AMC Workplace Based Assessment

Centre for Medical Professional Development

Assessor Information Booklet

Updated March 2023

NSW GOVERNMENT Health
Hunter New England
Local Health District

AMC WBA Program Team 2023

Professor Balakrishnan (Kichu) Nair AM..... Director, Centre for Medical Professional Development

Dr Timothy Walker…….. Clinical Dean, Calvary Mater Hospital

Dr Mulavana (Usha) Parvathy Director, Hospital Skills Program and International Medical Graduate Program

Dr Aditee Parab ……WBA Clinical Lead/Staff Specialist Dept. of Intensive Care John Hunter Hospital

Brooke Murphy..... Educational Consultant

Amy Neylan ..... Program Coordinator

WBA Office Contact Details

AMC Workplace Based Assessment Program
Centre for Medical Professional Development
PO Box 21
Waratah NSW 2298

Telephone: 02 49853313

Fax: 49853273

Email: HNELHD-WBA@health.nsw.gov.au

This document is true and correct at the time of printing on March 2023.. The AMC WBA Program Team reserves the right to make changes to terms and conditions of the WBA described in this document as necessary during the WBA period. Candidates will be informed in writing of any such changes.

Contents

Background

In 2010, the Centre for Medical Professional Development (CMPD), in collaboration with the University of Newcastle's School of Medicine and Public Health, was accredited by the Australian Medical Council (AMC) to conduct workplace based assessment (WBA) for international medical graduates (IMGs) in the standard pathway.

Hunter New England Local Health District (HNLEHD) was the first location in Australia where IMGs, seeking general registration through the AMC standard pathway, could be assessed using an alternative standard pathway offering workplace based assessment in place of the clinical examination.[1] Success in this process would lead to the granting of the AMC Certificate.

The strength of workplace based assessment lies in the direct observation of IMGs in their workplace. It involves having different assessment tools, used by multiple trained assessors in various clinical settings over an extended period of time. The process assesses the candidate's clinical skills as well as their communication skills and teamwork.

Regardless of the level at which an IMG is employed, all candidates in the AMC WBA Program are assessed as that of a graduate of an AMC-accredited medical program at the end of PGY1'1 (Internship).[1]

An essential part of the WBA Program is that at the conclusion of each Mini-CEX and CBD assessment candidates are provided with immediate constructive feedback by the assessor.

The AMC WBA Program is conducted over a six month period in hospitals within the Greater Newcastle Area, and Armidale and Tamworth Rural Referral Hospitals of HNELHD. Candidates are required to work for six months as a doctor in HNELHD prior to commencing the WBA Program.

1. AMC Workplace Based Assessment Resource Guide, 2009.

Assessor Training

An AMC requirement for Workplace Based Assessment is that all assessors attend an assessor training/calibration workshop and complete Module 3 of 'Teaching on the Run' prior to assessing. [Note: The WBA Program Team will organise training for those who have not yet completed the TOTR Module.]

For assessors who wish to familiarise themselves with more Mini-CEX assessments (including how to give feedback to candidates) the AMC WBA Resource Guides and DVDs are available for loan from the WBA Program Office.

Assessors are asked to email preferences to the WBA Program Office so that assessments can be timetabled to suit their availability.

Candidate Verification

Candidates have been instructed to wear their HNELHD Health photo ID (WBA candidate) to each assessment. Assessors are asked to verify the identity of candidates by checking their photo ID at the beginning of each Mini-CEX and CBD assessment.

Mini-CEX and CBD Assessments

No assessor may examine a candidate on more than one Mini-CEX per clinical area if possible. If requested, an assessor can have a second, more experienced assessor present at when conducting their first Mini-CEX or CDB assessment. This needs to be arranged beforehand with the Program Team.

- At the beginning of each Mini-CEX and CBD assessment, the candidate will take their allocated HNELHD WBA iPad to the assessment. Assessment must now only be completed electronically through the HPrime2 platform on the allocated iPads. The candidate will have the iPad opened at the correct assessment ready for the assessor to begin the assessment.
- At the completion of all Mini-CEX and CBD assessments the candidate will be ask the assessor to electronically sign on the iPad or if the form is being completed on a personal computer, the assessor signs the signature field with the mouse.

Each Mini-CEX assessment will take approximately 30 minutes, ie 10-15 minutes of the candidate-patient encounter and 10-15 minutes of immediate feedback. CBDs have the same time frame.

Assessors are encouraged to be frank, fair and fearless in their assessment of each candidate on each Mini-CEX and CBD as they are not the only assessor but one of a number of assessors who will determine the overall competence of each candidate.

Mini-CEX Assessments

Before the Assessment:

1 The WBA Program Coordinator will inform the assessor and candidate of the completion date for each Mini-CEX assessment and the specific clinical area being assessed (eg Physical Examination, History or Management).

2 The assessor will find an appropriate patient, ensure the patient consents and will be available at the required assessment time.

3 The assessor will arrange with the candidate when and where to meet for the assessment. This will be a mutually convenient time.

4 The candidate and assessor will meet at the scheduled time and place. The assessor will check the candidate's photo ID to verify they are assessing the correct candidate. The candidate will give the assessor their iPad and have it opened at the appropriate Mini-CEX assessment.

5 The assessor will brief the candidate on any information they need to undertake for the assessment. For example, if the subject of the Mini-CEX is 'Management' then the assessor will verbally summarise the relevant history, physical examination and diagnostic information for that patient. Assessors are asked not to change or embellish this briefing to make the case more interesting or testing.

6 The candidate will be allowed a few minutes to think about their approach to the patient interaction.

During the Assessment:

1 The candidate and assessor will go to the patient and introduce themselves. The assessor will explain to the patient that she/he will be observing the candidate and will not take part in the interaction.

2 The assessor will then 'step back' and observe the candidate's interaction with the patient for 10-15 minutes. At the end of the assessment the assessor and candidate will thank the patient and leave.

After the Assessment:

1 The assessor can ask one or two brief questions to clarify the candidate's reasoning. **However, this must not turn into a short case viva.**

2 The assessor can take a moment to think about and complete the assessment form. The assessor must complete all of the following sections:

- Assessor name
- Assessor position

The candidate assessment criteria:

- Medical interviewing / communication skills
- Professionalism / humanistic skills
- Organisation efficiency
- Clinical judgement / clinical reasoning
- History taking skills
- Physical examination skills
- Management skills

A rating must be given for each criteria ie:

- Below expected level = 1 or 2
- At expected level = 3
- Above expected level = 4 or 5

An overall Global rating of **Not Competent** or **Competent** must be given.

The assessor must provide a comment and describe:

- What was effective;
- What could be improved; and
- the overall impression

3 Where appropriate, areas for remediation may be recommended to the candidate.

4 Immediate feedback should then be given to the candidate, including their overall global rating. This should not be done in front of the patient, but preferably in a quiet, private environment.

5 The assessor must complete the Observation Time and Feedback Time.

6 At the completion of all Mini-CEX and CBD assessments the candidate will be ask the assessor to electronically sign on the iPad or if the form is being completed on a personal computer, the assessor signs the signature field with the mouse.

CBD Assessments

The WBA Program Coordinator will schedule and inform the assessor and candidate of the completion date for each CBD assessment.

The goal of CBDs is to assess the candidate's ability to discuss with the assessor the clinical reasoning involved in the clinical assessment, investigation, treatment, follow-up and overall clinical care of a particular patient. The CBDs also assess the candidate's record keeping abilities.

1 CBDs will take approximately twenty (20) minutes, followed by immediate feedback by the assessor on their performance for a further 10–15 minutes. The candidate's performance in the CBD is rated by the assessor using a standardised, structured rating form.

2 Candidates must undertake six (6) CBDs selected from their own patient cohort. The CBDs must be completed over the course of the 26 week WBA period.

- Four CBDs will be conducted from the candidate's patient cohort in the candidate's allocated discipline;
- Two CBDs will be conducted using patients that the candidate had been directly involved in managing and who had active co-morbid conditions in other disciplines eg a surgical patient with a co-morbidity in mental health.

Before the assessment . . .

3 For the four CBDs the candidate will undertake in the discipline that they work, the candidate will choose three (3) patients which they have seen in the previous two (2) weeks and provide the assessor with the MRN of each patient, age, gender and a brief description of their problem.

4 To qualify as a suitable patient for the assessment, the candidate must have made entries into the patient's clinical notes. A particular patient's case can only be used for one (1) CBD assessment (ie a new set of three (3) different patients must be provided for each CBD assessment).

5 The assessor will choose one patient to be subject of the assessment. The candidate will not be informed which of the patient cases the assessor has selected until the case based discussion assessment meeting.

6 For the remaining two CBDs the candidate will receive an email from the WBA Program Co-ordinator requesting the candidate to identify patients the candidate has been directly involved in managing that have a comorbidity outside of the clinical discipline the candidate is working in.

7 The patients identified by the candidate will be reviewed by the WBA Director and the Director will select which patient will be the subject of the assessment. The Program Coordinator will then notify the candidate and the assessor which patient case has been selected.

8 The candidate and the assessor will be informed by the WBA Program Coordinator of the date by which each patient based CBD should be completed.

9 The candidate must contact the assessor to arrange to meet at an appropriate time and venue to conduct the assessment.

During the assessment:

1 The candidate will take their iPad to the assessment and give to the assessor opened at the appropriate CBD assessment. The assessor and candidate will undertake the assessment based on the chosen patient. When the assessment is finished the assessor may need a moment to think about and complete the assessment form before giving the candidate their result and feedback.

After the Assessment:

1 The assessor can ask one or two brief questions to clarify the candidate's reasoning.

2 The assessor can take a moment to think about and complete the assessment form. The assessor must complete all of the following sections:

- Assessor name
- Assessor position

The candidate assessment criteria:

- Clinical record keeping
- History and examination
- Differential diagnosis and summary list
- Overall management plan (including follow-up, safety netting)
- Clinical judgement / clinical reasoning

A rating must be given for each criteria ie:

- Below expected level = 1 or 2
- At expected level = 3
- Above expected level = 4 or 5

An overall Global rating of **Not Competent** or **Competent** must be given.

The assessor must provide a comment and describe:

- What was effective;
- What could be improved; and
- the overall impression

3 Where appropriate, areas for remediation may be recommended to the candidate.

4 Immediate feedback should then be given to the candidate, including their overall global rating. This should not be done in front of the patient, but preferably in a quiet, private environment.

5 The assessor must complete the **Observation Time and Feedback Time.**

6 At the completion of the CBD assessments the candidate will be ask the assessor to electronically sign on the iPad or if the form is being completed on a personal computer, the assessor signs the signature field with the mouse.

Conflict of Interest

Assessors are reminded of the potential of conflict of interest in the assessment process. Ideally, an assessor should be at 'arm's length' and independent of the candidate. If a candidate is a relative or friend of an assessor, or if there is any potential conflict of interest, the assessment cannot proceed and the assessor should let the Program Team know as soon as possible.

Since every assessment is independent of all other assessments, candidates have been asked not to discuss their WBA progress and previous results with their assessors. If an assessor feels that a candidate is exerting pressure on them to pass, the assessor should halt the assessment and contact the Program Team immediately.

Candidate Appeals

The AMC WBA Program has an appeals process for candidates concerning the process of the assessment, including:

- personal circumstances (eg illness during the assessment);
- circumstances relating to the patient or the ward during the assessment (eg patient becoming unwell or a major disruption on the ward); or
- issues relating to the assessor's behaviour during the assessment (eg the assessor not allocating sufficient time for the assessment, taking phone calls during the assessment, etc).

Candidates are instructed to make appeals in writing to the WBA Program Director. They are instructed not to make appeals directly to individual assessors. The appeal will be reviewed in the first instance by the Director and if there are procedural issues, the candidate may be given further assessment after the review

If an appeal is made by a candidate the Program Director will contact the assessor to check the details before deciding what action is appropriate. If warranted, the appeal will go to the local WBA Program Appeals Committee. Further to that, candidates can appeal to the AMC Appeals Committee if a resolution cannot be achieved at the local level.

Candidate Level of Competence

All candidates, regardless of their current employment status, are to be assessed as that of a graduate of an AMC-accredited medical program at the end of PGY1'.[1]

(Refer to the accompanying material from the Confederation of Postgraduate Medical Education Council for a statement of skills and competencies for JMOs.)

1. AMC Workplace Based Assessment Resource Guide, 2009.

Feedback to Candidates

At the conclusion of each Mini-CEX and CBD assessment the assessor is asked to provide feedback to the candidate. This feedback needs to be honest, descriptive and constructive and to address any issues raised in the assessment form, particularly those relating to the critical (highlighted) items.

Where appropriate, remediation may be recommended to the candidate and documented in the assessment comments box. **Remediation is the responsibility of the candidate and WBA Program is not a bridging course for IMGs.**

(Refer to the accompanying material from the AMC WBA Resource Guide for useful tips on providing feedback to candidates.)

Assessors cannot offer to 're-do' the Mini-CEX or CBD if the candidate is not competent.

Program Dates

The WBA Program conducts two (2) programs per annum usually commencing in February and June/July. This could change depending on the number of candidates and to align with the AMC WBA Results Committee meetings.

Honorariums

Honorariums are paid to assessors at the conclusion of each AMC WBA Program period. The honorarium paid will depend on the number of assessments completed by individual assessors.

Program Office Contacts

If assessors have any questions relating to the AMC WBA Program or if any problems arise with assessments or candidates please contact:

Amy Neylan

Program Co-ordinator

WBA Program Office

PO Box 21

WARATAH NSW 2298

Or

Waratah Campus

Turton Road

WARATAH NSW 2298

Telephone - 49853313

Email: HNELHD-WBA@health.nsw.gov.au

Note: In an emergency, if you are unable to reach the WBA Program Office, contact Professor Kichu Nair through John Hunter Hospital switchboard on telephone 02 49213000.

NOTES:

Mini-CEX "How to" Steps – Assessors Guide

The Mini-CEX is a standardised and validated assessment tool. It involves the direct observation of a candidate in a clinical encounter with a patient for 10 – 15 minutes followed by immediate feedback by the assessor on their performance for a further 10 – 15 minutes. The candidate's performance in the Mini-CEX is rated by the assessor using the AMC standardized National WBA Assessment eform, through the Hprime system. The candidates are assessed at PGY1 level.

1. The candidate will contact the assessor and arrange a time and place to meet to do the assessment. The assessor has the main hand in deciding this but its good if you can agree on a time and place that is mutually acceptable.

2. The assessor will have to locate a patient that agrees be seen for the assessment. You need to match the patient to the type of assessment the candidate is scheduled to do (eg. History or Physical Examination or Management and so on). Explain to the patient that they will be part of an assessment and that you will correct any misconceptions or answer any questions that arise in the course of the assessment after they have been seen by the candidate.

3. At the appointed time you need to meet with the candidate and brief them on the patient's specifics which are relevant to the type of assessment. For example for a Management Mini-CEX you could brief them on the following: presentation/history, examination findings and any relevant test and investigation results, and presumably the diagnosis. Most assessors doing Management Mini- CEX assessments for example then do a brief Q&A on what the candidate thinks the management should be or entail and what they think they should say to the patient. This avoids the patient getting entirely the wrong story. This should not become a short case or a case based discussion.

4. **Defining the task**: **It is most important that the candidate leaves the briefing knowing exactly what you want them to do during their time with the patient: eg. "Discuss with the parents and child the discharge instructions for asthma" or "Take history relevant to Mr Jones's chest pain".**

5. The assessor takes the candidate to the patient to observe them interacting with the patient. **Your assessment is based on what you observe in this time.**

6. The assessor completes the assessment on the candidates HNELHD WBA iPad. The candidate will have the iPad opened at the appropriate assessment ready for the assessor to commence the assessment.

7. REGARDLESS OF HOW YOU SCORE ANY OF THE ITEMS (INCLUDING 1 or 2 which is "below expected level), you still need to give a "GLOBAL RATING" at the bottom of the form which is your overall assessment of the candidate's performance during the Mini-CEX. If any items on the score sheet are scored less than 3, these can be used as the basis for candidate immediate feedback. However, the GLOBAL RATING is your overall rating of the candidate's performance and professionalism in all areas.

8. The assessor will find a quiet place nearby, away from the patient, to give the candidate their result and feedback. Once you have finished scoring the candidate, you give them immediate feedback. We have told the candidates not to argue about your scoring and do not get into a debate with the candidate on their performance. Give your honest opinion on their performance. If the candidate wants to argue then you should tell them that they should use the normal appeal procedures if they have a problem.

9. At the completion of all Mini-CEX and CBD assessments the candidate will be ask the assessor to electronically sign on the iPad or if the form is being completed on a personal computer, the assessor signs the signature field with the mouse.

Tips for Assessors Conducting Mini-Clinical Evaluation Exercises (Mini-CEXs)

Here is a quick way of determining what needs to be done:

A

Appropriate for Intern level.
Appropriate patient – choose the right patient eg

- Physical Examination – choose a patient with definite signs
- History Taking – choose a patient where one can diagnose etc

B

Brief the patient and the candidate.
Patient may need debriefing too.

C

Competent or Not Competent is the term now used for the GLOBAL RATING.

D

Doubt
If in doubt about the process or completion of the form or the end result, please contact Professor Kichu Nair to discuss prior to asking the candidate to sign the form. Telephone 4985 3313 or speed dial 67042.

E

Education
The Mini-CEX has educational value and this is the reason for the feedback.

F

Feedback
You need to give constructive feed back to the candidate irrespective of the result.

Updated August 2019

Mini-CEX assessment form

Australian Medical Council Limited

Logo placement area

Candidate and assessor information

AMC candidate name		AMC candidate number	
Assessor name		Assessor position	

This Mini-CEX assesses the following domains (multiple options can be selected):

History ☐	Physical examination ☐	Management/Counselling ☐	
Clinical judgement ☐	Communication skills ☐	Working in a team ☐	Professionalism ☐
Cultural competence ☐		Patient safety and quality of care ☐	

Patient information

Age		Gender		Setting *(E.g. ED/GP/Ward)*		
Real Patient	Direct observation of an encounter with a real patient is mandatory.					
Problem(s)						
Please circle clinical area	Adult medicine	Adult surgery	Women's health	Child health	Mental health	Emergency medicine

Please record a rating for each criterion on the scale 1 (extremely poor) to 5 (extremely good). A score of 1-2 is considered below expected level, 3 at expected level and 4-5 above expected level, at the standard of an Australian graduate **at the end of PGY1**. The criteria where there are no **N/O** (*not observable in this encounter*) boxes are mandatory and must be rated for each assessment. Assessors should note that over all the encounters observed it is expected that all attributes are observed and scored at least once. Support all ratings with an explanation / example in the comments box.

Candidate assessment criteria	Below expected level		At expected level	Above expected level		
1. Medical Interviewing and Communication Skills	1	2	3	4	5	
2. Professionalism / humanistic skills	1	2	3	4	5	
3. Organisation / efficiency	1	2	3	4	5	
4. History taking skills	1	2	3	4	5	N/O
5. Physical examination skills	1	2	3	4	5	N/O
6. Counselling, education and management skills	1	2	3	4	5	N/O
7. Clinical judgement / clinical reasoning	1	2	3	4	5	

Global rating An overall rating of this doctor's performance and professionalism in all areas. The global rating is not an algorithmic calculation of the candidate assessment criteria ratings but a judgement about the overall performance of the candidate.

Not competent ☐ Competent ☐

Assessors comments (*compulsory*) Please describe what was effective, what could be improved and your overall impression. If required, please specify suggested actions for improvement and a timeline.

Signature of Assessor:		Signature of Candidate:	
Date: / /		Date: / /	
Observation time:		Feedback time:	

Mini-CEX

The mini-clinical evaluation exercise is the process of directly observing a doctor in a focused patient encounter for the purposes of assessment. It entails observing a candidate perform a focused task with a real patient such as taking a history, examining or counselling a patient. The assessor records judgments of the candidate's performance on a rating form and conducts a feedback session on the candidate's performance.

Descriptors of criteria assessed during Mini-CEX

Medical Interviewing and Communication Skills

- Facilitates patient's telling of story and explores the patient's problem(s) using plain English.
- Effectively listens and uses questions/directions to obtain accurate/adequate information needed
- Responds appropriately to affect non-verbal cues, establishes rapport.

Professional/humanistic skills

- Is aware of safety issues; washes hands; maintains a professional approach to patient; demonstrates an understanding of the role of teams in patient care; attends to the patient's needs of comfort and any disabilities; and is respectful of colleagues Is open honest, empathetic and compassionate.

Organisation/efficiency

- Makes efficient use of time and resources; is practised and well-organised.

History taking skills

- Uses questions effectively to obtain an accurate, adequate history with necessary information; clearly identifies presenting problem and other active problems; identifies relevant features of past, social and family history.

Physical examination skills

- Follows an efficient and logical sequence; performs an accurate and relevant clinical examination; explains process to patient; correctly interprets any significant abnormal clinical signs.

Counselling, education and management skills

- Demonstrates an understanding of different cultural beliefs, values and priorities regarding their health and health care provision, and communicates effectively; manages informed consent; appropriate level of information provided; ability to use available educational resources; provides accurate information according to best practice guidelines; recommends sources of quality information.

Clinical judgement/clinical reasoning

- Integrates and interprets findings from the history and/or examination to arrive at an initial assessment, including a relevant differential diagnosis; interprets clinical information accurately; and counselling takes account of the patient's socio-economic and psychosocial circumstances. Considers patient safety as a priority

Global rating

- An overall judgement of performance at the expected level of an Australian graduate at the end of PGY1.

Tick* those questions you'd like to ask; *add any others not on this sheet but specific to the case under discussion
Stick to the 'there and then'; don't go into the future (i.e. no "what if" questions)

Competence	Proposed Questions	Evidence Obtained
Practising holistically *(physical, psychological, socio-economic and cultural dimensions; patient's feelings and thoughts)*	☐ What do you think was the patient's agenda (her I.C.E.)? How did you elicit this? Why present now? ☐ What effect did the symptoms have on her work, family and other parts of her life? *(illness vs. disease)* ☐ How did the symptoms affect her psychosocially? What phrase(s) did you use? ☐ What prior knowledge of the patient did you have which affected the outcome of your consultation(s)? ☐ Did you identify any ongoing problems which might have affected this particular complaint? ☐ How did you establish the patient's point of view? What consultation skills did you use to do this? Other Qs	**Note:** In general, when asking the GPR to present the case, ask them to also say: 1. what **issues** they felt the case **raised** 2 what **issues** they felt **needed resolving** 3 what bits they found **challenging/difficult** **This will help you focus your questions.** ☐ Needs develpmt. ☐ Comptnt ☐ Excllnt ☐ Not assessd
Data gathering and interpretation *(gathering and using data for clinical judgement, the choice of examination and investigations and their interpretation)*	☐ Ask about the specifics of the case and diagnoses eg what biological features of depression did she show? How long did she have it for? etc ☐ What bits of information did you find helpful in this case? Why? How did you phrase that? ☐What other information did you use to help formulate your diagnosis/decision? ☐ Did you refer to any previous investigations to help you? What were they? ☐ What skills did you use to obtain the history in this case? ☐ What examination did you make? ☐ I see from the notes that there is no reference to examining her "chest"; Do you think this might have been helpful? In what way? ☐ Had you gathered any further information about this case from others? ☐ Was there any other information you would have liked? How would that have helped you? Other Qs	☐ Needs develpmt. ☐ Comptnt ☐ Excllnt ☐ Not assessd
Making diagnoses & decisions *(conscious, structured approach to decision-making)*	*DIAGNOSIS* ☐ What were you particularly worried about in this case? ☐ How did you come to your final diagnosis? Remind me which bits of the history and examination were instrumental in this? ☐ Did you use any tools or guidelines to help you? *TREATMENT* ☐ What were your options? Which did you choose? Why this one? Convince me that you made the right choice. ☐ Did you consider any evidence in your final choice? Tell me about it? ☐ How did the patient feel about your choice of treatment? Did this influence your final decision? ☐ Did you consider the implications of your decision for the relatives/doctor/practice/society? Tell me more about how they might feel? How did this influence your final decision? ☐ Did you use any framework or model to help justify your decision? Other Qs	☐ Needs develpmt. ☐ Comptnt ☐ Excllnt ☐ Not assessd
Clinical Management *(recognition and management of common medical conditions)*	☐ What made you prescribe xxx? How did you come to choosing that? What does the evidence say about it? ☐ Had you thought of any other options at the time? What were they? Tell me about some of the pros and cons of these options so I can get an idea of why you went for what you did. Do you know the evidence behind any of these? What were your main priorities here? ☐ Why did you do those investigations? What were you looking for? ☐ Why did you make that referral? What worried you that led to that referral? Did you speak to them? What were you hoping the referral might achieve? What did you actually put in the referral letter?	

	☐ Did you put into place any follow up/review? How long? Why do you want to see her again? Other Qs	☐ Needs develpmt. ☐ Comptnt ☐ Excllnt ☐ Not assessd
Managing medical complexity *(beyond managing straight-forward problems, eg managing co-morbidity, uncertainty & risk, approach to health rather than just illness)*	☐ How did you generally FEEL about this case? ☐ Do you think the patient kind of pushed you into investigation/referral/treatment with abx? How do you feel about this? What have you learned from this case? ☐ What did you do to alter her help seeking behaviour? ☐ Was there a difference of agendas? How did you tackle this? (eg demanding patient, difficult angry patient, overbearing heartsinks etc). Tell me exactly how you managed to merge agendas. ☐ What made this case particularly difficult? How did you resolve that? ☐ Were there any ongoing problems that added to the complexity of this case? Other Qs	☐ Needs develpmt. ☐ Comptnt ☐ Excllnt ☐ Not assessd
Primary care admin and IMT *(primary care admin systems, effective recordkeeping and online info to aid patient care)*	☐ Look at the registrar's electronic recording of information. Do you think it was satisfactory? Ask what the registrar thinks on reflection- "Do you think what you have documented is adequate?" Any important negatives left out? The patient's narrative? Concise yet thorough? ☐ Did you use any online information to help you? What? How? Other Qs	☐ Needs develpmt. ☐ Comptnt ☐ Excllnt ☐ Not assessd
Working with colleagues and in teams *(working effectively; sharing information with colleagues)*	☐ Did you involve anyone else in this case? Why? How did they help? ☐ Did you involve any other organisations in this case? For what purpose? ☐ How did you ensure you had effective communication with others involved in this particular case? ☐ If many people/organisations are involved in the case, ask: "What do you see as your role considering loads of people are involved in this case?" Other Qs	☐ Needs develpmt. ☐ Comptnt ☐ Excllnt ☐ Not assessd
Community orientation *(management of health and social care of local community)*	☐ Did you think about the implications of your treatment/investigations/referral on the individual patient and on society? Tell me more…OR Is there a potential for harm in the way you approached this case? OR Can you see any ethical dilemmas in this particular case? OR Had you any ethical considerations when dealing with this case? Tell me more. ☐ Had you any thoughts at the time about the cost of treatment/investigation/referral? Other Qs	☐ Needs develpmt. ☐ Comptnt ☐ Excllnt ☐ Not assessd
Maintaining an ethical approach to practice *(ethical practise, integrity, respect for diversity)*	☐ What ethical principles did you use to inform your choice of treatment? ☐ How did you ensure the patient had an informed choice when it came to management? What are patients' rights? How did this influence your handling of the case? ☐ Sick Notes – individual vs. society thing. Other Qs	☐ Needs develpmt. ☐ Comptnt ☐ Excllnt ☐ Not assessd

Fitness to practise *(awareness own performance, conduct or health, or of others; action taken to protect patients)*	☐ Excluding the serious stuff eg What alarm features did you enquire about?; How did you carry out a suicidal risk assessment?; How did you know her headaches are not a result of a brain tumour?; How did you exclude a brain tumour? ☐ Safety Netting – How did you close the consultation with the patient? Did you advise on when to come back? What did you actually say? ☐Are there any other responsibilities you have to patients in general? How do they apply to this case? How did you make sure you observed them? Why are they important? ☐ Did you use a chaperone? ☐ Did you wear a glove before taking blood/doing a PV/PR/giving the injection? Other Qs	☐ Needs develpmt. ☐ Comptnt ☐ Exclint ☐ Not assessd

KEYPOINTS

- Case selection is dead important
- KISS principle - Keep It Simple!
- CBD needs preparation on both parts - trainer and registrar. Look at the case prior to the meeting! Don't try and blag it.
- Some of the questions can be mapped out before hand - the "aid" will help you with this
- Remember, the aim is to stay in the "here and now". Questions should be based on the "here and now" eg *what were her concerns then? what did she think was going on? How did you elicit that?* That is how it differs from RCA, which often enables one to go into fantasy... (but it must not be forgotten, is still a valuable tool). Also, with RCA, you can go anywhere (analogy: branches of a tree). But with CBD, you have to ask questions to assess the areas of competence they want you to assess; don't leave the path!
- So, stay away from "what if....." questions. You can ask them: *"what is your next step?"* but **not** take them down a line of hypothetical exploration.
- No need to panic. You've got til 2008 to get used to it

Case-based discussion assessment form

Australian Medical Council Limited

Logo placement area

Candidate and assessor information

AMC candidate name		AMC candidate number	
Assessor name		Assessor position	

This Case-based discussion assesses the following domains (multiple options can be selected):

History ☐	Physical Examination ☐	Management/Counselling ☐	
Clinical Judgement ☐	Communication Skills ☐	Working in a team ☐	Professionalism ☐
Cultural Competence ☐		Patient Safety and Quality of Care ☐	

Patient information

Age		Gender		Setting *(E.g. ED/GP/Ward)*		
Real Patient	Direct observation of an encounter with a real patient is mandatory.					
Candidate involved in patient's care	Y ☐ N ☐					
Problem(s)						
Please circle Clinical area	Adult medicine	Adult surgery	Women's health	Child health	Mental health	Emergency medicine

Please record a rating for each criterion on the scale 1 (extremely poor) to 5 (extremely good). A score of 1-2 is considered below expected level, 3 at expected level and 4-5 above expected level, at the standard of an Australian graduate **at the end of PGY1**. The criteria where there are no **N/O** (*not observable in this encounter*) boxes are mandatory and must be rated for each assessment. Assessors should note that over all the encounters observed it is expected that all attributes are observed and scored at least once. Support all ratings with an explanation / example in the comments box.

Candidate assessment criteria	Below expected level		At expected level	Above expected level		
1. Clinical record keeping	1	2	3	4	5	
2. Differential diagnosis and summary list	1	2	3	4	5	N/O
3. Management plan – Investigations, treatment and follow-up	1	2	3	4	5	N/O
4. Clinical judgement / clinical reasoning	1	2	3	4	5	

Global rating An overall rating of this doctor's performance and professionalism in all areas. The global rating is not an algorithmic calculation of the candidate assessment criteria ratings but a judgement about the overall performance of the candidate.

Not competent ☐ Competent ☐

Assessors comments (*compulsory*) Please describe what was effective, what could be improved and your overall impression. If required, please specify suggested actions for improvement and a timeline.

Signature of assessor:		Signature of candidate:	
Date: / /		Date: / /	
Observation time:		Feedback time:	

Case-Based Discussion (CBD)

Case-based discussion is an assessment focused on discussion of a case record of a patient for whom the candidate has been involved in their care. Usually, the candidate selects the medical records of two or three patients they have helped manage. An assessor selects one of the records and discusses patient care with the candidate and provides feedback at the completion of the discussion. The goal of the discussion is to assess the candidate's clinical reasoning in relation to the decisions made in the patient assessment, investigation, referral, treatment and follow-up. The technique can also allow assessment of the candidate's professionalism and record keeping.

Descriptors of criteria assessed during the CBD

Clinical record keeping

- Demonstrates clarity in structure and content of the record in the patient's notes:
  History, physical examination, summary and problem list, management plan, procedures and operations, progress notes and treatment chart
- Creates notes that are satisfactory for use by other health professionals caring for that patient and for the doctor's own use in following up the patient

Differential diagnosis, summary and problem list

- Provides appropriate summary/diagnostic formulation and problem list
- Relates the patient's symptoms to the examination findings to form a diagnosis
- Communicates the clinical assessment in an appropriate manner to the patient

Management plan – Investigations, treatment and follow-up

- Demonstrates critical selection of investigations that will most efficiently assist with the diagnostic formulation and problem management
- Chooses treatment that is evidence-based and effective for the patient in his/her context
- Chooses medications and other treatments in keeping with the requirements of the health service
- Documents clearly the treatments ordered on the treatment chart
- Informs the patients and, where appropriate, obtains formal consent
- Includes follow-up as part of the discharge process from a hospital or clinic setting
- Includes investigations, treatment, prevention and patient education in the management plan
- Follow-up is made at a time appropriate for the clinical problem

Clinical judgement /clinical reasoning

- Demonstrates a successful problem solving process, including collection of data, evaluation of information and formation of decisions about diagnosis, prognosis, treatment and prevention

Global rating

- An overall judgement of performance at the expected level of an Australian graduate at the end of PGY1.

Multisource feedback assessment form (*Medical colleague*)

Australian Medical Council Limited

Logo placement area

Candidate and medical colleague assessor information			
AMC candidate name		AMC candidate number	
Assessor name		Assessor position	

This Multisource feedback form assesses the following domains (multiple options can be selected):

History ☐	Physical Examination ☐	Management/Counselling ☐	
Clinical Judgement ☐	Communication Skills ☐	Working in a team ☐	Professionalism ☐
Cultural competence ☐		Patient safety and quality of care ☐	

Please record a rating for each criterion on the scale 1 (extremely poor) to 5 (extremely good). A score of 1-2 is considered below expected level, 3 at expected level and 4-5 above expected level, at the standard of an Australian graduate **at the end of PGY1**. The criteria where there are no **N/O** (*not observable in this encounter*) boxes are mandatory and must be rated for each assessment. Assessors should note that over all the encounters observed it is expected that all attributes are observed and scored at least once. Support all ratings with an explanation / example in the comments box.

This doctor:	Below expected level		At expected level	Above expected level		
1. Communicates well with patients	1	2	3	4	5	
2. Reaches the correct diagnosis in a timely manner	1	2	3	4	5	N/O
3. Refers patients appropriately	1	2	3	4	5	N/O
4. Provides appropriate information for colleagues to provide follow-up patient care	1	2	3	4	5	N/O
5. Accepts responsibility for care of ongoing issues	1	2	3	4	5	N/O
6. Provides pertinent and timely information about patients when required	1	2	3	4	5	N/O
7. Recognises and takes action when urgent intervention is required	1	2	3	4	5	N/O
8. Takes responsibility for actions and decisions	1	2	3	4	5	
9. Demonstrates appropriate clinical judgement	1	2	3	4	5	
10. Maintains patient confidentiality	1	2	3	4	5	
11. Works well with colleagues	1	2	3	4	5	
12. Speaks respectfully of colleagues in conversations with patients and co-workers	1	2	3	4	5	
	1		3			

Multisource feedback assessment form (*Medical colleague*)

13.	Documents care appropriately		2		4	5	
14.	Is willing to take responsibility for error						

This doctor:	Below expected level		At expected level	Above expected level		
15. Contributes to administrative practices supporting good medical care (office protocols, timely reports / information flow)	1	2	3	4	5	N/O
16. Writes prescriptions and orders clearly	1	2	3	4	5	N/O
17. Appears committed to and current with advances in medical education	1	2	3	4	5	

Global rating An overall rating of this doctor's performance and professionalism in all areas. The global rating is not an algorithmic calculation of the candidate assessment criteria ratings but a judgement about the overall performance of the candidate

Not competent ☐ Competent ☐

Assessors comments (*compulsory*) Please add comments about this doctor's strengths and weaknesses that support your ratings. All comments are deidentified and aggregated for feedback.

Signature of assessor: _____ Date: ☐☐ / ☐☐ / ☐☐

Observation time: _____ Feedback time: _____

Multi-source feedback (MSF)

Multi-source feedback provides evidence on performance of a candidate from a variety of sources. These sources may include colleagues, other co-workers (nurses, allied health) and patients. Questionnaires completed by each of these groups assess a candidate's performance over time in contrast to a specific candidate encounter. MSF enables the assessment of proficiencies that underpin safe and effective clinical practice, yet are often difficult to assess including interpersonal and communication skills, team work, professionalism, clinical management and teaching abilities.

The following pages are an extract from the Australian Medical Council's Workplace Based Assessment Resource Guide booklet dated November 2009.

7. FEEDBACK TO CANDIDATES

The role of feedback in workplace-based assessment

The built-in feedback loop is one of the notable advantages of workplace-based assessment over other assessment formats. Workplace-based assessment is based on IMGs seeing real patients, and feedback given enables the setting of action plans for improved performance in the future.

Feedback enables the setting of action plans for improved performance in the future

A recent survey report of trainees registered in a specialist medical college training program summarised what they considered to be the characteristics of good supervisors:

- Be available to teach
- Be willing to spare time for trainees
- Observe trainees at work
- Give constructive, honest feedback
- Assess regularly and objectively
- Be trained to teach and assess.[37]

These characteristics also refer to good supervisors of IMGs.

Workplace-based assessment comprises observation (to enable a judgment to be made on performance) and feedback (information that is timely, specific to the IMG's performance and relevant to effective performance in the workplace).

Observation

A study in 1990 by Day et al, citing the low priority traditionally placed on observation, points out that without observation there is no opportunity for the assessment of day-to-day clinical skills or provision of feedback that might lead to improved performance.[38] There is a need for observations to be guided by clear and coherent assessment criteria, which can also serve as focal points during feedback discussions with IMGs.

Feedback

Here are some examples of feedback that are well meaning but unlikely, on their own, to effect change in workplace performance:

- 'You're doing fine, really, but you need to improve in some areas.'
- 'Sometimes you just don't seem to measure up.'
- 'They're saying that you are not a good listener.'
- 'You need to work on your communication skills.'
- 'You're not decisive enough.'
- 'Where did you learn that?'
- 'That was a sloppy performance.'
- 'That was an excellent performance.'

Useful feedback requires time, commitment and precision.

Comments that fail to assist improvement are typically too general, too long after the event, second-hand views, solely negative (negative without including advice for improvement) and/or do not ensure the IMG has understood the advice and knows how to address the problem.

There is no place for personal issues or perceived personality clashes to be raised during feedback on clinical performance. Effective feedback will involve a dialogue between the assessor and the IMG, aiming to identify what was done well and not done well, and helping to develop a plan for improvement. In a feedback session, IMGs should be challenged to address each of these issues, with the assessor doing it for them when they lack the insight to do so on their own. Useful feedback requires time, commitment and precision.

Giving effective feedback

Start with the learner's agenda when giving feedback. Ask 'What do you think you did well?' 'What do you think needs improvement?'

In giving feedback, some words that describe effective feedback are 'specific', 'immediate', 'first-hand', 'constructive', 'descriptive', 'action-affirming' and 'adequate'. These descriptors of feedback are outlined as follows:

Specific

The feedback is restricted to the task just performed, and does not include comments that refer generally to other events.

Immediate

The feedback is provided immediately following, or as soon as practicable after, the observed performance.

First-hand

The feedback describes what has just been observed by the supervisor/assessor, and does not include what others might be saying.

Constructive

The feedback provides helpful suggestions for improving performance and/or directs the IMG to resources that can assist; it serves to motivate and reinforce desirable behaviour.

Descriptive

The feedback describes what was good about the performance, plus what was missing and what needs to be done to improve; an honest appraisal—which may contain information the IMG would prefer not to hear—is most appropriately delivered through describing what has just been observed and specifying the actions/behaviour that were not satisfactory. Describe behaviours with 'I' statements, such as; 'I observed that…', 'This is what I think you did well….', 'These are the areas that I saw need improvement'.

Action-affirming

The feedback sketches out an action plan—which may be recorded on the spot—to give the IMG a summary of expectations. Encourage self-assessment: 'How might you try to improve?' 'Here are some ways you might like to consider.' Indicate if there are resources that can support achievement.

Adequate

The feedback is detailed and clear, and ensures that the IMG has understood the message being given.

Feedback on under-performance

While assessors and candidates would like to see a successful outcome of the assessment process, the reality is that this will not always be the case. Many assessors find giving feedback to candidates difficult where candidates are not proceeding through the assessment process as might reasonably be expected, or have failed their assessment. The most difficult feedback sessions are those with individuals who lack insight and fail to reflect on their actions, or have not been successful in their performance.

It is important that assessors meet their responsibilities in this regard – a poor or failing performance should be recorded as that.

To deal with this situation, assessors will need:

- Training on giving feedback and handling more difficult cases, prior to their appointment as assessors;
- Clear guidelines on the passing standard and calibration;
- The timeline within which assessment must be completed;
- Information on opportunities for remediation;
- Information on the processes for:
  - » the re-assessment of candidates;
  - » reporting to appropriate authorities any serious negative outcomes from the assessment process;
  - » handling reviews and appeals, with formal processes to handle appeals in a manner that adheres to the principles of procedural fairness.

It will assist candidates in this situation to:

- Receive clear, timely and ongoing feedback so that they have had advance warning of their performance issues;
- Have clear information about the assessment processes and processes for appeals.

For the assessment system to be robust and defensible it is important that:

- There are fair and transparent processes;
- Valid and reliable methods are used, data are appropriately collated, standards are set, results are defensible and methods are accurate;
- Processes are followed for all candidates, without exception;
- Well documented and public processes are in place to handle complaints/appeals.

Introduction

The prevocational phase of medical training and development encompasses the period between graduation and vocational training.The Australian Curriculum Framework for Junior Doctors (ACF) is an educational template outlining the learning outcomes required of prevocational doctors, to be achieved through their clinical rotations, education programs and individual learning, in order to promote safe, quality health care. The ACF is built around three learning areas: Clinical Management, Communication, and Professionalism. These areas are divided into categories each of which is further subdivided into learning topics. These topics have been identified in the literature and from supervisors' experiences as being critical to both safe prevocational practice and a basis for future training.
The principles that underpin the ACF include:

- Adult Learning theory, including: respect for prior learning and experience, provision of clear learning outcomes, regular feedback on performance and provision of opportunities for reflection
- A focus on translating learning from university into performance in the workplace
- Vertical integration of medical education across the continuum
- Clear expectations of outcomes for all involved in prevocational medical education and training
- Safety and quality in healthcare.

The ACF is a continuing collaborative project between Postgraduate Medical Councils (PMCs) and a broad range of stakeholders under the leadership of the Confederation of Postgraduate Medical Education Councils (CPMEC) and funded by the Australian Government Department of Health and Ageing.

The history of the development of the ACF, references and useful downloads and links are available on the CPMEC website: **www.cpmec.org.au**

Using the AFC

The ACF can be used in a variety of ways to support prevocational training and development:

For Prevocational Doctors

- The ACF can be used to guide your journey through the prevocational years. It outlines the desired learning outcomes, however it is recognised that proficiency in achievement of the capabilities will occur at different stages in your training but should ideally be achieved prior to vocational training.
- The ACF is designed to be used as a self-assessment tool to identify strengths, weaknesses and opportunities for learning and professional development. It can then be used as a basis for monitoring your progress during the prevocational years.
- When commencing new rotations, the ACF provides a useful guide for discussing the learning opportunities that may be available from a given term. It may help to identify particular skills and procedures that may be learnt during the term and to plan in advance to receive such training.

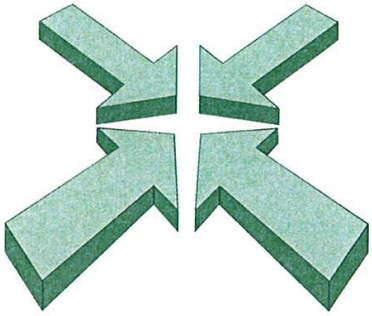
For Supervisors, educators, employers and managers:

- The ACF can be used to review the learning opportunities offered by existing rotations or to plan the development of innovative positions in new and expanded settings. For example, clinical staff can use the ACF as a starting point for discussions about what doctors in vocational training should learn and how best to teach it.
- The ACF can be mapped to undergraduate and vocational training curricula, prevocational education programs, position descriptions and rosters in order to identify gaps or duplication across the continuum of medical education.
- Clinical unit staff can use the ACF as a starting point for discussions about innovative approaches to clinical teaching and professional development.
- The ACF provides a structure for mid and end of term feedback and assessment.

ACKNOWLEDGEMENTS

CPMEC would like to acknowledge the following:
The Australian Government Department of Health and Aging for their ongoing financial support of the ACF project.
The time and effort of the ACF Revision Working Group members including:

Dr Greg Keogh
Prof Brian Jolly
Prof Fiona Lake
Prof John Wilson
Prof Richard Ruffin
Ms Debbie Paltridge
Dr Jag Singh
Assoc Prof Merrilyn Walton
Dr Alex Markwell
Mr Jamie Alexander
Dr Derinda Arangala
Ms Susanne Le Boutillier



Confederation of Postgraduate Medical Education Councils

AUSTRALIAN CURRICULUM FRAMEWORK FOR JUNIOR DOCTORS

version2.2

- Introduction
- Clinical Management
- Professionalism
- Communication
- Clinical Problems and Conditions
- Skills & Procedures

ADV = PGY2 or above

Clinical Management

SAFE PATIENT CARE

Systems

Works in ways which acknowledge the complex interaction between the healthcare environment, doctor & patient

Uses mechanisms that minimise error e.g. checklists, clinical pathways

Participates in continuous quality improvement e.g. clinical audit

Risk & prevention

Identifies the main sources of error & risk in the workplace

Recognises and acts on personal factors which may contribute to patient and staff risk

Explains and reports potential risks to patients & staff

Adverse events & near misses

Describes examples of the harm caused by errors & system failures

Documents & reports adverse events in accordance with local incident reporting systems

Recognises & manages adverse events & near misses (ADV)

Public health

Informs authorities of each case of a 'notifiable disease'

Acts in accordance with the management plan for a disease outbreak

Identifies the determinants of the key health issues and opportunities for disease prevention in the community (ADV)

Infection control

Practices correct hand-washing and aseptic techniques

Uses methods to minimise transmission of infection between patients

Rationally prescribes antibiotic/antiviral therapy for common conditions

Radiation safety

Minimise the risk to patient or self associated with exposure to radiological investigations or procedures

Rationally requests radiological investigations and procedures

Regularly evaluates his/her ordering of radiological investigations and procedures (ADV)

Medication safety

Identifies the medications most commonly involved in prescribing & administration errors

Prescribes & administers medications safely

Routinely reports medication errors & near misses in accordance with local requirements

PATIENT ASSESSMENT

Patient identification

Follows the stages of a verification process to ensure the correct identification of a patient

Complies with the organisation's procedures for avoiding patient misidentification

Confirms with others the correct identification of a patient

History & Examination

Recognises how patients present with common acute and chronic problems and conditions

Elicits symptoms & signs relevant to the presenting problem or condition

Undertakes and can justify clinically relevant patient assessments

Problem formulation

Synthesises clinical information to generate a ranked problem list containing appropriate provisional diagnoses

Discriminates between the possible differential diagnoses relevant to a patient's presenting problems or conditions

Regularly re-evaluates the patient problem list as part of the clinical reasoning process

Investigations

Selects, requests and can justify investigations in the context of particular patient presentation

Follows up and interprets investigation results appropriately to guide patient management

Identifies and provides relevant and succinct information when ordering investigations

Referral & consultation

Identifies & provides relevant & succinct information

Applies the criteria for referral or consultation relevant to a particular problem or condition

Collaborate with other health professionals in patient assessment

EMERGENCIES

Assessment

Recognises the abnormal physiology & clinical manifestations of critical illness

Recognises & effectively assesses acutely ill, deteriorating or dying patients

Initiates resuscitation when clinically indicated whilst continuing full assessment of the patient

Prioritisation

Describes the principles of triage

Identifies patients requiring immediate resuscitation & when to call for help e.g. Code Blue / MET

Provides clinical care in order of medical priority

Clinical Management

EMERGENCIES

Basic Life Support

Implements basic airway management, ventilatory & circulatory support

Effectively uses semi-automatic and automatic defibrillators

Advanced Life Support

Identifies the indications for advanced airway management

Recognises malignant arrhythmias, uses resuscitation/drug protocols & manual defibrillation

Participates in decision-making about & debriefing after cessation of resuscitation

Acute patient transfer

Identifies factors that need to be addressed for patient transfer

Identifies and manages risks prior to and during patient transfer (ADV)

PATIENT MANAGEMENT

Management Options

Identifies and can justify the patient management options for common problems and conditions

Implements and evaluates a management plan relevant to the patient following discussion with a senior clinician

Therapeutics

When prescribing, takes account of the actions and interactions, indications, monitoring requirements, contraindications & potential adverse effects of each medication used

Involves nurses, pharmacists & allied health professionals appropriately in medication management

Evaluates the outcomes of medication therapy (ADV)

Pain management

Specifies and can justify the hierarchy of therapies and options for pain control

Prescribes pain therapies to match the patient's analgesia requirements (ADV)

Evaluates the pain management plan to ensure it is clinically relevant (ADV)

Fluid, electrolyte & blood product management

Identifies the indications for and risks of fluid & electrolyte therapy and use of blood products

Recognises and manages the clinical consequences of fluid & electrolyte imbalance in a patient

Develops, implements, evaluates and maintains an individualised patient management plan for fluid,electrolyte and blood product use

Maintains a clinically relevant patient management plan of fluid, electrolyte and blood product use with relevant pathology testing (ADV)

Subacute care

Identifies appropriate subacute care services for a patient

Identifies patients suitable for aged care, rehabilitation or palliative care programs

Ambulatory & community care

Identifies and arranges ambulatory and community care services appropriate for each patient

Discharge planning

Identifies the elements of effective discharge planning e.g. early, continuous, multidisciplinary

Follows organisational guidelines to ensure smooth discharge

Identifies and refers patients to residential care consistent with clinical indications and regulatory requirements (ADV)

End of Life Care

Arranges appropriate support for dying patients

SKILLS & PROCEDURES

Decision-making

Explains the indications and contraindications for common procedures

Selects appropriate procedures with involvement of senior clinicians and the patient

Informed consent

Applies the principles of informed consent in day to day clinical practice

Identifies the circumstances that require informed consent to be obtained by a more senior clinician

Provides a full explanation of procedures to patients

Preparation & anaesthesia

Prepares & positions the patient appropriately

Recognises the indications for local, regional or general anaesthesia (ADV)

Arranges appropriate equipment & describes its use

Procedures

Provides appropriate analgesia and/or premedication

Arranges appropriate support staff & defines their roles

Post-procedure

Monitors the patient & provides appropriate aftercare

Identifies & manages common complications

Interprets results & evaluates outcomes of treatment

Communication

PATIENT INTERACTION

Context

Arranges an appropriate environment for communication, e.g. private, no interruptions

Uses principles of good communication to ensure effective healthcare relationships

Uses effective strategies to deal with the difficult or vulnerable patient

Respect

Treats patients courteously & respectfully, showing awareness & sensitivity to different backgrounds

Maintains privacy & confidentiality

Provides clear & honest information to patients & respects their treatment choices

Providing information

Applies the principles of good communication (e.g. verbal and non verbal) and communicates with patients and carers in ways they understand

Uses interpreters for non English speaking backgrounds when appropriate

Involves patients in discussions and decisions about their care

Meetings with families or carers

Identifies the impact of family dynamics on effective communication

Ensures relevant family/carers are included appropriately in meetings and decision-making

Respects the role of families in patient health care

Breaking bad news

Identifies symptoms and signs of loss and bereavement

Participates in breaking bad news to patients & carers

Shows empathy & compassion

Open disclosure

Explains and participates in implementing the principles of open disclosure

Ensures patients and carers are supported & cared for after an adverse event

Complaints

Acts to minimise or prevent the factors that would otherwise lead to complaints

Uses local protocols to respond to complaints

Adopts behaviours such as good communication designed to prevent complaints

MANAGING INFORMATION

Written

Complies with organisational policies regarding timely and accurate documentation

Demonstrates high quality written skills e.g. writes legible, concise & informative discharge summaries

Uses appropriate structure & content for specific correspondence e.g. referrals, investigation requests, GP letters

Accurately documents drug prescription and administration

Electronic

Uses electronic patient information & decision-support systems recognising his/her strengths and limitations

Uses electronic resources in patient care e.g. to obtain results, discharge summaries, pharmacopoeia

Complies with policies regarding information technology e.g. passwords, e-mail & internet

Health Records

Complies with legal/institutional requirements for health records

Uses the health record to ensure continuity of care

Facilitates appropriate coding & classification by accurate documentation

Evidence-based practice

Describes the principles of evidence-based practice & hierarchy of evidence

Uses best available evidence in clinical decision-making (ADV)

Critically appraises evidence & information (ADV)

Handover

Describe the importance and features of handover that ensure patient safety and continuity of care

Performs effective handover e.g. team member to team member, hospital to GP, to ensure patient safety and continuity of care

WORKING IN TEAMS

Team structure

Identifies the healthcare team (e.g. medical team, multidisciplinary stroke team) most appropriate for a patient

Includes the patient & carers in the team decision making process where possible

Identifies that team leaders can be from different health professions and respects their roles

Uses graded assertiveness when appropriate

Respects the roles & responsibilities of team members

Team dynamics

Contributes to teamwork by behaving in ways that maximises the teams' effectiveness including teams which extend outside the hospital

Demonstrates an ability to work with others and resolve conflicts when they arise

Demonstrates flexibility & ability to adapt to change

Communication

WORKING IN TEAMS

Teams in action

Identifies and adopts a variety of roles within a team (ADV)

Case Presentation

Presents cases effectively, to senior medical staff & other health professionals

Professionalism

DOCTOR & SOCIETY

Access to healthcare

Identifies how physical or cognitive disability can limit patients' access to healthcare services

Provides access to culturally appropriate healthcare

Demonstrates a non-discriminatory approach to patient care

Culture, society & healthcare

Behaves in ways which acknowledge the social, economic & political factors in patient illness

Behaves in ways which acknowledge the impact of culture, ethnicity & spirituality on health

Identifies his/her own cultural values that may impact on his/her role as a doctor

Indigenous patients

Behaves in ways which acknowledge the impact of history & the experience of Indigenous Australians

Behaves in ways which acknowledge Indigenous Australians' spirituality & relationship to the land

Behaves in ways which acknowledge the diversity of indigenous cultures, experiences & communities

Professional standards

Complies with the legal requirements of being a doctor e.g. maintaining registration

Adheres to professional standards

Respects patient privacy & confidentiality

Medicine & the law

Complies with the legal requirements in patient care e.g. Mental Health Act, death certification

Completes appropriate medico-legal documentation

Liaises with legal & statutory authorities, including mandatory reporting where applicable (ADV)

Health promotions

Advocates for healthy lifestyles and explains environmental & lifestyle risks to health

Uses a non-judgemental approach to patients & his/her lifestyle choices (e.g. discusses options; offers choice)

Evaluates the positive and negative aspects of health screening and prevention when making healthcare decisions (ADV)

Healthcare resources

Identifies the potential impact of resource constraint on patient care

Uses finite healthcare resources wisely to achieve the best outcomes

Behaves in ways that acknowledge the complexities and competing demands of the healthcare system (ADV)

PROFESSIONAL BEHAVIOUR

Professional responsibility

Behaves in ways which acknowledge the professional responsibilities relevant to his/her health care role

Maintains an appropriate standard of professional practice & works within personal capabilities

Reflects on personal experiences, actions & decision-making

Acts as a role model of professional behaviour

Time management

Prioritises workload to maximise patient outcomes and health service function

Demonstrates punctuality

Personal well-being

Is aware of and optimises personal health & well-being

Behaves in ways to mitigate the personal health risks of medical practice e.g. fatigue, stress

Behaves in ways which mitigate the potential risk to others from your own health status e.g. infection

Ethical practice

Behaves in ways which acknowledge the ethical complexity of practice & follows professional & ethical codes

Consults colleagues about ethical concerns

Accepts responsibility for ethical decisions

Professionalism

PROFESSIONAL BEHAVIOUR

Practitioner in difficulty

Identifies the support services available
Recognises the signs of a colleague in difficulty
Refers appropriately & responds with empathy

Doctors as leaders

Shows an ability to work well with and lead others
Exhibits the qualities of a good leader and takes the leadership role when required (ADV)

Professional Development

Explores and is open to a variety of career options
Participates in a variety of continuing education opportunities

TEACHING, LEARNING & SUPERVISION

Self-directed learning

Identifies and addresses personal learning objectives
Establishes and uses current evidence based resources to support own learning
Seeks opportunities to reflect on and learn from clinical practice
Seeks and responds to feedback on learning
Participates in research and quality improvement activities where possible

Teaching

Plans, develops and conducts teaching sessions for peers and juniors
Uses varied approaches to teaching small and large groups
Incorporates teaching into clinical work
Evaluates and responds to feedback on own teaching

Supervision

Provides effective supervision e.g. by being available, offering an orientation, learning opportunities, and by being a role model
Adapts level of supervision to the learner's competence and confidence

Assessment and Feedback

Provides constructive, timely and specific feedback based on observation of performance
Participates in feedback and assessment processes
Provides constructive guidance or refers to an appropriate support to address problems (ADV)

Skills & Procedures

Doctors should be able to provide safe treatment to patients through competently performing certain procedural and/or assessment skills (ADV = ADVANCED i.e. more likely to be learnt in PGY2 or above).

GENERAL

Measurement

Blood pressure
Pulse oximetry

Interpretation of results

Pathology
Radiology
Nuclear Medicine

Intravenous

Venepuncture
Intravenous cannulation
Intravenous infusion set up
Intravenous drug administration
Intravenous fluid & electrolyte therapy

Diagnostic

Blood Sugar Testing
Blood culture
Wound swab

Respiratory

Oxygen therapy
Nebuliser/inhaler therapy
Bag & Mask ventilation
LMA and ETT placement (ADV)

Therapeutics/Prophylaxis

Anticoagulant
Antibiotic
Insulin
Analgesia
Bronchodilators
Steroids

GENERAL

Injections

Intramuscular injections
Subcutaneous injections
Joint aspiration or injection (ADV)

WOMEN'S HEALTH

Palpation of the pregnant abdomen
Foetal heart sound detection
Urine pregnancy testing
Speculum examination
Diagnosis of pregnancy
Endocervical swab / PAP smear
Gynaecological pelvic examination

CHILD HEALTH

Infant respiratory distress assessment
Infant/child dehydration assessment
Apgar score estimation (ADV)
Newborn examination
Neonatal and Paediatric Resuscitation (ADV)

SURGICAL

Scrub, gown & glove
Assisting in the operating theatre
Surgical knots & simple wound suturing
Local anaesthesia
Simple skin lesion excision
Suture removal
Complex wound suturing (ADV)

EAR, NOSE & THROAT

Throat swab
Anterior rhinoscopy
Anterior nasal pack insertion
Auroscopy/otoscopy
External auditory canal irrigation
External auditory canal ear wick insertion (ADV)

Skills & Procedures

CARDIOPULMONARY

12 lead electrocardiogram recording and interpretation
Arterial blood gas sampling and interpretation
Peak flow measurement
Spirometry
Pleural effusion/pneumothorax aspiration
Central venous line insertion (ADV)

GASTROINTESTINAL

Nasogastric tube insertion
Rectal examination
Anoscopy/proctoscopy (ADV)
Abdominal paracentesis (ADV)

NEUROLOGICAL

Glasgow Coma Scale (GCS) scoring
Assessment of Neck stiffness
Focal neurological sign identification
Papilloedema identification (ADV)
Lumbar puncture (ADV)

MENTAL HEALTH

Mini-mental state examination
Psychiatric Mental State Examination
Suicide risk assessment
Alcohol withdrawal scale use
Application of Mental Health Schedule

OPHTHALMIC

Visual field assessment
Visual acuity assessment
Direct ophthalmoscopy
Eye drop administration
Eye bandage application
Eye irrigation
Eyelid eversion
Corneal foreign body removal
Intraocular pressure estimation (ADV)
Slit lamp examination (ADV)

UROGENITAL

Bladder catheterisation (M&F)
Urine dipstick interpretation
Bladder Scan
Urethral swab

TRAUMA

Primary trauma survey In-line immobilisation of cervical spine
Cervical collar application
Pressure haemostasis
Volume resuscitation
Peripheral neurovascular assessment
Plaster cast/splint limb immobilisation
Joint relocation
Secondary trauma survey (ADV)
Intercostal catheter insertion (ADV)

Clinical Problems and Conditions

Doctors should be able to appropriately assess patients presenting with common, important conditions, including the accurate identification of symptoms, signs and/or problems and their differential diagnosis and then use that information to further manage the patient, consistent with their level of responsibility. The assessment and management of these common conditions will vary depending on the setting in which they are seen

GENERAL

Genetically determined conditions
Functional decline or impairment
Cognitive or physical disability

DERMATOLOGICAL

Skin conditions
Skin malignancies

NEUROLOGICAL

Loss of consciousness
Seizure disorders
Syncope
Delirium
Falls, especially in the elderly
Headache
Stroke / TIA
Subarachnoid haemorrhage
Spinal disease

MUSCULOSKELETAL

Joint disorders

CIRCULATORY

Hypertension
Heart failure
Chest pain
Cardiac arrhythmias
Electrolyte disturbances
Ischaemic heart disease
Leg ulcers
Limb ischaemia
Thromboembolytic disease

RESPIRATORY

Breathlessness
Asthma
Cough
Chronic Obstructive Pulmonary Disease
Pneumonia / respiratory infection
Upper airway obstruction
Obstructive sleep apnoea
Pleural diseases

ORAL DISEASE

Toothache
Oral Infections

GASTROINTESTINAL

Nausea and Vomiting
Abdominal pain
Gastrointestinal bleeding
Constipation
Diarrhoea
Jaundice
Liver disease

RENAL / UROGYNAECOLOGICAL

Dysuria &/or frequent micturition
Pyelonephritis and UTIs
Reduced urinary output
Renal failure
Urinary Incontinence
Abnormal menstruation
Contraception

OBSTETRIC

PainPain and bleeding in pregnancy

ENDOCRINE

Diabetes: new cases & complications

HAEMOPOIETIC

Anaemia

NUTRITION / METABOLIC

Weight gain
Weight loss

MENTAL STATE

Disturbed or aggressive patient

PSYCHIATRIC / DRUG & ALCOHOL

Psychosis
Depression
Anxiety
Deliberate self-harm
Dementia
Addiction (smoking, alcohol, drug)
Substance abuse

INFECTIOUS DISEASES

Non-specific febrile illness
Septicaemia
Sexually Transmitted Infections

ONCOLOGY

Neoplasia

IMMUNOLOGY

Anaphylaxis

PHARMACOLOGY / TOXICOLOGY

Poisoning
Envenomation

CRITICAL CARE / EMERGENCY

Injury prevention
Non-accidental injury
Minor trauma
Multiple trauma
Child abuse
Domestic violence
Elder abuse
Postoperative care
Shock

1 Background

In 2010, Hunter New England Health (HNELHD) was the first location in Australia where IMGs seeking general registration through the AMC Standard Pathway could be assessed using an alternative Standard Pathway offering Workplace Based Assessment in place of the Standard Pathway with clinical examination (AMC Examination)[1,2]

The Centre for Medical Professional Development (CMPD), in collaboration with the University of Newcastle's School of Medicine and Public Health, was granted accreditation by the Australian Medical Council (AMC) to conduct Workplace Based Assessment (WBA) for International Medical Graduates (IMGs) on the Standard Pathway (Workplace Based Assessment) ("WBA Program").

The strength of Workplace Based Assessment is in the direct observation of IMGs in their workplace. It involves having different assessment tools, used by multiple calibrated assessors in various clinical settings over an extended period of time. The process assesses the candidate's clinical skills and performance as well as their communication and teamwork skills. An essential part of the WBA is that at the conclusion of each Mini-CEX (mini-clinical evaluation exercise) and Case Based Discussion ("CBD") assessment, candidates are provided with constructive feedback by the assessor. They also get feedback about their professional behaviour after the multisource feedback.

Regardless of the level at which an IMG is employed, all candidates in the AMC WBA Program are assessed against the standard expected of a graduate of an AMC-accredited medical program at the end of PGY1 level. (Internship). [1,2]

Candidates on the WBA Program who successfully complete the Program's requirements are awarded the AMC Certificate, which provides a qualification required for registration.

The WBA program run by HNELHD is conducted over a six month period in hospitals within the Greater Newcastle Area, Armidale, Manning and Tamworth Rural Referral Hospitals.

In order to deliver the WBA Program and provide a high quality skills assessment program, HNELHD has a number of operational requirements regarding employees, including a requirement for candidates to complete an agreed number of hours as an employee of HNE prior to commencing on the WBA program and rostering/attendance obligations while undertaking the WBA program.

1 *Workplace Based Assessment: Resource Guide. Australian Medical Council, 2009.*

2 ***RG 02: Principles of Assessment | Production-WBAonline (amc.org.au)***

2 Program Requirements

2.1 To be eligible for selection onto the WBA, candidates must:

1. Apply to the WBA Program Office at Hunter New England Local Health District.

2. Have passed the AMC Computer Adaptive Test Multiple Choice Question (CAT MCQ) examination (i.e. the normal AMC criteria for the clinical exam).

3. Provide evidence (confirmed by their manager) that they have completed 26 weeks of paid employment (minimum 0.6 FTE worked) within HNELHD immediate proceeding commencement of the WBA program.

4. Have a contract of employment to work primarily at one of the locations within HNELHD where WBA is offered (i.e. Newcastle, Armidale, Tamworth and Manning).

5. Be able to commit to remaining employed and working at no less than 0.6 FTE for the duration of the WBA program (26 weeks) and must anticipate taking no more than 2 weeks absence from duties for any reason.

6. Agree to notify the WBA Program Director of any significant change in their employment arrangements, or if there is a reasonable change that they will be unable to comply with the required timeframes outlined above, this includes advising the WBA Program Coordinator prior to applying for annual leave.

7. Understand that AMC rules and processes mean that a candidate who accepts a place on the WBA Program cannot apply to sit the AMC Clinical Examination during the six month assessment period of the WBA.

2.2 To successfully complete HNELHD's WBA program, the WBA Program candidates must:

1 Provide evidence (confirmed by their manager(s)) that they have fulfilled the employment/attendance requirement of being employed at no less than 0.6 FTE by HNELHD for the duration of the WBA program (26 weeks). During this time the candidate's work must be distributed more or less evenly over the period.

2 Provide evidence (confirmed by their manager) that they have not been absent from duties for a period exceeding two (2) weeks during the 26 week assessment period. This requirement is based on the premise that the WBA Program assesses candidate performance over time in everyday clinical practice, across a variety of situations (night, weekend and business hours) and with a variety of clinical teams. This allows assessment of the candidate's progress in integrating clinical knowledge and skills as a basis for safe, effective clinical judgments and decision making. It also assesses how well candidates deliver the best possible care to patients and participate productively in a team of healthcare professionals.

3 Successfully complete the assessments stipulated by the AMC and described in Section 7 Mandatory Assessments.

3 Program Committees

There are a number of committees responsible for the governance of the WBA Program:

- Program Team, which is responsible for the day-to-day running of the Program;
- Governance Committee, which provides overall advice and direction for the program on behalf of HNELHD (this is HNE program);
- The 360º Review Panel, which reviews results from the 360º assessments;
- Appeals Committee; and
- Special Consideration Review Committee.

4 Review and Appeals Process

4.1 Review

Candidates seeking to have the result of an assessment reviewed should email the WBA Program Office no later than three (3) working days after the result has been made available. The candidate must clearly specify the error they believe has been made in the determination of their result and how they reached this conclusion, providing evidence and specific examples if possible. The WBA Program Director may, in a timely manner, elect to seek a recommendation from the original assessor and may determine to:

a) Leave the original result unchanged;

b) Amend the result; or

c) Ask an independent assessor to reassess.

The WBA Program Director will email the candidate and assessor once a determination has been made.

4.2 Appeals

Should a WBA Program candidate be deemed “Not Competent” overall, the candidate may lodge an appeal. To lodge an appeal, the candidate must submit a written application with the WBA Program Office within 10 working days. Only appeals submitted to the WBA Program email account HNELHD-WBA@health.nsw.gov.au will be assessed, i.e. candidates are not to make appeals directly to individual assessors.) In response to an appeal application, the WBA Program Appeals Committee, which is independent of the Program Team and the WBA Governance Committee, is convened. The Appeals Committee operates according to its Terms of Reference and will consider the following in relation to the AMC required assessments:

- Candidate personal circumstances (e.g. illness during the assessment);
- Circumstances relating to the patient or the ward during the assessment (e.g. patient becoming unwell or a major disruption on the ward); and
- Allegations that the assessor did not administer the assessment properly.

The WBA Program Appeals Committee may determine to:

- Leave the original result unchanged;
- Amend the result
- Approve the candidate to sit a supplementary assessment.

The Appeals Committee will not consider operational requirements/employment related matters (e.g. pre-WBA 26 weeks requirement, accommodations for unplanned absence from work during the WBA etc.)
If the appeal process is exhausted at the level of HNELHD and the candidate has grounds for appeal, an appeal application can be lodged with the AMC through the WBA Guideline for Appeal process (refer to clause 5.2 Systematic Complaints).

4.3 Special Consideration

Candidates wishing to appeal the outcome of AMC mandated assessments must apply via the Appeals Process to the Appeals Committee.
Should a WBA candidate's circumstances require special consideration in relation to the operational requirements/employment related matters (e.g. pre-WBA working requirement, accommodations for unplanned absence from work during the WBA etc.) the candidate must make a written submission to the WBA Program Director, who will consider the request according to HNELHD's WBA special consideration guideline and provide a response with written reasons.
If the candidate disagrees with the decision of the WBA Program Director, the candidate may seek a review of the decision by the Special Consideration Committee, which is comprised of the Executive Medical Director, Executive Director Workforce and the Operational Executive. All requests for special consideration must be emailed to the WBA Program Director via the WBA Program office email at HNELHD-WBA@health.nsw.gov.au.

5 Complaints

Candidate complaints broadly may be either personal complaints or systemic complaints. Personal complaints are those where the complainant seeks to bring about a change in their personal situation and include, for example, matters such as selection, recognition of prior learning/experience, training post allocation, assessment outcomes or dismissal from training. Systemic complaints are those which evidence a potential failure by HNELHD to meet its accreditation standards.

5.1 Personal Complaints

Personal complaints regarding:

- Assessment matters are to be addressed as described in Section 4 Review and Appeals Process of this document.
- Special consideration is to be addressed as described in Section 4 Review and Appeals Process of this document.
- employment matters are to be raised with the IMG's line manager
- any other matter is to be raised with the WBA Program Office

5.2 Systemic Complaints

Candidates wishing to make a systemic complaint, should first raise their concerns, in writing, with the WBA Program Office. Should the complaint be unresolved, they should refer to the AMC's *Complaints about programs of study, education providers and organisations accredited or being accredited by the Australian Medical Council*.

6 Instructions for candidates

6.1 General:

- While on the WBA Program, candidates will continue to meet HNELHD's employment expectations.
- Candidates are responsible for their own learning and, where required, their own remediation.
- Candidates must notify the WBA program director of any significant change in their employment arrangements, or if there is a reasonable change that they will be unable to comply with the required timeframes outlined above, this includes advising the WBA Program Coordinator prior to applying for annual leave.

6.2 Assessments

- The candidate is to ensure that preparing for or attending WBA assessments does not interfere with their rostered duties. If required, cover should be arranged with colleagues.
- Candidates are to wear their HNELHD WBA photo ID to assessments and present it to the assessor for verification.
- The candidate is responsible for ensuring they take the HNELHD WBA iPad issued to them to every assessment. Assessment must now only be completed electronically through the HPrime2 platform on the allocated iPads or using the newly released HPrime App.
- Since every assessment is carried out independently of the results of all previous assessments, candidates are not to discuss their WBA progress with the assessor (i.e. the candidate cannot let the assessor know the results of previous assessments).
- If an assessor feels they are being pressured by a candidate to pass them, the assessor is instructed to terminate the assessment and contact the WBA Program Office immediately.
- If an assessment involving a patient has to be terminated because of patient related issues, the assessment will be rescheduled as soon as possible by the WBA Program Team.

Candidates are not to discuss their current level of employment with the assessor as all candidates, regardless of their position, all candidates in the AMC WBA Program are assessed to the standard of a graduate of an AMC-accredited medical program at the end of PGY1 (Internship). [3,4]

- Candidates will not be assessed by an assessor who is a relative or friend. An assessor must be 'at arm's length' and independent of the candidate.
- A candidate should not attend an assessment if they are ill. In the case of illness the candidate should immediately contact the assessor and call the WBA Program

3 *(Ref Workplace Based Assessment: Resource Guide. Australian Medical Council, 2009.*

4 ***RG 02: Principles of Assessment | Production-WBAonline (amc.org.au)***

Office. A medical certificate will be required to be submitted to the WBA Program Office if a candidate misses a WBA assessment because of illness.

- Candidates should familiarise themselves with the sample assessment forms at the back of this Resource Kit so they know what is expected of them.
- Candidates must turn off their mobile phones during all WBA Program assessments. Please note if you take a call whilst you are undertaking your WBA assessments, the assessor will cease the assessment immediately and contact the WBA Office. Please ensure that you do not book your WBA assessments whilst you are on call.
- Candidates hand the iPad to the assessor prior to commencing the assessment.

6.2.1 Mini-CEX and CBD Assessments

At the completion of all Mini-CEX and CBD assessments the candidate will ask the assessor to electronically sign on the iPad or HPrime App or if the form is being completed on a personal computer, the assessor signs the signature field with the mouse.

6.2.2 360º Assessments

The candidate is responsible for completing and returning by email to the WBA Program Coordinator, the 360 Nominee form with all details of medical colleagues and co-workers the candidate is nominating to complete the 360 form at month one and month six. Once the WBA Program Coordinator reviews the list provided, the candidate then must upload the nominee details into the HPrime system when notified.

7 Mandatory Assessments

There are three (3) mandatory assessment tools being used in the AMC WBA. They are:

1. Mini Clinical Evaluation Exercise (Mini-CEX)
2. Case Based Discussion (CBD)
3. 360º Assessment

For the AMC Workplace Based Assessment, to be competent overall a candidate must be competent in all four (4) forms of assessment.

Each mandatory assessment will now be described in detail.

7.1 Mini Clinical Evaluation Exercise (Mini-CEX)

The Mini-CEX is a standardised and validated assessment tool. It involves the direct observation of a candidate in a clinical encounter with a patient for 15 - 20 minutes followed by immediate feedback by the assessor on their performance for a further 10 – 15 minutes. The candidate's performance in the Mini-CEX is rated by the assessor using a standardised, structured rating form.

Each candidate is required to undertake a total of twelve (12) Mini-CEX assessments, specifically, two (2) Mini-CEX assessments in each of the six (6) clinical areas.

The six clinical areas are:

- Adult Medicine
- Adult Surgery
- Emergency Medicine
- Mental Health
- Child Health
- Women’s Health

Not all aspects of the clinical encounter are covered with all patients in the Mini-CEX assessments. The assessments are blueprinted to ensure coverage of the six (6) clinical areas. See Table 1.

Clinical Areas	Blueprint Areas
Adult Medicine	Physical Examination
	Management & Prescribing
Adult Surgery	Physical Examination
	Management
Emergency Medicine	History & Investigation
	Management
Mental Health	History
	Management & Counselling
Child Health	History
	Counselling & Patient Education
Women's Health	Investigation & Diagnosis
	Management & Prescribing /Counselling

Table 1: Blueprint for Mini-CEX assessments

7.1.1 How to book in your Mini- CEX Assessment

8. With the introduction of the HPrime2 electronic system, candidates and the assessors will be notified electronically of the completion date for each Mini-CEX assessment and the specific clinical area being assessed, e.g. Surgery – Physical Examination, Mental Health – Management & Counselling etc. Candidates must contact the assessor to set up an assessment time.

    1. The **assessor** will find a suitable patient and arrange with the candidate to meet at an appropriate time and venue (e.g. ward, outpatient clinic) to conduct the assessment.

    2. The candidate will take their iPad to the assessment and give to the assessor. The candidate is to ensure that the correct assessment is open and ready at the time of the assessment.

    3. The assessor will brief the candidate on any information they need prior to undertaking the assessment. For example, if the subject of the Mini-CEX is 'Management' then the assessor will verbally summarise the relevant history, physical examination and diagnosis for the patient. The candidate will be given a few minutes to think about how they will approach the patient interaction.

    4. After both the candidate and the assessor have introduced themselves to the patient the assessor will 'step back' and observe. The assessor will not be involved in the encounter between candidate and patient.

    5. When the encounter is complete the assessor may ask the candidate one or two brief questions to clarify the candidate's reasoning. The assessor may need a moment to think about and complete the form, sign it electronically and tap the "Submit" button. The assessor will find a quiet place nearby, away from the patient, to give the candidate their result and feedback.

It is anticipated that a candidate will complete a minimum of one Mini-CEX assessment every two weeks over the assessment period. The WBA Program Co-coordinator will schedule these assessments, however the candidate negotiates the assessment details with the assessor. Each Mini-CEX, including immediate feedback by the assessor, will take approximately thirty (30) minutes.

For the Mini-CEX – to be Competent overall a candidate must:

- pass a minimum of nine (9) out of twelve (12) Mini-CEX assessments, and
- complete all twelve (12) Mini-CEX assessments in the WBA period, and
- pass at least one (1) Mini-CEX in each of the six (6) clinical areas.

To be judged competent overall on a Mini-CEX, the candidate must receive a Global rating of *'Competent'*. In keeping with AMC practice in clinical exams, a candidate who passes only eight (8) out of twelve (12) Mini-CEX assessments may be offered a supplementary exam with two (2) assessors in one of the clinical areas in which the candidate is not competent.

7.2 Case Based Discussions (CBDs)

The goal of CBDs is to assess the candidate's ability to discuss with the assessor the clinical reasoning involved in the clinical assessment, investigation, treatment, follow-up and overall clinical care of a particular patient. The CBDs also assess the candidate's record keeping abilities.
CBDs will take approximately twenty (20) minutes, followed by immediate feedback by the assessor on their performance for a further 10–15 minutes. The candidate's performance in the CBD is rated by the assessor using a standardised, structured rating form.
Candidates must undertake six (6) CBDs selected from their own patient cohort. The CBDs must be completed over the course of the 26 week WBA period.

- Four CBDs will be conducted from the candidate's patient cohort in the candidate's allocated discipline;
- Two CBDs will be conducted using patients that the candidate had been directly involved in managing and who had active co-morbid conditions in other disciplines e.g. a surgical patient with a co-morbidity in mental health.

For the four CBDs the candidate will undertake in the discipline that they work, the candidate will choose three (3) patients which they have seen in the previous two (2) weeks and provide the assessor with the MRN of each patient, age, gender and a brief description of their problem.
To qualify as a suitable patient for the assessment, the candidate must have made entries into the patient's clinical notes. A particular patient's case can only be used for one (1) CBD assessment (i.e. a new set of three (3) different patients must be provided for each CBD assessment).
The assessor will choose one patient to be subject of the assessment. The candidate will not be informed which of the patient cases the assessor has selected until the case based discussion assessment meeting.
For the remaining two CBDs the candidate will receive an email from the WBA Program Co-ordinator requesting the candidate to identify patients the candidate has been directly involved in managing that have a co-morbidity outside of the clinical discipline the candidate is working in.
The patients identified by the candidate will be reviewed by the WBA Director and the Director will select which patient will be the subject of the assessment. The Program Coordinator will then notify the candidate and the assessor which patient case has been selected.

7.2.1 How to book in your CBD Assessment

6. The candidate and the assessor will be informed by the WBA Program Coordinator via a HPrime2 generated email of the date each CBD should be completed.
7. As soon as possible the candidate must contact the assessor to arrange to meet at an appropriate time and venue to conduct the assessment.

8. The candidate will take their iPad to the assessment and hand to the assessor. The candidate is to ensure that the iPad is opened at the correct assessment and ready at the time of the assessment. The assessor and candidate will undertake the assessment based on the chosen patient. The assessor may need a moment to think and complete the form, sign it electronically and tap the "Submit" button. The assessor will find a quiet place nearby, away from the patient, to give the candidate their result and feedback.

For the CBD – to be Competent overall a candidate must:

- pass a minimum of five (5) out of six (6) CBDs, and
- complete all six (6) CBDs in the WBA period.

To be judged competent overall on a CBD the candidate must receive a 'Global Rating' of 'Competent'.

9.

7.3 360º Assessments – also known as Multi-Source Feedback

7.3.1 Description of 360º Assessment

A 360º Assessment is multi-source feedback. It provides evidence of a candidate's performance over time from a number of medical colleagues and co-workers and does not relate to any one specific patient encounter. It has been used in the workplace in Australia for a number of years with the aim of improving performance.
A 360º Assessment enables appraisal of a group of proficiencies that are the basis of safe and effective clinical practice, including interpersonal and communication skills, team work, professionalism and clinical management. [5,6]

7.3.2 Nominees for 360º Assessment

On commencement, candidates are asked to complete the nomination form, stating the names and contact details of six (6) medical colleagues and co-workers as described on the nomination form, and return it to the Program Office. The 360º Assessment **cannot** be completed by a fellow WBA candidate.
Candidates are asked to approach colleagues they wish to nominate and get their agreement to complete a 360º Assessment. Nominees may need to know that the form will take approximately 5 - 10 minutes to complete. Their responses will be kept confidential.
For the first 360º Assessment, those candidates who are just about to or who have recently started a new term can nominate medical colleagues and co-workers with whom they have worked with the previous six months.
For the second 360º Assessment at month six, candidates will be asked to nominate a different cohort of medical colleagues and co-workers to those nominated at the first assessment at month one. **These must be staff with whom the candidate is currently working.**
A medical colleague or co-worker may, if they wish, complete 360º Assessments for more than one AMC WBA candidate.

7.3.3 360º Assessments by medical colleagues and co-workers

All six (6) nominees must respond for the assessment task to be completed.

---

[5] *Workplace Based Assessment: Resource Guide. Australian Medical Council, 2009*

[6] *RG 04: Decide on assessment methods | Production-WBAonline (amc.org.au)*

The data from the returned medical colleagues and co-workers will be de-identified and a report will be provided to each candidate concerning their overall performance.
The first 360º Assessment by medical colleagues and co-workers at month one is formative. The second 360º assessment by medical colleagues and co-workers at month six is summative and critical to the satisfaction completion of your AMC WBA results.
A Global Rating of Competent by all 6 respondents is deemed to be a satisfactory result overall.
PLEASE NOTE – In 2021 all 360° / Multi-Source Feedback Forms will be distributed electronically and recipients must complete electronically on any device i.e. iPad. Laptops or Desktop Computer.

7.3.4 360º Panel Review

The 360º Review Panel will review your performance from the month one (formative) and month six (summative) 360º assessments by medical colleagues and co-worker assessments.

For 360º Assessments – to be competent overall a candidate must:

- have two (2) sets of 360° assessments completed by medical colleagues and co-workers in the WBA period; and

- either:
  - score a global rating of COMPETENT by ALL SIX (6) RESPONDENTS i.e. medical colleague and co-worker 360o assessment forms at Month six, or
  - be recommended as competent after review by the WBA 360º Review Panel.

The month one 360º assessment by medical colleagues and co-workers is formative. A candidate who is not competent in the month one 360º assessment (i.e. does not receive a 'Competent' Global rating from all six 360 respondents) will receive advice from the 360º Review Panel about where the candidate might obtain support and remediation.
The month six 360º assessment by medical colleagues and co-workers is summative. A candidate who does not receive a 'Competent' Global rating from all six 360 respondents will be deemed to be not competent in the 360º assessment and NOT COMPETENT overall in the AMC WBA Program.

8 Assessment Tool Samples Attached

8.1 Electronic Assessment Tools

- Sample of Australian Medical Council National Assessment Forms:
- Mini-Clinical Evaluation Exercise – Mini-CEX
- Case-Based Discussion Forms
- 360º Assessment Forms also known as Multi-Source Feedback
    - Nomination Form for Month One - Sample
    - Nomination Form for Month Six – Sample
    - 360º Assessment – Medical Colleague Questionnaire – Sample
    - 360º Assessment – Co-Worker Questionnaire - Sample