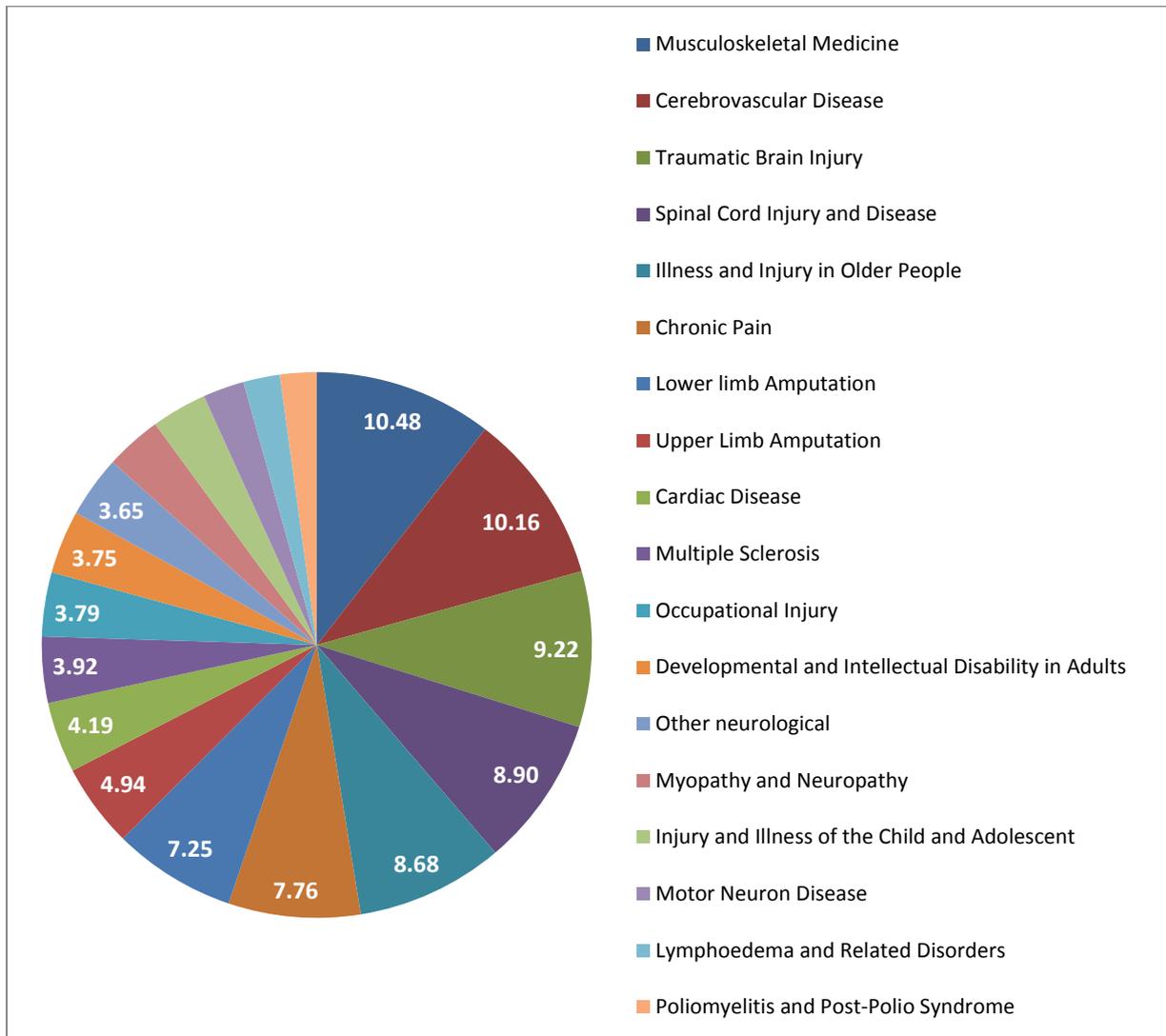
**Appendix 3 – Factors facing Rehabilitation Medicine in Australia and New Zealand over the next 10-20 years – percentage of respondents who identified issues as being of critical importance in response to this question: “In your opinion, how important will each of the following issues be for Rehabilitation Medicine in Australia and New Zealand in the next 10-20 years?”**



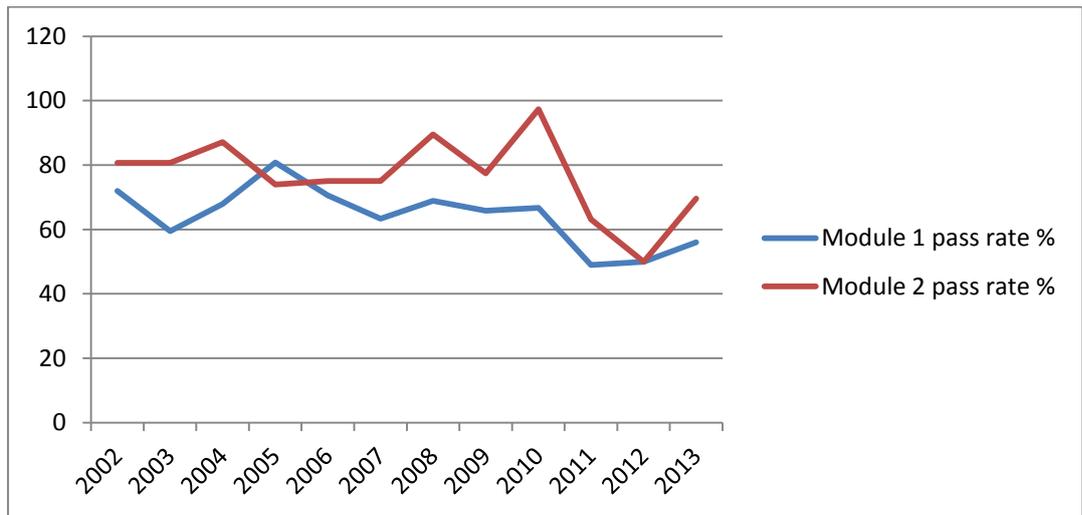
**Figure 1 – Rating response for presented options for Rehabilitation Medicine training. Respondants were asked to “Rate how strongly you agree or disagree” for each option on a seven point scale, with ratings between -3 and +3. This graph indicates the rating average for each option.**



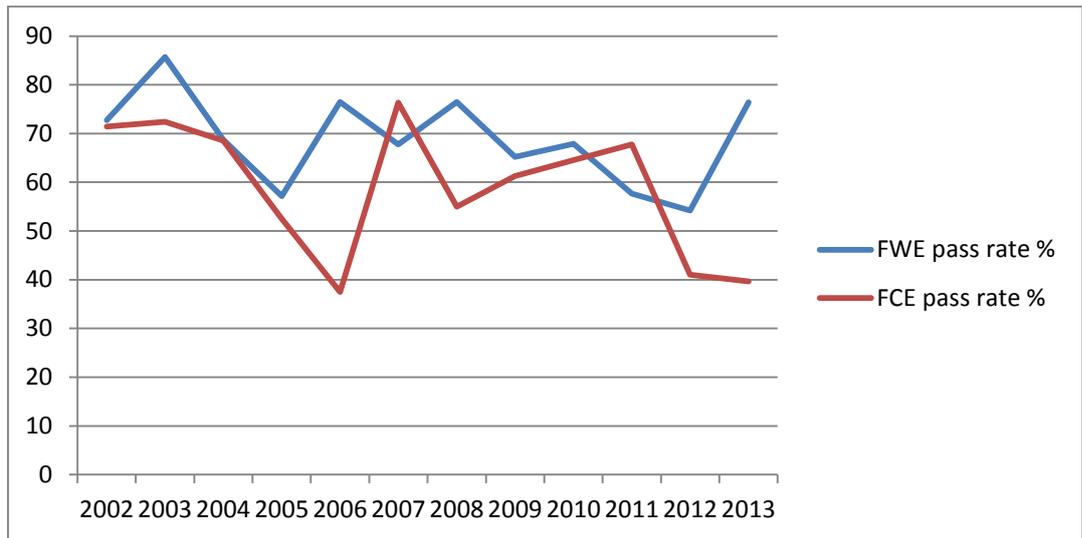
Appendix 5 – Suggested topic weightings (%) for curriculum – received from Training Survey – results from question: “The topic areas (themes) from the AFRM clinical Syllabus are listed below. For each, please indicate the weighting % you believe each should be assigned within the clinical syllabus.”



Appendix 6 – Results Adult Rehabilitation Medicine Module 1 and 2 examinations 2002 to 2013



Appendix 7 – Results Adult Rehabilitation Medicine Fellowship clinical and written examinations 2002 – 2013



Appendix 8 – Pass rates for BPT written and clinical examinations, and AFRM Module 1 and 2 examinations from 2007 to 2012

