Australian
Medical Council Limited

Review of the National Framework for Medical Internship

Part 2 Consultation questions: Review and development work

Your feedback

We would like to hear your perspectives on the review and development work to date. We will consider all the feedback we receive when shaping our proposals for change. The AMC will communicate a summary of its consideration and response to the feedback provided.

The AMC's primary responsibility is to ensure that standards of education, training and assessment of the medical profession promote and protect the health of the Australian community and the final content of the National Framework must reflect this. If you would like further information about how to engage with the review please visit the AMC website.

We are seeking feedback by **3 November 2020.**
To enable efficient evaluation of the feedback our preference is for responses to be provided in a **Word document** using this **template** to prevac@amc.org.au. If this is not possible, please provide a non-protected PDF.

This template

This template provides questions against each major component of the Framework for consultation, as follows:

1. Framework overall
2. Training and assessment
3. Training environment
4. E-portfolio specifications

This template should be read in conjunction with the **Part 1: Consultation Paper**, which outlines the background and review process. Relevant attachments include:

ATTACHMENT A: Training & assessment: Prevocational training outcome statements –Draft for consult Sept 20

ATTACHMENT B: Training & assessment: Prevocational entrustable professional activities – Draft for consult Sept 20

ATTACHMENT C: Training & assessment: Proposed revisions to prevocational assessment processes–for consult Sept

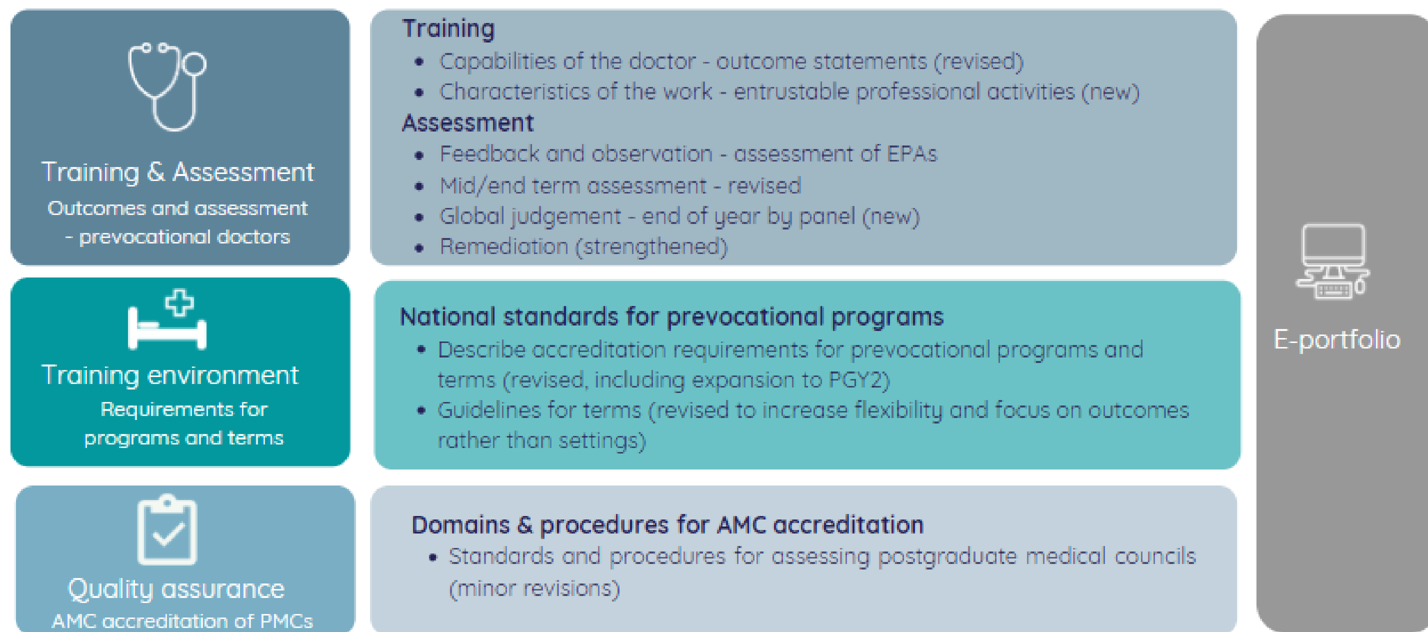
ATTACHMENT D: Proposed revisions to prevocational programs and terms – for consult Sept 20

ATTACHMENT E: High-level specifications for prevocational e-portfolio – Draft for consult Sept 20

We recognise that all questions will not apply to all stakeholders, please only respond to those that are of relevance to you. There are also spaces for general comments.

1. Framework overall

A summary of the major components of the proposed framework, including the change from one to two years, is provided in the table. It is important to note that that while the National Framework will be expanded to include postgraduate year 2, the point of general registration will remain at the end of postgraduate year 1. The revised two-year framework builds on the existing National Framework with revisions and new developments. There are some significant changes proposed, in particular to assessment, program structure and the development of an e-portfolio. Details regarding these changes are outlined in the relevant sections below.



The Medical Board of Australia is in the final stages of developing a new Continuing Professional Development Registration Standard. PGY1 doctors in an accredited program will be exempt from the requirements, but they will apply to PGY2. The Board and the AMC will ensure that requirements for PGY2 are aligned and complementary.

Questions

i. The AMC is proposing to change the name of the framework from the National Framework for Medical Internship to the National Framework for Prevocational Training to reflect expansion to PGY2. Do you have any concerns or suggestions for alternatives?

It is acknowledged that a name change is required, however there are concerns regarding the proposed terminology to be used being 'Prevocational Training' when such a scheme would be limited to PGY1 and PGY2 Medical Officers. Prevocational Medical Officers and the associated training span years broader than just those of PGY1 and PGY2 and as such it is considered that the name / terminology does not accurately reflect the scope of the framework. In addition, the purpose of the PGY1 and PGY2 years should be explicitly defined and considered in the title of the framework, as should any specialist training program that may commence in the PGY2 year and the entry of international medical graduates into such a framework. The terminology of 'prevocational training' may be interpreted as a framework designed to specifically prepare PGY1 and PGY2 Medical Officers for vocational training pathways. The use of terminology, such as 'Foundational years' is suggested to more accurately reflect the purpose and intent of the framework.

ii. The Medical Board of Australia's revised CPD requirements will apply to PGY2 doctors: a minimum of 50 hours of CPD per year that includes at least 25 per cent on activities that review performance, at least 25 per cent on activities that measure outcomes and at least 25 per cent on educational activities. The AMC is proposing that these activities are integrated into the National Framework. Do you have any concerns or suggestions?

This proposal is supported. In addition, it is suggested that formalised processes to recognise that supervisors who are engaging in such a system of assessment will also be inherently undertaking professional development activities and a streamlined approach for recognition of this is in their CPD requirements is also suggested.

iii. Do you have any other comments or suggestions about the overall Framework?

Firstly, as stated above the purpose or intent of the PGY1 and PGY2 years require clear and explicit definition. This will assist users to better understand the scope and purpose of the framework and may further assist in the successful implementation of the revised framework. Secondly, and arguably more importantly is that the authority for the accreditation of the PGY2 components of the framework needs to be defined. Currently the authority for PGY1 accreditation is derived from the National Law and associated Registration Standard, however in this proposal there will be no changes to these, and as such the authority for the PGY2 component is unclear. This could both, potentiate vulnerabilities for those implementing the framework and administering the system of accreditation, and result in significant jurisdictional variances as a dependence on each jurisdictions acceptance and willingness to exercise local authority is created.

2. Training and assessment

The AMC is proposing some significant changes to prevocational Training and Assessment. A summary of the review and development work to date is provided below.

Current components	Summary of confirmed scope
Outcomes: Key outcomes that interns should achieve by the end of their one-year program: Intern outcome statements	• Expand to PGY2 • Revise prevocational outcome statements • Develop entrustable professional activities (describing the key work of the PGY1/PGY2 doctor) • Revise assessment processes, including process for assessing EPAs, revising mid/end of term assessment and strengthening remediation
National assessment form and standards on assessment and remediation processes: • Assessment form • Certifying completion • Improving performance action plan	

A. Prevocational outcome statements – characteristics of the prevocational doctor

The Intern Training – Intern outcome statements state the broad and significant outcomes that interns should achieve by the end of their programs. The first revisions have been made to the outcome statements on the basis of the scoping and evaluation activities in 2019. Changes to the outcome statements will be iterative over the period of the review; they will continue to be revised as required alongside the changes to the Framework (including EPAs and the term assessment form).

The Intern outcome statements are aligned with the medical school graduate outcome statements. The AMC considers this alignment important. A review of the medical school accreditation standards has commenced and it is intended that the outcome statements for each phase of training will continue to be aligned.

It is considered that the current outcomes are applicable at completion of PGY1 and PGY2, acknowledging the level of responsibility, supervision, and entrustability will be different between the two years.

In revising the Framework, the AMC is also considering different methods of demonstrating and tracking achievement of the outcome statements across the two years in the e-portfolio.

The initial revisions to the outcome statements are at **ATTACHMENT A.** A summary of the revisions is provided below:

Area	Initial revisions to outcome statements for consultation
Overall	• Expansion to PGY2: Agreed not to make distinction between PGY1/PGY2 outcomes. • Areas relevant across all outcomes have been moved into the introduction: o Importance of safety and quality

	◦ Adherence to MBA's Good Medical Practice – not an outcome but an expectation of practice • Paragraph to describe the 'intent' of the domains.
Domain 1: Scientist and scholar	• Revised wording of attributes 1.1 and 1.2 to improve clarity and relevance • Moved attribute 3.4 on quality assurance from Domain 3
Domain 2: Practitioner	• Revised wording of attributes to improve clarity and relevance • Broadened 2.7 to focus on adapting to changing technology and systems
Domain 3: Health advocate	• Significant revisions in line with stakeholder feedback, attributes cover: ◦ Population health, whole of person care, Aboriginal and Torres Strait Islander Health, culturally reflective practice, patient journey in the broader system.
Domain 4: Professional and leader	• Revision to attribute 4.6 to include awareness of own rights, the rights of others, and responsibility to contribute to safe work environments

Questions

i. The revisions to the outcome statements (ATTACHMENT A) have been made in response to evaluation and stakeholder feedback to better align them with contemporary expectations of the role of prevocational doctors and to clarify the relevance and wording to that role (in particular Domain 3). What are your views on the initial revisions to the outcome statements, including whether additional revisions are required?

Overall feedback from stakeholder consultation reflected that the revisions were generally seen to be appropriate and accepted. A number of comments in regard to specific standards are outlined below:

- Competencies focused on cultural capability were limited to Aboriginal and Torres Strait Islander peoples. This is important, however this should not be limited and should be expanded to reflect the diverse nature of the Australian population
- The revision of Domain 4 sees the removal of the word 'leader'. It is suggested however that the notion of the Doctor as a 'leader' is fundamental, with Doctors requiring an understanding of their role as a 'leader' from the beginning professional practice. A such it is suggested that this terminology be returned to this Domain.
- Domain 4 alludes to shared decision-making and requirements of informed consent. These are key aspects of competent, safe and professional medical practice and this should be more explicitly reflected in the outcome statements. Domain 4 is seen to be the appropriate domain for this to be included.
- Further consideration should be awarded to how procedural competence for a range of 'core' procedures e.g. intravenous cannulation, BLS, use of defibrillator, mental health assessment, indwelling urinary catheter and nasogastric tube insertion within the domains. Junior doctors, particularly PGY2 doctors should not only be competent in such procedures but are also frequently called upon to undertake these procedures when other skilled staff are unable to – eg. They are the escalation point for 'difficult' cannulations, catheter insertions etc and as such these should be addressed within the outcome statements – either specifically through listing procedures or through a requirement for the administering facility to determine the procedures in which competence is required for prevocational doctors. The former option is preferred.

ii. It is considered that the current outcomes are applicable at completion of PGY1 and PGY2, acknowledging the level of complexity, responsibility, supervision and entrustability, as well as context, will be different between the two years. It is not proposed to specifically distinguish outcomes between the years. What are your views on this? Are there any areas that should have specific outcomes for PGY1 or PGY2?

While this approach, in theory, sounds sensible the operationalisation of such may prove problematic as there is potential variability as to the expected 'level'. This will be influenced by many factors and may potentially 'evolve' over time to differ from what the initial intent was. Perhaps a mitigating strategy could be to build in periodic 'moderation' activities both in and across jurisdictions.

iii. The review is considering the role of the e-portfolio in demonstrating and tracking achievement against the outcome statements. In the current framework, this relies largely on the term assessment forms and it is apparent that some outcomes remain 'not observed' by the end of the year. It intended that in the revised Framework, the achievement of outcomes will be part of the prevocational doctor's training portfolio and could be achieved by a combination of assessment and formal education. What are your views on this?

The approach to consider a combination of assessment and formal education more accurately reflects what often occurs now, however more importantly this supports the notion that the focus is on 'outcomes' rather than on the journey to achieve these. In addition, such an approach will support the delivery of training in a broader contexts or settings and assist both supervisors and prevocational doctors to acknowledge the role that both clinical and educational experiences offer either in isolation or combination.
Such an approach, however, does require some parameters to ensure not only validity but that the outcome has been achieved and can be performed within the intended context, being the complex health care environment where a range of personal, professional, clinical, leadership and organisational skills are required simultaneously. It is suggested that a minimum requirement for 80% of outcomes to be demonstrated through assessment would be appropriate.

iv. The prevocational training component comprises outcome statements (describing the characteristics of the doctor) and the entrustable professional activities (describing the work performed by the prevocational doctor). The Australian Curriculum Framework for Junior Doctors was referenced in the initial version of the National Framework for Medical Internship but this document is now out of date and unlikely to be revised. Is there a need for any additional components in the National Framework for Prevocational Training?

The inclusion of the Australian Curriculum Framework for Junior Doctors in the initial Framework for Medical Internship resulted in much confusion with minimal return. The removal of this will assist in clarifying and strengthening the revised framework. The inclusion of outcome statements relating to informed consent and specific procedural competence is required. Please see the response to (i) above.

v. Do you have any other comments on the prevocational outcome statements?

No

B. Entrustable professional activities – characteristics of the work of the PGY1 and PGY2 doctors

The AMC has drafted four entrustable professional activities (EPAs) as part of the revised two-year framework. The EPAs aim to describe the key work of PGY1 and PGY2 doctors, providing clarity around the most important work and learning activities. Anchored to the prevocational outcome statements, the EPAs help to align the role, outcomes and assessment of PGY1 and PGY2 doctors. The assessment of EPAs will increase structured opportunities for observation, feedback and learning and inform global judgements at the end of terms/ years.

The draft EPAS have been developed using the Royal Australasian College of Physician Basic Training Curriculum EPA structure and content, with permission.

The AMC's thinking on the EPAs in the prevocational context is as follows:

- An EPA is a description of work: This contrasts with outcomes or capabilities which describe characteristics of the doctor.
- An EPA is not an assessment tool, but performance of an EPA can be assessed. The assessment of EPAs will include judgements about entrustability, the level of supervision required for the junior doctor to perform the work safely.
- While the same EPAs will be assessed for PGY1 and PGY2 doctors, they will be assessed at a higher level for PGY2 doctors based on the complexity, responsibility, level of supervision and entrustability, as well as the context, of PGY2 doctors' work.

The AMC held workshop sessions in June to test the draft EPAs with small groups of stakeholders (including Directors of Clinical Training, Medical Education Officers, supervisors, registrars and interns) in each state/territory. Feedback from these groups was broadly positive, and supportive of the structure and content of the draft EPAs with some suggestions for revision. The AMC has also sought expert input from Dr Claire Touchie, Chief Medical Education Advisor, Medical Council of Canada, on the draft EPAs. Dr Touchie evaluated the EPAs using the EQual rubric[1] and her feedback on the draft EPAs was that they were largely of good quality.

The draft EPAs are at **ATTACHMENT B**, a summary is provided below:

[1] Taylor DR, Park YS, Egan R, et al. EQual, a Novel Rubric to Evaluate Entrustable Professional Activities for Quality and Structure. Acad Med. 2017;92(11S Association of American Medical Colleges Learn Serve Lead: Proceedings of the 56th Annual Research in Medical Education Sessions)

EPA	Summary
EPA 1: Clinical assessment	Conduct a clinical assessment of a patient incorporating history, examination, and formulation of a differential diagnosis and a management plan. (Based on RACP's EPA 1)
EPA 2: Acutely unwell patients	Recognise, assess, escalate appropriately, and provide immediate management to deteriorating and acutely unwell patients. (Based on RACP's EPA 7)
EPA 3: Prescribing	Appropriately prescribe therapies (drugs, fluids, blood products, inhalational therapies including oxygen) tailored to patients' needs and conditions, either in response to a request by the treating team or self-initiated. (Based on RACP's EPA 4)
EPA 4: Communicating about patient care	Communication about patient care, including accurate documentation and written and verbal information to facilitate high quality care at transition points and referral. (Based on combining RACP's EPA 3 (documentation) and 5 (transfer of care))

Questions

Important note: the AMC's initial thinking regarding the processes for assessing the EPAs is described in section C.

Content

i. Do the EPAs describe the key work of the prevocational (PGY1 and PGY2) doctor?

1, 2 and 4 achieve this, however it is suggested that EPA 3 is renamed and expanded to address a more longitudinal process of implementation of pharmaceutical management of patients. A suggested name is 'implementation of patient management plans – including prescribing' where this includes not only the decision to prescribe and the process of prescribing itself but the management of the patient and medications – for example the management of a delay in antibiotic administration for a septic patient due to difficulties / delay in IV access and the escalation of deviations from the expected pathway.

ii. Is there anything included in the EPAs that is not appropriate for the work of the PGY1 or PGY2 doctor?

No

iii. Are any key components of the work of PGY and PGY2 doctors missing? Are there any specific areas that should be strengthened? Are there any specific areas that are emphasized too strongly?

Please refer to previous response. It is suggested that patient consent and shared decision making be included / incorporated into the EPA's.

iv. It is proposed that the same EPAs will be assessed for PGY1 and PGY2 doctors but at a higher level for PGY2 doctors based on the complexity, responsibility, level of supervision and entrustability, as well as the context, of PGY2 doctors' work. This will be an important focus of supervisor training. Do you have any suggestions or concerns about this approach?

No, however this approach creates a dependency on the adequacy and effectiveness of supervisor training and the local implementation. Again a assurance mechanism is suggested to ensure this is implemented as intended.

Structure and clarity

v. It is proposed that the EPAs will be included in an e-portfolio, which will enable their presentation in a more streamlined format with links to additional information as required by trainees and supervisors. Do you have any feedback on the structure or clarity of the EPAs?

The structure appears sound, however emphasis should be placed on the attainment of the EPA by the end of term or throughout the year, as it is likely some prevocational doctors will still have significant learning needs or be slower to address these than others throughout a given term, and as such may at a point achieve an unsatisfactory outcome, however by the end of term be able to demonstrate the required level of performance. This should be made explicit to prevocational doctors and supervisors.

vi. Do any providers have interest in trialling the EPAs in 2021?

Yes – very!
There are a number of facilities interested in trialling EPA's in Queensland

vii. Do you have any other comments or suggestions about the draft EPAs?

C. Proposals for revisions to assessment

In line with the confirmed scope and evaluation feedback, the AMC has developed some initial proposals for revisions to assessment processes for PGY1 and PGY2 doctors.

There are three principles guiding the proposed changes to assessment:

- Strengthening the quality, consistency, relevance and longitudinal nature of assessment, including increasing opportunities for feedback.
- An e-portfolio will support the revised assessment process, including as a mechanism to facilitate a longitudinal approach to assessment and to streamline the process.
- Supervisor training and engagement will be critical. The AMC review is proposing that supervisor training requirements be strengthened, including development of online training materials and recognition of training completed for supervision of medical students or College trainees. This will include consideration of the role of and support for registrars.

A summary of the proposals for change to the assessment processes is provided in **ATTACHMENT C.** An outline is provided below:

Assessment components	Proposed change/ new development
Initial discussion	Strengthen the requirement for a beginning of term discussion between the prevocational doctor and the supervisor to outline the learning goals and assessment processes of the term.
Mid-term	Increased flexibility to enable registrars to contribute to/conduct mid-term assessments, with a process for formal sign off by the supervisor. Revisions to streamline the mid-term assessment form.
Assessment of EPAs	A specified number of EPAs to be assessed each term by the term supervisor to increase opportunities for feedback based on observed clinical practice. Some assessments may be performed by registrars. A draft EPA assessment form and proposed supervisory scale will be included in the next consultation.
End of term	Revisions to streamline the end of term assessment form.
Certifying completion	Global judgement by an assessment panel (rather than an individual) at the end of each year, taking account of EPA assessments and all end of term assessment forms. As is currently the case, satisfactory performance will be judged on attainment of the required standard by the end of the year rather than a requirement to pass a specified number of EPA or end of term assessments. Satisfactory completion of PGY1 will continue to be a requirement for general registration. A certificate of completion will be issued at the end of PGY2. The AMC is proposing that this certificate should be a pre-requisite for entry into (or continuation of) vocational training.
Remediation	Strengthening remediation processes and guidance provided to trainees and supervisors.

Questions

i. Do you have any feedback on the initial proposals for changes to the assessment processes **(ATTACHMENT C)**, including:

   a. Strengthening the requirement for a beginning of term discussion

This is well supported however as ongoing development is arguably as equally important and ensuring all prevocational doctors achieve the ‘required’ level it is suggested that this is documented in an improving performance action plan and that this document is not just limited to those prevocational doctors identified as having ‘development needs’ or those in ‘difficulty’. This will support both a continuous development approach, as intended by the framework and also assist in ‘normalising’ the use of such a document and associated process and subsequently may support early remediation, as the disincentive of ‘additional’ work / paperwork is removed. Obviously the content and execution of the IPAP will be different for the prevocational doctor who is performing at the expected level than that of the one who has identified learning or development needs.

   b. Changes to the mid-term assessment and flexibility to include registrars in the assessment, with appropriate sign off

The inclusion of registrar's in the assessment process is a practical and efficient proposal, however, there needs to either be provision for facilities to use discretion as to the appropriateness of this for each situation or minimum requirements articulated. The former would be the preferred option as there are likely to be many variances in such considerations. At a minimum, registrars should be trained and supported for their role with the authority and responsibility of the registrar and supervisor clearly defined.

c. The assessment processes for EPAS including the number, format and who should perform the assessment. The AMC is proposing:

- A minimum of 10 EPAs in total across the year and a minimum of 2 in each rotation.
- EPA 1 assessed in each rotation, and EPAs 2-4 assessed a minimum of two times each throughout the year.
- Opportunities to increase the EPAs for individuals with development needs.

Do you have any comments or suggestions about this proposal? Do you have any comments on registrars conducting some of the EPA assessments?

10 EPA's across the year will place a heavy workload on both the prevocational doctor and supervisors. The evidence for this number is unclear in the proposal, and unless there is strong evidence that 10 EPA's each year will support better outcomes then a reduction of this is suggested. 6-8 EPA's per year is seen as more achievable.

The repetition of EPA's particularly EPA 1 each term seems theoretically sound, with the assumption that the prevocational doctors practice continues to develop throughout the PYG1 or PGY2 year, however there needs to be a process to ensure and encourage continued growth and development, particularly for those prevocational doctors who are performing at the expected level –while performance at the expected level is required, ongoing development for those achieving this level should be encouraged and arguably considered a professional skill. As such the opportunities to increase EPA's for individuals with developmental needs is supported, however this opportunity should be afforded to all prevocational doctors and implemented as part of the individuals ongoing performance discussions. As the rational for the opportunity to increase the number of EPA's is to support continued growth and development this should be available to all prevocational doctors. In addition, the risk that this 'opportunity' for additional EPA's for prevocational doctors with developmental needs is viewed as a 'requirement' or an 'additional workload' needs to be managed as it will potentially act as a disincentive to award unsatisfactory ratings or initiate structured support processes.

d. Decision by an assessment panel at the end of each year. What are your views on this, including any resource implications? Do you have any suggestions about the composition of this panel?

This proposal is supported. Many stakeholders have expresses that the responsibility for this will sit as an extension to assessment review / remediation groups currently in place in many facilities. The workload of this is acknowledged to be considerable and will be largely dependent on localised processes.

e. The process for certifying completion of PGY2.

The certification of completion should be based on a global judgement as proposed and it is agreed, in theory, that this should form a requirement for entry into or continuation of college training programs. The operationalisation of this, however, is much less clear and appears to rely heavily on the individual colleges to administer through their 'agreed' co-operation. This is considered a vulnerability and non-compliance has the potential significantly undermine the intent of this framework. Addressing the authority for the PGY2 component will assist in addressing this.

ii. Feedback on the current National Framework indicates that the remediation processes need strengthening and additional guidance. It is hoped that the assessment of EPAs will help in earlier detection of those requiring additional support. What else would help with strengthening the current remediation processes? (e.g. a resource guide, supplementary assessments for remediation such as multi-source feedback or additional EPAs?)

The focus on strengthening remediation processes, in particularly early identification and early localised remediation is welcomed. Resources to support the use of EPA's in identifying those at risk, wording and expectations around the specific outcomes so there are standardised processes is also considered to be of assistance. The use of an algorithm to provide a graphical depiction of the prevocational doctor's performance and development which could be linked to the EPA's or e-portfolios would also be of assistance.

Supplemental assessments and additional EPA's may be of assistance however the use of these needs to be discretionary and focused on supporting achievement of the outcome. The risk of these being seen as additional workload will act as a disincentive for robust assessment and must be considered.

The normalisation of the improving performance action plan or IPAP will also likely support remediation processes. Inherent to the title, this document and subsequent process is focused on improving performance. All prevocational doctors should be focused on the ongoing improvement of their performance regardless of if they are identified as having developmental needs or not. Review of such a document, at the time of assessment and / or initial goal setting discussions each term, for all prevocational doctors will support the 'normalisation' of this process and potentially a more proactive approach to the identification of learning needs by the prevocational doctor and supervisor. Such a process will also assist in managing the 'grey' area that often arises between the expected level of performance and needing formalised intervention, as this will be addressed through the normal process of documented, targeted and specific processes for the goal setting, support strategies, learning needs and specific remediation activities. Obviously, there will be a graded approach to the use of such a processes with the IPAP for those performing at the expected level looking quite different to that of the prevocational doctor with identified developmental needs.

iii. In line with feedback, the AMC is proposing strengthening the standards and requirements for supervisor training and engagement, acknowledging broader system issues, such as time and resource constraints. The AMC considers there are some common features of good supervision across the medical education continuum, (e.g. giving feedback), and sees opportunities for recognition of training completed for supervision of medical students or College trainees, and opportunities for sharing resources. What specific training or additional resources would be required or helpful for prevocational (PGY1/PGY2) supervisors (both supervisors and registrars)?

Structured training providing opportunity for both initial training and ongoing development. This should be available through a range of mediums including face to face and online and include components for supported feedback on supervisor performance and processes for supporting ongoing supervisor development. Incentives for this should be incorporated into the system either at employer level, acknowledging the difficulties in this given the authority of this framework over organisational processes, or be considered as a component of college training programs of CPD. The current framework does require that training providers award priority to education and training relative to other responsibilities, however while measurement and interpretation of this is often difficult, consideration should be given to the organisations support of supervisors and recognition of the integral role they play within the system.

iv. The New Zealand prevocational model includes an educational supervisor (in addition to the term clinical supervisors and Directors of Clinical Training) who has oversight of a maximum of 10 prevocational doctors for one or two years. This person supports longitudinal development and monitoring of training and assessment requirements. The AMC recognizes that this would be challenging to achieve in the resource constrained environment of Australian prevocational training, particularly in health services with large numbers of prevocational trainees. What are your views on ways in which longitudinal support could be provided to prevocational doctors?

The New Zealand experience has seen good initial outcomes as a result of this, and while longitudinal supervision is certainly supported and should be aspired to the resource implications of such an approach, in the current Australian context, however would likely be prohibitive. Given the current resource constraints perhaps a long term goal of achieving this with staged implementation over a number of years may be the best means to address.

v. Do you have any other comments or suggestions about the proposed revisions to assessment?

No

3. Training environment

Current components	Summary of confirmed scope
National standards for programs Guidelines for terms Registration standard	• Expand to PGY2 • Review term structures in relation to quality of learning, relevance and flexibility. Focus on outcomes/experience over setting • Support expanded settings • Strengthen national standards

The AMC is proposing some significant changes to prevocational program and term requirements. This is in line with stakeholder feedback received during the evaluation phase of the review. The AMC has commenced preliminary review and development work on these requirements.

One of the proposed changes is to discontinue the current mandatory term model. Feedback from stakeholders suggests the current model creates a number of challenges in the current healthcare environment, including that:

- The model is not reflective of community health needs, and limits opportunities for expanded settings
- The model restricts flexibility to explore and take advantage of valuable learning experiences in other settings
- Capacity constraints and changing models of care (e.g. high acuity, short stay, increasing specialisation) have resulted in significant variations in interns' experience of mandatory terms. Health services report that they face challenges in providing enough terms that meet current requirements
- Defining the 'setting' does not necessarily ensure relevance, quality or consistency of learning experience

The revisions are aimed at improving the longitudinal nature and flexibility of the prevocational training programs and the quality and relevance of learning experiences. Important note: the removal of mandatory term requirements would not require an immediate change to the current program term structure.

A summary of proposed changes is provided at **ATTACHMENT D.** An outline is provided below.

Area	Initial revisions for consultation
Guidelines for terms (Based on National registration standard)	Initial proposals for change to program and term structures including removal of mandatory setting requirements, with introduction of other parameters to ensure the retention of important features such as the generalist experience and continuity. Parameters being considered include: • Breadth of experiences • Min/max length of terms • Limits on the number or duration of relief or out of hours rotations each year The AMC has commenced discussions with the Medical Board of Australia about aligning the National Framework for Prevocational Training with changes to the MBA's registration standard and CPD requirements.
National standards for programs	Initial proposals for change to the national standards for programs in line with key themes discussed above, including strengthening standards for supervision.

Questions

Proposals for change to guidelines for terms

i. Do you have any feedback on the proposals for change to the guidelines to terms (**ATTACHMENT D**)?

Yes – it is important to acknowledge that in the current framework the challenges that arise as a result of the 'mandatory' terms often occur as a result of the extensive 'required' experiences in each of these terms rather than the context in which the term is required. A move towards increased emphasis on the learning experience and learning outcomes with longitudinal flexibility is welcomed. In addition, it is important that the learning

environment or terms are considered as 'components' of the program, rather than in isolation and as such any changes to the framework should consider how the combination of terms that may be offered provide the required learning experiences and in combination, provide the opportunity to achieve the required learning outcomes (outcome statements).

ii. The AMC is proposing the introduction of parameters to maintain important features, such as generalist experience, in the absence of mandatory term requirements. In thinking about the parameters suggested:
    - What do you see as the most important (if any)? Why (rationale)?
    - What are your thoughts about proposing minimum and maximum term lengths? Should there be differences for PGY1 and PGY2? What might be the impacts of this?
    - What parameters might need to be in place to ensure a "generalist" experience or breadth of experience? (for example: by settings/environments? By patient profiles? By specialty exposure? Exposure to out of hours work? By exposure to ambulatory and inpatient care?
    - How important is being part of a (medical) team (compared with ward-based terms) to the overall experience of prevocational trainees? How might this be addressed?
    - Are there any additional considerations required regarding term allocation/ rostering?

Broad exposure across a variety of specialities and contexts is required to ensure a 'generalist' experience and arguably, to better reflect community health needs , however this should be considered longitudinally across the 24 months and support experiences and their associated learning outcomes rather than focus on the setting in which they occur. Experiences in general practice, community health, mental health, emergency medicine, general or specialist medicine and surgery are seen as valuable experiences, however, it is important to recognise that these experiences can be gained in a variety of settings, the uniqueness of which needs to be acknowledged. Opportunities to achieve the required learning outcomes need to be mapped longitudinally across all terms within the program. This will provide prevocational doctors increased opportunities to undertake terms in diverse learning environments while ensuring opportunities to meet the required outcomes and mitigate the current challenges we see associated with current alignment of term setting and required experience. In designing such, consideration needs to be also awarded to organisational requirements and the impact this may have on the 'transportability' of the program across providers or jurisdictions.

The proposal for minimum and maximum term lengths to be articulated by the framework is supported. From a learning outcomes perspective longer length of terms is supported, however the impact this may potentially have on training providers is acknowledged. It is suggested that, while minimum and maximum term lengths are stipulated within the framework, the execution of this acknowledges the requirements for the achievement of learning outcomes as well as service delivery. This could, potentially be achieved through a variation in term length, for example for each year the requirement of, a minimum of two terms with a duration of 10 - 13 weeks and a maximum of one term for a duration of less than 6 weeks. In addition to term length there should be requirements to ensure that terms are undertaken in a variety of contexts. This may be assisted by the use of broad 'categories' under which terms can be classified.

Exposure to 'out of hours' work is often well received by junior doctors who report that significant learning often occurs during such experiences. In addition, the requirements for many health care institutions or providers to continue to delivery services outside 'standard business' hours need to be acknowledged, as does the role of the prevocational doctor in this. It is important however, that the context in which this work or experience occurs is acknowledged and that the risk is carefully assessed, as is the prevocational doctor's preparedness to undertake such work. The required 'preparedness' is likely to vary from setting to setting and will be influenced by such factors as the role required, availability of supervision and other support structures. The framework should include a mechanism to ensure that this is considered alongside the prevocational doctor's previous performance and purposeful decisions are made, in the interest of the prevocational doctor and their learning needs as opposed to the service delivery requirements alone.

Ward-based work seems to result in a much more 'task focused' experience for prevocational doctors when compared to being part of a team, and arguably changes their educational and clinical experience. Assignment to a 'team' is much preferred over a ward-based rotation and better supports the achievement of the range of

clinical, professional and organisational skills required by the outcome statements. The risks and limitations that result from a ward-based allocation could, in part, be mitigated by the requirements for a breadth of experience, in particular the continuum of care and opportunities for a range of experiences. While, it is important to acknowledge ward based experiences may offer valuable learning opportunities, the revised framework must purposefully act to ensure that prevocational doctors are provided experiences that require them to function as part of a 'medical' team. In addition, it is arguable that term based experience will support more robust, reliable and holistic assessment.

Proposals for change to national standards for programs

iii. Feedback on the proposals for change to the national standards for programs (ATTACHMENT D)?

Overall the proposal appears sound and is supported, however how this is implemented within the overall framework will be important. While feedback is provided above it is difficult to consider such changes in isolation as the framework has many interdependencies that will influence the outcomes. For example, the number of EPA's that will be required, the potential combination of assessment and learning experience and the implementation of such changes either across the longitudinal two year program or considered within each year.

iv. How might the AMC support expanded settings (eg general practice, community health, drug and alcohol services) in the revisions to national standards?

An increased focus on opportunities to support the achievement of the required learning outcomes across each year, as opposed to the current focus on settings and experiences will better support this, as will consideration of the combination of formal assessment and educational experiences. In addition, definitions of supervision need to consider how supervision occurs in these expanded settings as currently the supervision is adequate in such settings, however the delivery of such differs from the more 'traditional' model seen within the hospital system. It is not necessarily the requirements for supervision that need to change, it is how this is articulated and the inferred flexibility in models with a focus on the adequacy rather than the 'how'.

v. Do you have any other comments or suggestions about the proposed revisions to guidelines for programs?

4. E-portfolio specifications

The AMC has been appointed by the Australian Health Ministers' Advisory Council to develop E-portfolio specifications to support the implementation of a two-year capability and performance framework.

The prevocational E-portfolio is a critical component of the revised Framework. It is intended to provide greater individual accountability for learning and support the assessment processes. It will also facilitate a longitudinal approach to prevocational training, providing a mechanism to support development across the two years and streamline administration of the program. A diagram illustrating possible functions of the e-portfolio is provided below.

The draft key functions at **ATTACHMENT E** have been developed by the AMC on the basis of other similar systems (for example the Medical Council of New Zealand's E-Port) and stakeholder feedback to date.

Important note: The 2018 Health Ministers' response to the 2015 Review of Medical Intern Training included a recommendation for national specifications for the e-portfolio with development and implementation at state and territory level. In consultations, the AMC has received strong feedback from stakeholders supporting a national approach to development and implementation of a prevocational e-portfolio. Reasons have included national consistency, efficiency and cost effectiveness. The AMC is engaging in discussions about the possibility of a national system with relevant stakeholders.

Questions

i. Feedback on e-portfolio specifications presented (**ATTACHMENT E**) including:

- Is there anything missing or unnecessary in the key functions/ elements?
- Does anything need to be reclassified (critical, desirable, for consideration)?

Overall the e-portfolio specifications are supported with a national approach preferable, however a number of aspects require further clarification to fully respond to these questions. In particular, this includes details as to how information may be input and accessed as well as how completeness, authenticity and confidentiality will be assured. It is considered that such information is required prior to awarding further consideration of how verification may occur and how the interplay between such a system and organisational processes designed to support and monitor individual development and performance could occur.

Generally speaking, any e-portfolio system should enable a intersect between the portfolio and organisational processes. Feedback functions are considered to be essential to support this as well as ongoing quality improvement for employing facilities and relevant departments.

ii. Do you have any other comments or suggestions about the draft e-portfolio specifications?

Overall feedback evidenced strong 'in principle' support however further details are required as the proposal progresses. A number of facilities have expressed an interest in trialling such a system.