Australian Medical Council Limited

Review of the National Framework for Prevocational Medical Training

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 **30 April 2021.**
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 updates and questions against each major component of the Framework for consultation, as follows:

1. Framework overall
2. Training and assessment
3. Training environment
4. Quality Assurance
5. 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: Requirements for prevocational training programs – Draft for consult Mar 21

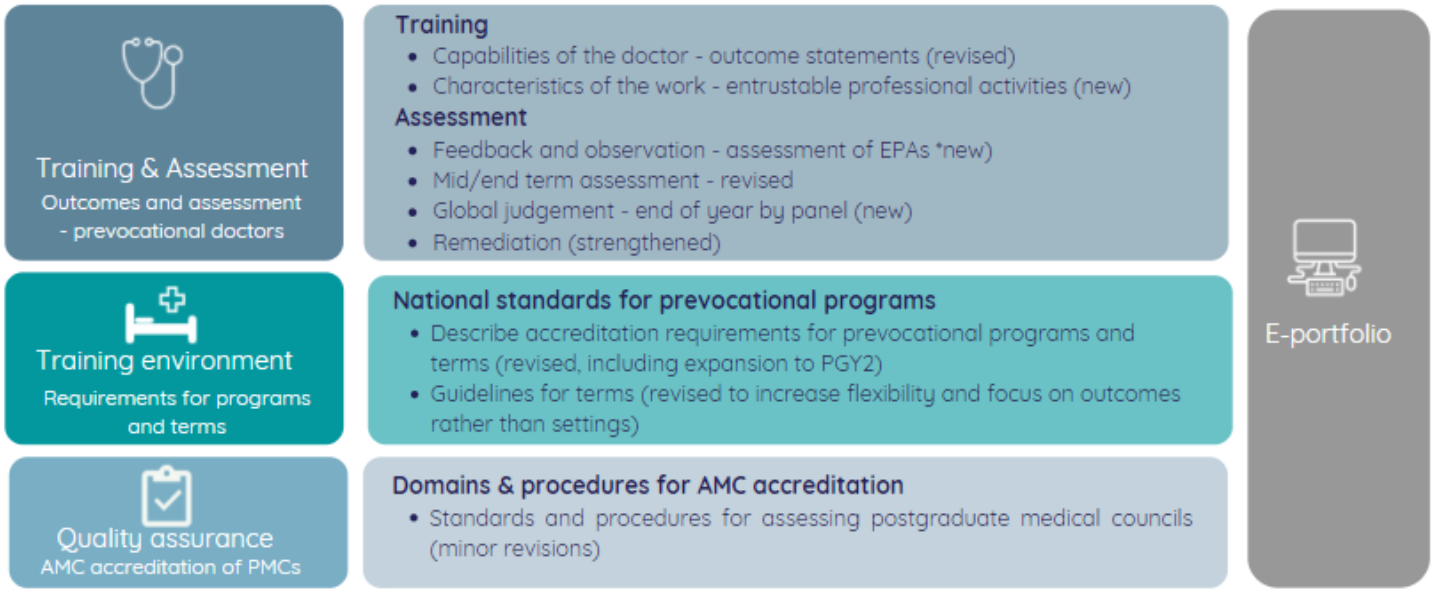
ATTACHMENT B: Training Environment: National standards and guidelines for prevocational training programs – Draft for consult Mar 21

ATTACHMENT C: High-level specifications for prevocational e-portfolio – Draft for consult Mar 21

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 intention is to provide additional support and structure around PGY2, while continuing the flexibility for prevocational doctors to enter specialist training programs. 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.

In 2020 the AMC consulted on a number of areas relevant to the Framework overall. Changes and stakeholder responses are summarised below:

Component	Response and changes
Name change	In the November 2020 consultation, the AMC proposed 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. Stakeholder feedback was broadly supportive of the change, noting that it would be important to include a definition in the documents.
Medical Board of Australia's Continuing Professional Development Registration Standard	The November 2020 consultation noted the intention to integrate the Medical Board of Australia's new Continuing Professional Development Registration Standard requirements for PGY2 into the Framework. 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. Stakeholders were supportive of this approach.

Questions

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

Overall supportive of the proposed changes. The integration of the requirements of the Continuing Professional Development Registration Standard for PGY2's into the framework is strongly supported.

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.

ATTACHMENT A - describes the training and assessment requirements for prevocational programs. A summary of areas for consultation and status in review is provided below:

Component	Section	Status in review
Training	2A. Outcome statements	Draft revised document consulted on in 2020. The current draft includes feedback and changes made in response to previous consultation.
	2B. Entrustable professional activities	Draft revised document consulted on in 2020. The current draft includes feedback and changes made in response to previous consultation.
	2C Record of learning	New component that will form part of the e-portfolio.
Assessment	3A. Assessment process	Draft revised document. Concepts were consulted on in 2020. Further detail added. The current draft includes feedback and changes made in response to previous consultation.
	3B. Improving performance	New revisions to previous remediation processes. Changes to strengthen and clarify requirements, including a focus on support.
	3C. Certifying completion	New revisions to processes, further detail added, including suggestions for the panel composition.
	3D. Forms – EPA assessment form	Newly developed. First consultation on form.
	3E. Forms – Term assessment form	Revised version of current mid/end of term assessment form. First consultation on changes.

A. Prevocational outcome statements – characteristics of the prevocational doctor

The previously titled Intern Training – Intern Outcome Statements outline the outcomes that interns should achieve by the end of PGY1. In 2020 the AMC consulted on the first revisions 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 prevocational 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.

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. Stakeholder feedback has been supportive of this approach.

The revisions to the outcome statements are at **SECTION 2A ATTACHMENT A.** This includes a summary of the changes made in response to feedback in the 2019 consultation. A summary of the revisions is provided below:

Area	Initial revisions to outcome statements for consultation	Stakeholder feedback and further changes
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	• Noted need to address this in supervisor training. • Stakeholder feedback broadly supportive of changes across the domains. • Stakeholder feedback suggested that additional training components were not required.

	○ Adherence to MBA's Good Medical Practice – not an outcome but an expectation of practice • Paragraph to describe the 'intent' of each domain. • Queried whether additional training components were required.	• Additional text added to the introduction to emphasise the importance of quality and safety specific to the Aboriginal and Torres Strait Islander context.
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	• Minor wording changes to reflect stakeholder feedback. • 1.3 revised based on stakeholder feedback and to further align with new CPD requirements.
Domain 2: Practitioner	• Revised wording of attributes to improve clarity and relevance • Broadened 2.7 to focus on adapting to changing technology and systems	• 2.1 Based on stakeholder feedback, added examples back in and strengthened emphasis on legal requirements. • 2.6 changes made including encompassing allied health treatments. • Minor wording changes to reflect stakeholder feedback.
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.	• 3.1 Revised wording based on feedback. • 3.4 is being revised with Aboriginal and Torres Strait Islander stakeholders.
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	• Minor revisions to clarify wording based on feedback.

Questions

i. The outcome statements have been revised further based on stakeholder feedback and 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 this iteration of revisions to the outcome statements, including whether additional revisions are required? (Note the AMC is running a separate process to develop content with Aboriginal and Torres Strait Islander stakeholders. The outcomes of this process will form part of the next formal consultation process).

Outcome Statement 2.1 – The use of delegation for a junior doctor may be a confusing term. Collaboration and knowing when and how to seek help may be more appropriate in a junior doctor context.

Outcome Statement 2.5 – Acknowledge that the intention is for the e-portfolio to capture the individualised procedural lists. Believe there is a missed opportunity though to create a universal procedural list that all prevocational doctors will perform as a foundation task. Such as insertion of an I.V. Will there be opportunity to obtain macro de-identified data from the e-portfolio and aggregate to common procedural lists for future use?

Outcome Statement 2.8 – Acknowledge that a deteriorating patient can be broader than physical deterioration, where however will BLS be captured if not in this section?

ii. The review has determined not to create a mandatory procedural list. It is intended that the e-portfolio will allow prevocational doctors to capture individualised procedural experience. As procedural experience varies based on term experiences, particularly in PGY2, this approach has been deemed more appropriate than a generic list. What are your views on this approach?

See above response

iii. 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 clinical 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.

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: Recognition and care of the acutely unwell patient	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: Team communication	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))

Update since the last consultation. The four EPAs were part of the formal consultation process in September - November 2020. In general, stakeholders agreed that the EPAs do describe the key work of the prevocational doctor, that they do not contain tasks inappropriate for the prevocational doctor and that no important tasks were missing from the EPAs. Stakeholders suggested that the ways in which assessments of EPAs for PGY1 and PGY2 doctors differ will form an important focus of supervisor training. There was broad support for the EPAs and their assessments being provided in the e-portfolio and multiple providers expressed their interest in trialling the EPAs in 2021. The draft revised EPAs and responses to stakeholder feedback are at **SECTION 2B ATTACHMENT A.** There are no major structural

[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)

changes included in the revised document, most likely due to the EPAs being workshopped with various stakeholder groups prior to formal consultation.

Questions

Important note: the AMC's initial thinking regarding the processes for assessing the EPAs is described in **SECTION 3A ATTACHMENT A.**

i. The EPAs have been revised based on stakeholder feedback. What are your views on the revised version of the EPAs, including whether additional revisions are required?

   Acknowledge that there are no major changes to this section; it is noted that the proposed revisions to the assessment process were part of the formal consultation process in October 2020.

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

C. Record of learning

The review is proposing that a record of learning will be incorporated into the revised framework and captured in an e-portfolio. This would include components such as:

- Training requirements (e.g. outcome statements and entrustable professional activities)
- Longitudinal attainment of outcome statements in each year (including evidence of any additional activities (courses, training modules etc) undertaken to achieve individual outcomes that may not be met during the terms completed during the year)
- Record of additional training – e.g. procedural skills or basic life support
- Personal reflections and goals

Questions

Important note: Further information about the e-portfolio is provided in **Section 5** of this document.

i. Are there additional components that should form part of the record of learning for prevocational doctors?

D. Proposals for revisions to assessment (including improving performance and certifying completion)

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; 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. The AMC will develop online training materials for supervisors of prevocational trainees. This will include training and support for registrars. Prior training completed for supervision of other cohorts (such as for medical students or college trainees) would be recognised.

Update since the last consultation. The proposed revisions to the assessment process were part of the formal consultation process in September - November 2020. In general, stakeholders were supportive of the changes proposed. A summary of the proposals for change to the assessment processes, including responses to stakeholder feedback, is provided in **SECTIONS 3A-C ATTACHMENT A.** A high-level summary is provided below:

Assessment components	Proposed change/ new development	Stakeholder feedback and further changes
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.	Broadly supportive. The review is proposing to mandate the beginning of term discussion.
Mid-term	Increased flexibility to enable registrars to contribute to/conduct mid-term assessments, with a process for formal sign off by the term supervisor. Revisions to streamline the mid-term assessment form.	Stakeholders supported involvement of registrars in mid-term assessments with appropriate training.
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.	Support for introduction of EPA assessments. There were mixed views about the proposed number of EPA assessments (ten per year) - ranging from too few to too many. The review plans to continue with the proposed ten assessments, evaluate when the Framework is implemented and adjust as required. Language describing the format of the EPA assessment has been adjusted to clarify the intention to incorporate this assessment in routine daily work. The review is proposing that other team members might conduct the EPA assessment - e.g. the ward pharmacist for the prescribing EPA.
End of term	Revisions to streamline the end of term assessment form.	Use of the e-portfolio will enable data from other sources, such as EPA assessments, to be incorporated into the term assessment forms.
Remediation (changed to Improving Performance)	Strengthening remediation processes and guidance provided to trainees and supervisors.	New changes are proposed in this consultation. The intention is to strengthen and clarify the processes, including emphasising early identification, feedback and support. processes
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.	Stakeholder support for a panel for decision-making. There was agreement that the process needs to be streamlined to avoid additional burden. There was strong feedback that it will be important to avoid duplication of assessment and certification for those PGY2 doctors who have commenced a vocational training program.

Questions
SECTION 3A ATTACHMENT A - Assessment approach

i. Revisions have been made to the assessment approach based on stakeholder feedback to the proposed changes. What are your views on the approach, including whether additional revisions are required?

The proposed changes seem sound, however the stipulated requirement for one mid-term assessment each term is likely to be onerous and of little benefit for shorter terms – suggest that this requirement has a caveat along the lines of 'for terms of more than 6 weeks duration'. Overall, the assessment process would benefit from an increased emphasis on a trajectory of 'improving individual performance' rather than just meeting the requirements. While the mandating of the 'beginning of term discussion' goes some way to support this, consideration needs to be awarded to how this is individualised and awards the appropriate priority to learning outcomes achieved through the delivery of service and the learning outcomes that are specific to the individual and their learning needs. This could be achieved through the 'normalisation' of an improving performance plan or documentation of learning outcomes with formal mechanisms for review at mid and end of term.

SECTION 3B ATTACHMENT A - Improving performance (previously "Remediation")

ii. The review has restructured the current remediation processes to strengthen and provide additional guidance, as well as refocusing the processes on support and improving performance. Do the three phases of the new improving performance process seem appropriate? Do they provide the intended constructive feedback and support? Are additional changes necessary?

The three steps are logical and reasonable, however seem to heavily focus on a cyclical process that recommences each term. Dialogue should be included as to how this becomes more longitudinal across the program, for example should an intern not demonstrate satisfactory performance in a term or should all the identified learning outcomes identified in phase 1 or 2 not be achieved by the conclusion of the term. This would best fit as an addition to 'Phase 2'. Progression of the three phases and their relationship with the likely escalating nature of the 'issue' could also be strengthened, as while the use of the term 'issue' initially enables the commencement of phase 1 for a range of circumstances, with potentially a relatively low threshold, the delineation and subsequent escalation to phase 2 and 3 may be better supported through the inclusion of a terminology change to, for example 'performance concern'.

SECTION 3C ATTACHMENT A - Certifying completion

iii. The AMC is proposing that prevocational training providers have flexibility in determining composition of the assessment panel. Examples of assessment panel composition are provided. Does this seem appropriate and is there further information required to clarify the assessment panel requirements?

iv. The evidence required for decision-making by the assessment panel has been outlined. It is intended this information will be collected and reported through the e-portfolio. To streamline the assessment panel process it is proposed that the panel might consider evidence in varying levels of detail based on the outcomes of assessment for each individual. For example routine, routine with some areas for discussion and complex cases. Does this approach seem appropriate?

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

There will be some resource implications, however this function will likely be an extension of assessment review groups already in place in most facilities, and the options to consider evidence in varying levels of detail will support a more efficient approach and the best use of these resources. The intent of the 'global rating of progress towards completion….' is strongly supported, however the language has the potential to result in confusion with 'global judgement' used to certify completion. The removal of the word 'global' from the term assessments could be removed with supervisors providing a 'rating of progress towards completion….' with minimal loss of intent.

E. Revised - Term assessment form

Initial revisions to the previous Intern Training - Term Assessment form (SECTION 3D ATTACHMENT A) have been made on the basis of the scoping and evaluation activities in 2019 and to reflect the requirements of the revised two-year framework.

The Intern Training - Term Assessment form was designed to facilitate assessment against the intern outcome statements. The assessment form, last revised in 2014, is used during the mid-term and end of term assessments of

PGY1 doctors. In some States and territories the form is also used for PGY2. The form allows initial self-assessment by the intern for discussion with the supervisor. The form is nationally available but is not currently mandated and there has been some adaptation of the form at the local level in each State and Territory. To ensure consistency of implementation, the AMC is proposing to mandate the use of a new revised form within the e-portfolio.

Note: This form will be translated into an online version prior to implementation. To reduce the burden on supervisors completing the form, most of the details in the form will be pre-populated in the e-portfolio. In response to stakeholder feedback the form has also been streamlined to reduce the length.

A summary of the revisions to the form is provided below:

Preliminary administration questions	There is an additional question in the term details section to record which year (PGY1 or PGY2) and what term of that year the prevocational doctor is undertaking. There is an additional question to record the sources of information used to complete the form, including: • consultation with members of the healthcare team • Assessment of EPAs • Record of learning
Introductory text	About this form: Includes a statement allowing registrars to contribute to mid- and end of term assessments. Final sign off by the term supervisor is still required. Instructions for prevocational doctors: Includes a statement to encourage prevocational doctors to think about ways they could improve their performance. Instructions for supervisors: Updated to reflect changes made to the structure of the form and the process for completing it including: • Ratings to be by domain rather than by individual outcome statements. • An explanation of what different ratings along the 5-point scale mean. • Advice to liaise with the DCT or MEU to help improve performance where required. Relevant documents: This section will be updated to reflect the revised Framework.
Structure and process (Significant changes including to rating scales)	Ratings are to be by domain, rather than rating each outcome statement individually. However, the supervisor is required to tick which outcome statements the assessment of the domain is based on for prevocational doctor. The form includes an acknowledgement that some outcomes are harder to directly observe than others, and provides examples of other evidence that would demonstrate progress against a particular outcome (specific to Domains 1 and 3) If any of outcomes are recorded as 'not observed' a matrix table will ask to identify: • a) which outcome(s) and • b) whether additional evidence was provided in the learning plan against that outcome (e.g. attendance at a course) Rating scale and descriptors have been made consistent across all domains: 1. Rarely met 2. Inconsistently met 3. Consistently met 4. Often exceeded 5. Consistently exceeded Further information is required when a rating of 1 or 2 is given for a domain
Global rating	The "Borderline" rating has been changed to "Conditional pass." Text has been included asking the supervisor to consider performance expectations "for the level of training" when making the global rating.
Additional support	The question asking if an Improving performance Action Plan (IPAP) needs to be completed has been removed. The e-portfolio will automatically flag ratings of 1 or 2 to the DCT. A new section titled "Additional Support" has been added in which the supervisor is encouraged to liaise with the DCT or MEU if the prevocational doctor requires further support to meet the required standard.

Questions

Note: It is planned that this form will be translated into an online version prior to implementation. Most of the details in the form will be pre-populated in the e-portfolio.

i. Currently the term assessment form is 'nationally available'. To ensure consistent implementation of the revised framework the AMC is proposing to mandate the use of this form. It is anticipated this will be supported by the e-portfolio. What are your views on mandating the form? Are there any areas within the form that require flexibility at a local level?

   Support mandating the form so consistent data can be captured across jurisdictions and that the assessment of prevocational training is consistent across all states and territories. The form should allow for flexibility at local level should this be required; however this should be considered an exception rather than norm.

ii. Significant changes have been made to the structure of the form with ratings made against the domains, rather than at the level of each individual outcome statement. The descriptors against each outcome statement have also been removed. The form still includes a mechanism to capture which outcomes were included in the assessment and this will be captured in the e-portfolio to track achievement of outcomes longitudinally in each year (PGY1 and PGY2). What are your perspectives on ratings against domains? Do you have any concerns with this approach?

   Support the approach to rate against the domain rather than the individual outcome statements. The form provides a mechanism for the supervisor to clearly articulate which outcome statement the assessment of the domain relates to.

iii. Where an outcome statement has not been observed during the course of the term, the form will include an option to record other evidence provided to demonstrate progress against a particular outcome (e.g. attendance at an educational session). This is intended to reinforce the importance of attainment of outcomes that have consistently been marked as 'not observed' in the current PGY1 assessment process. What are your perspectives on this change?

   Supported.

iv. The rating scale against each of the domains has been revised from a five point scale with tailored descriptions for ratings 5,2 and 1 to a consistent five point scale of 1) rarely met, 2) inconsistently met. 3) consistently met, 4) often exceeded and 5) consistently exceeded. What are your perspectives on the five point rating scale?

   Support 5-point rating scale for domains as articulated. Rating scale and descriptors are clear. A universal scale used across all domains provides increased clarity.

v. The middle rating of the Global Rating at the end of the assessment form has been changed from 'borderline' to 'conditional pass' to reflect the principle that assessment is a longitudinal process across the year. This terminology is used by the Medical Council of New Zealand. What are your perspectives on this change?

Note the inconsistency between the dialogue above either the terminology of 'conditional pass' to that on the proposed assessment form being 'conditional'. Support the use of the term 'conditional' and the associated dialogue on the proposed form, however the use of the terminology 'pass' should be removed to ensure the notion of longitudinal assessment.

F. Draft - Entrustable Professional Activity assessment form

An assessment form has been developed to assess the new entrustable professional activities (EPAs) (**SECTION 3E ATTACHMENT A**). There is an assessment form for each of the four EPAs. Note: This form will be translated into an online version for use in the e-portfolio prior to implementation. Most of the details in the form will be pre-populated in the e-portfolio.

Questions
i. Structure - Do you have any feedback on the structure, clarity and/or utility of the draft EPA assessment form? ii. Content – Do you have any feedback on the information included in the form, including the administrative information, EPA description or sections to be completed by the prevocational doctor and assessor? Is there anything missing or additional data that would be important to capture? iii. Entrustability scale – The AMC has developed a three point entrustability scale (requires direct supervision, requires proximal supervision and requires minimal supervision). Supervisors are asked to make a judgement on the degree of entrustment - the level of supervision required appropriate to the level of training (acknowledging that supervision requirements for PGY1 or PGY2 are different). What is your perspective on this scale? iv. Case complexity - As prevocational doctors progress through PGY1 and PGY2, it expected that the cases the EPAs are assessed on increase in complexity. For example, low to medium complexity cases would be expected in early PGY1, moving towards high complexity cases throughout PGY2. What are your views on incorporation and classification of case complexity in EPA assessment? v. Case details – The form requires information on the case from the prevocational doctor and the assessor. What type of data and level of detail do you think is required? For example, what clinical settings are important to capture? Who should fill out this information, the assessor or the prevocational doctor? vi. The AMC is planning to develop training resources to support EPA assessments. What do you think should be covered in the training? What is being proposed in the documentation is clear, concise and appropriate. In previous feedback we advised that 10 EPAs per year may not be achievable. The attachments to the revised document addresses this. Acknowledge that the proposal is to continue with the proposed 10 assessments, evaluate when the framework is implemented and adjust as required.

3. Training environment

The AMC is proposing some significant changes to prevocational program and term requirements in line with stakeholder feedback received during the evaluation phase of the review.

ATTACHMENT B - describes the accreditation requirements of prevocational programs. A summary of areas for consultation and status in review is provided below:

Component	Status in review
Section 2. National standards for programs	Draft revised document. Concepts for change were consulted on in 2020. Further detail has been added and a number of changes have been made, based on responses to previous consultation.
Section 3. Requirements and guidelines terms and programs	Draft revised document (previously Intern Training – Guidelines for Terms). Concepts for change were consulted on in 2020. Further detail has been added and a number of changes have been made, based on responses to previous consultation.
Registration standard	The Medical Board of Australia standard on granting general registration to Australian and New Zealand medical graduates on completion of internship sets out the current term requirements. The registration standard will be amended to reflect the revised framework in consultation with the Board.

A. Proposals for change to the National standards for programs

The previously titled Intern Training – National Standards for Programs outlines the requirements for process, systems and resources that contribute to good intern training. Postgraduate medical councils are currently required to map their accreditation standards to these program standards.

The consultation in Sept – Nov 2020 included a summary of the concepts for change in the standards based on the scoping and evaluation activities. Consultation feedback was supportive of the proposed changes. Detailed revisions and some significant structural changes have now been made to the standards. Changes to the national standards will be iterative over the period of the review; they will continue to be revised, particularly in relation to ensuring, where practical, alignment with the AMC medical schools accreditation standards.

Detailed changes to the standards are provided at **SECTION 2 ATTACHMENT B**. A summary of significant proposed changes is provided below.

Area	Initial revisions for consultation
Overall	Changes made to strengthen a number of areas previously consulted on including: • Expansion to PGY2 • Aboriginal and Torres Strait Islander health (content is being reviewed through a separate process with Aboriginal and Torres Strait Islander stakeholders prior to broader consultation). • Supervisor training • Quality of training and assessment (including clinical exposure, supervision and learning experiences) • Longitudinal approach to internship • Expanded settings
Structural and content changes	Standard 1 - Context – other standards relating to governance have been included in this standard to achieve better alignment. There have been minor wording changes. Standard 2 – Purpose and outcomes – this standard has been split to differentiate between purpose and outcomes. The relationship between training linking to community health needs and the goal of generalist clinical training have been strengthened. The review intends to strengthen the focus on Aboriginal and Torres Strait Islander health. Standard 3 – Program structure and content – the original standard 3 about training and standard 5 about assessment have been combined. Wording has been updated to reflect new framework requirements. Standard 4 – Program delivery – standards relevant to work based teaching and supervision have been moved into this standard to reflect the importance of clinical learning. Standard 5 – Prevocational trainees – standards relevant to wellbeing and support have been strengthened and clarified. Standard 6 – Monitoring, evaluation and continuous improvement – this standard has been moved to the end of the document and wording clarified.
Supervisor training	Stakeholder feedback was strongly supportive of strengthening supervisor engagement, training and support, acknowledging opportunities for recognition of prior learning. Some specific training modules will be developed for the revised framework components, e.g. assessment of EPAs. The AMC is proposing mandating supervisor training for term supervisors within three years of implementation of the new Framework. Prior training completed for supervision of other cohorts (such as for medical students or college trainees) would be recognised.
Mandating the national standards	A comparative analysis of the accreditation standards used by accreditation authorities (postgraduate medical councils) and feedback provided during consultation discussions has highlighted that there is variation in interpretation of the national standards at a local level. The national standards are set at a high level to allow local flexibility, which is appropriate in some circumstances. The AMC is proposing to mandate the use of the

	national standards by postgraduate medical councils, still allowing states and territories to develop additional requirements to support their local context.

Questions

Note: the order and overall structure of the standards may change in response to the work of this review and the AMC's review of medical schools standards. We ask that you provide feedback on the standards as they are currently written.

i. Do you have any feedback on the proposed revisions to the structure and content of the national standards for programs (**SECTION 2 ATTACHMENT B**)?

Introduction – Dot Point 3. The AMC has noted that "explanatory notes are included to clarify meaning, but the notes are not *prescriptive.* While PMAQ appreciates the AMC's intent regarding this statement, it is recommended that the AMC revisit this as it is PMAQ's view that the standards, by their nature require prescription in order to address existing issues regarding the consistency of their interpretation and application within and across jurisdictions. PMAQ does however support the AMC's decision to allow local flexibility in some circumstances. It is recommended that the option for 'local flexibility' is however noted where the AMC considers this appropriate to ensure there is a nationally shared understanding of this option. For example, the notes applying to Standard 1.4 are currently used by PMAQ to convey to providers the agency's minimum requirements for an appeals process. This information is also helpful in explaining to providers the difference between Standard 1.4 and Standard 5.2.7 which would be difficult for PMAQ to articulate and/or defend with providers were these notes not 'prescribed'.

PMAQ supports the proposal for the national standards to become mandatory for accreditation authorities. Further detail is however required in the document regarding where the authority for these standards is drawn from (for example, national law, the registration standard, continuing professional development etc). This is particularly relevant to implementation of PGY2 as while Queensland Health is broadly support of the introduction of accredited training for PGY2+ doctors, it is currently unclear what the overarching authority is that requires jurisdictions to implement this change.

Below is PMAQ's feedback against the proposed changes to the standards:

- Standard 1.1 – Governance – supported
- Standard 2 – Purpose and prevocational training outcomes
  - 2.1 Organisational purpose – it is recommended that the AMC consider providing notes to clarify what is meant by 'high standards of medical practice and training' to allow this requirement to be benchmarked.
  - 2.2 Supported.
- Standard 3 – Prevocational training program – Structure and content – supported
- Standard 4 – Prevocational training program – delivery - supported
- Standard 5 – Prevocational training program – prevocational doctors – supported
- Standard 6 – Monitoring, evaluation and continuous improvement - supported

ii. The AMC is proposing to mandate the use of the national standards by accreditation authorities (postgraduate medical councils), still allowing state and territories to develop additional requirements to support their local context. If the national standards are mandated, do states/territories have key areas of interest or specific requirements that may need to be or inclusion in the national standards?

With the exception of minor differences to Standard 3.1.3, the PMAQ Standards for the accreditation of intern training programs in Queensland are already aligned with the AMC Standards.

3.1.3a Interns participate in formal orientation programs at the commencement of their employment with the health service (including campuses and sites), which are designed and evaluated to ensure comprehensive and relevant learning occurs
3.1.3b Interns participate in formal orientation programs, at the commencement of each rotation, which are designed and evaluated to ensure relevant learning occurs
3.1.3c Interns participate in effective handover processes between terms and between shifts.

These changes were purposely made to ensure the orientation and handover processes offered at both the program and term levels were consistent and comprehensive. These additions also align with the existing descriptive notes for Standard 3.1 included in the AMC Standards.

Queensland notes the inclusion of remote health care settings in addition to rural and metropolitan. The inclusion of Aboriginal and Torres Strait Islander health care is a welcome inclusion.

iii. The AMC is proposing mandating supervisor training for term supervisors within three years of implementation of the revised Framework in 2023, with recognition of prior training e.g. supervisor training for medical schools or specialist colleges. What are your thoughts on mandating supervisor training and the proposed timeframes?

This change is fully supported however it is recommended that consideration be awarded to expansion of the mandate to include clinical supervisors, given in most circumstances it is the clinical supervisors that work most closely with junior doctors. Training or preparation of clinical supervisors should be congruent to their role.

iv. What level of training should term supervisors be required to undertake in order to complete assessments of prevocational doctors? These assessments are/ and will be undertaken by others within the team such as the registrar or another clinical supervisor – what level of training should other doctors completing assessments (who are team members but not the term supervisor) be required to undertake?

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

The standards are very comprehensive and clear. The additional training, monitoring and reporting requirements for supervisors will need to be considered in the context of the supervisor's current workload. There may be a risk that should the training and reporting be too onerous, potential supervisors may be reluctant take on the role. Where registrars are expected to take on supervisory roles, the registrar's own experience, workload and training requirements will need to be considered.

B. Proposals for change to the requirements and guidelines for programs and terms

The previously titled Intern Training – Guidelines for Terms outlines the experience that interns should obtain during terms and builds on the Medical Board of Australia's general registration standard. The September – November consultation proposed concepts for change. The term guidelines have now been reviewed in response to stakeholder feedback and a number of significant changes are being proposed.

One of the proposed changes is to discontinue the current mandatory term model. Feedback from stakeholders suggests that the mandatory term model has been challenging to implement in the current healthcare environment and does not necessarily meet the intended purpose of standardising the intern experience. Key issues raised by stakeholders during previous consultation include:

- The current acute public hospital model is not reflective of community health needs
- The model restricts flexibility to explore and take advantage of valuable learning experiences in expanded settings (outside acute public hospitals)
- Defining the setting does not necessarily ensure relevance, quality or consistency of the learning experience
- 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.

The proposed revisions are aimed at improving the longitudinal nature and flexibility of the prevocational training programs and the quality and relevance of learning experiences.

A summary of the concepts for change and feedback from the last consultation is provided in the table below. The revised requirements and guidelines document, including parameters to replace current mandatory term requirements, is at **SECTION 3 ATTACHMENT B.**

The Medical Board of Australia's Registration Standard "defines the supervised intern (provisional registration year) training requirements that must be completed in order for graduates of Australian and New Zealand medical programs accredited by the Australian Medical Council and approved by the Medical Board of Australia to be eligible for general registration."

The registration standard defines the current mandatory term requirements, which the review is suggesting should be revised. If this occurs the registration standard will require review. Detailed proposals will be included in the next consultation process.

Area	Stakeholder feedback and response
Overall feedback	Mandatory term structure: General support for changes to mandatory terms. However, support is dependent on ensuring that clear parameters are articulated that: ensure a generalist experience; avoid early streaming; balance health service priorities and training needs; and provide clarity for health services developing terms as well as accreditation authorities accrediting them. The review is proposing that mandatory term requirements be replaced by a set of parameters that reflect these conditions. Afterhours/relief: The review is proposing a maximum proportion of each postgraduate year working in after hours and relief positions. Program length (47 weeks): Feedback suggests that the current requirements require clarification.
Expanded settings	Stakeholder feedback was strongly supportive of better alignment of prevocational training with community health needs, particularly offering training opportunities outside the acute hospital environment in community settings. While acknowledging the challenges of mandating community terms within current Australian governance and funding models, the AMC is proposing to signal its intention to introduce mandatory prevocational community terms in the future, noting that this will require funding and organisational support from a range of stakeholders.
Term parameters	The review has accepted stakeholder feedback that the following parameters should be included in the revised guidelines for terms and programs. • Breadth of clinical exposure ensuring generalist experience • Term length • Exposure to the 24 hour cycle of healthcare • Being part of a clinical team
Minimum and maximum term lengths	There was a general consensus that terms should be a minimum of 10 to 13 weeks, acknowledging the advantages and disadvantages of longer/shorter terms in relation to continuity vs breadth of experience.
Breadth of experience	There was strong feedback on: • the importance of a generalist experience • experiences in settings such as primary care, community care, mental health and other areas to reflect community health needs • expanding learning opportunities outside of metropolitan centres and in specialties with workforce shortages. A large number of suggestions for breadth parameters were received. These have been distilled into the proposed options in the next section.
Being part of a clinical team (vs ward based care)	Stakeholder feedback supported the importance of being embedded in a clinical team. This included opportunities to be part a multidisciplinary team.
Allocation and rostering considerations	Stakeholder feedback supports setting limits to term length, noting: • the impact of variable term lengths on orientation, workforce allocation and patient care • the importance of adequate leave for prevocational doctors' wellbeing • the significant challenges of establishing a PGY2 program for health services without an existing intern program.

Questions

vi. Do you have any feedback on the proposed revisions to structure, clarity and content of the Prevocational training - Requirements and Guidelines for Programs and Terms (**SECTION 3 ATTACHMENT B**)?

No.

vii. The review is proposing the introduction of parameters for terms and programs to replace the mandatory term requirements. Stakeholder feedback was broadly supportive of the replacement of mandatory terms provided the following were maintained: generalist clinical experience, avoiding early streaming, balancing health service priorities and training needs, and clarity for health services developing terms and those accrediting them. Do the proposed parameters adequately achieve these aims for PGY1 and PGY2? If not, what could be done to improve the parameters?

Generally supportive of parameters for terms and programs to replace mandatory term requirements. Supportive of intention to provide generalist clinical training across both PGY1&2 years. A move towards increased emphasis on the learning experience and learning outcomes with longitudinal flexibility is welcomed.

viii. The review is proposing a maximum period of three years for PGY2 training undertaken part time to align with current requirements for PGY1. What are your perspectives on this maximum period of training?

Support provided there are mechanisms/processes/avenues available for those that require extended-completion times due to sickness/health issues etc.

ix. Key considerations in revising the term requirements include to better align with current community needs and modern healthcare delivery, to enable greater flexibility and support training in expanded settings and to focus on the quality of the learning experience over setting. Do you think these have been achieved through the revised parameters? If not, what would improve the parameters to better support these aims?

Yes.

x. There are a number of areas where the proposed parameters for PGY1 and PGY2 differ (breadth of experience, time in a clinical team, term length and time in service terms). The intention is to provide some additional flexibility for PGY2 doctors. What are your perspectives on the different requirements for PGY1 and PGY2? Support delineation. Parameters are clearly articulated by level.

xi. Stakeholder feedback was strongly supportive of better alignment of prevocational training with community health needs, particularly training in community settings. Acknowledging the challenges of mandating community terms within current Australian governance and funding models, the AMC is proposing to signal its intention to introduce mandatory prevocational community terms in the future, noting this will require funding and organisational support from a range of stakeholders. What are your perspectives on this proposal?

Supportive of increasing prevocational training within the community sector. A discussion paper on funding ramifications would be beneficial to ascertain cost impact to various stakeholders involved in proposed changes.

xii. Is further clarification or guidance required for health services or accreditation authorities to support the implementation of any of the revised parameters?

Possibly – although the staged/phased-implementation approach will allow HHSs/accreditation authorities to test the guidance provided and prior to full implementation.

xiii. Do you have any other comments or suggestions about the proposed revisions to the requirements and guidelines for terms and programs?

No.

4. Quality Assurance

In the National Internship Framework, the AMC accredits the bodies that accredit intern training programs. The AMC does this on behalf of the Medical Board of Australia. Currently, a separate organisation in each state/territory is responsible for accrediting intern training posts and programs.

The AMC began the accreditation of intern training accreditation authorities in 2013, and has completed the first cycle of accreditations of the established authorities.

The AMC assesses the performance of each of the intern training accreditation authorities against the requirements in Intern training – Domains for assessing accreditation authorities. The Domains were last reviewed in December 2016 when changes were made to clarify expectations about junior doctor wellbeing and processes for responding to known patient safety issues.

The AMC has standard policies on the conduct of its accreditation processes. These describe how the AMC manages confidentiality, conflicts of interest, complaints and appeals, and the key steps in any accreditation process, such as appointment of a team to complete the assessment, the activities of the team, and the interactions between the team and the organisation being reviewed.

The AMC procedural documents for each training stage are broadly aligned, with some differences in the processes. Additionally, the AMC conducts regular evaluations of its accreditation processes across the training continuum and adjustments are made to all the procedural documents as required. The Procedures for assessment and accreditation of intern training accreditation authorities by the Australian Medical Council are available here. These procedures were last updated in 2019.

Based on stakeholder feedback to the scoping consultation, the AMC is proposing that major changes to the Domains and Procedures are not required. On review of the documents the AMC is proposing the following concepts. As noted above, the most significant change proposed is mandating the use of the National Standards for Prevocational Programs. A summary of the proposals for change to the Domains and Procedures are provided below.

Component	Changes
Domains	
Overall	• Language changes to reflect updated Framework and expansion to PGY2. • As noted in previous section, the AMC is proposing to mandate the use of the national standards by accreditation authorities (postgraduate medical councils). Authorities are currently required to map their standards to the national standards.
Domain 1 - Governance	• Proposed new Domain: "Purpose", refers to the accreditation authority's commitment to ensuring high quality education and training, and facilitating training to meet health needs of the community. Alternatively, "Purpose" could be incorporated into the existing Domain 1. • Attribute 1.3: The AMC is proposing to clarify what is meant by financial viability in this attribute by including the words "organisational stability and ongoing funding to allow continuous sustainable accreditation." There will also be clarification in the notes on what evidence could be provided against this attribute.
Domain 2 - Independence	• There was strong feedback that it is critical to retain the strength of this Domain. • The AMC is proposing the word "funder" rather than "purchaser" and a requirement to include a recognition of independence in the relevant formal agreement with the funder. • Notes: will clarify that independence is required at multiple levels across the Domains: o Governance – organisation level o Accreditation process – teams, appointments

	○ Governance – accreditation level
Domain 3 – Operational management	• Noted related to resources will be clarified.
Domain 4 – Processes for accreditation of intern training programs	• A reference to the PGY2 certificate of completion will be include in the introductory sentence. • Attribute 4.8: Add "external sources of information" to this attribute, e.g. Medical Training Survey (MTS) data (notes) • Proposed new attribute: Ensuring accreditation authorities have mechanisms to deal with external sources of data that come to light outside of the regular cycle of accreditation – e.g. MTS (notes) • Attribute 4.11: Recommend that accreditation authorities publish a summary of accreditation outcomes including: ○ the duration of accreditation ○ number of conditions and commendations ○ a brief high-level summary of each condition and commendation (one sentence).
Domain 5 – Stakeholder collaboration	• Attribute 5.1: Add "Medical Schools and Specialist Colleges" to the list of stakeholders • Attribute 5.4: Clarify the intention of this attribute and the various ways it could be achieved e.g. representation on accreditation teams/ committees • Notes: Strengthen the importance of prevocational training as part of the medical education continuum. Interaction with medical schools should include discussion of preparedness for internship, and with colleges should include pathways into vocational training.
Procedures	
Overall	• The AMC is proposing that major changes are not required due to regular internal reviews. This has been supported by stakeholder feedback • There will be changes to language to reflect the updated Framework. • The AMC will make a wording change in Section 1: Management of the Accreditation Process if National standards are mandated.

Questions

i. Do you have any feedback on the initial proposals for changes to the Domains? Are there additional areas that require clarification or strengthening?

Queensland Health broadly supports the proposed changes to the domains for assessing accreditation authorities. It is however recommended that the AMC reconsider the following:

Attribute 1.3 – The use of organisational stability is subjective, as an accreditation service that is a part of a Health Department, the Department is responsive to the needs of the population it services, organisations periodically need to refocus and re-purpose such as in response to the current pandemic. As a result, organisational stability cannot be assumed, would prefer language such as 'an enduring commitment to the provision of high-quality prevocational accreditation services' This could also simply be 'assurance of the ongoing viability and sustainability of the accredited training provider in the delivery of accreditation services'.

Strongly support the requirement for independence across the domains, however this should not be limited to the 'funder' or 'purchaser'. All accreditation authorities will have multiple 'funder's' as AHPRA providers a financial contribution to each authority and the requirement for independence should be much broader. Suggest removal of the word 'funder' and have the domain focus on the requirements for independence.

Attribute 4.11 - remove the inclusion of commendations. The AMC accreditation framework is a minimum standards framework that's remit is in determining the baseline education standards for junior doctor training as opposed to an excellence framework. Each authority should have mechanisms for identifying excellence and

promoting quality improvement, however this infers there is a requirement for 'commendations' in each system and that these should be awarded to each accredited program. The intent of publication of outcomes is supported, however this should be more thematic and summative in nature. In addition the four-year accreditation cycle should be acknowledged through the inclusion of a requirement to also publish the ongoing performance of the program, specifically in addressing any deficits / concerns / areas for improvement so that any publicly available information regarding the accreditation decisions and outcomes associated with a program are more contemporaneous. In addition this standard should require accreditation authorities to have mechanisms in place to ensure a summary of accreditation outcomes are publicly available as it is not necessarily the authority that may publish these, rather the authority could have a mechanism to ensure that providers publish their own accreditation outcomes.

As such, it is PMAQ's understanding that the agency is responsible for ensuring training providers meet the minimum standards for junior doctor education not to identify where, or to what extent a training provider excels. As such PMAQ does not provide commendations to providers. While it is acknowledged that there is variation in the quality of intern training programs across Queensland, these variations are measured within the national minimum standards, not within an excellence framework.

Attribute 5.1 – Agreed regarding adding Medical Schools and Specialist Medical Colleges, need to expand the reason within the attribute as the Medical Schools and Specialist Medical Colleges are the entry and exits for an intern so they are a part of the whole continuum of lifelong education and training

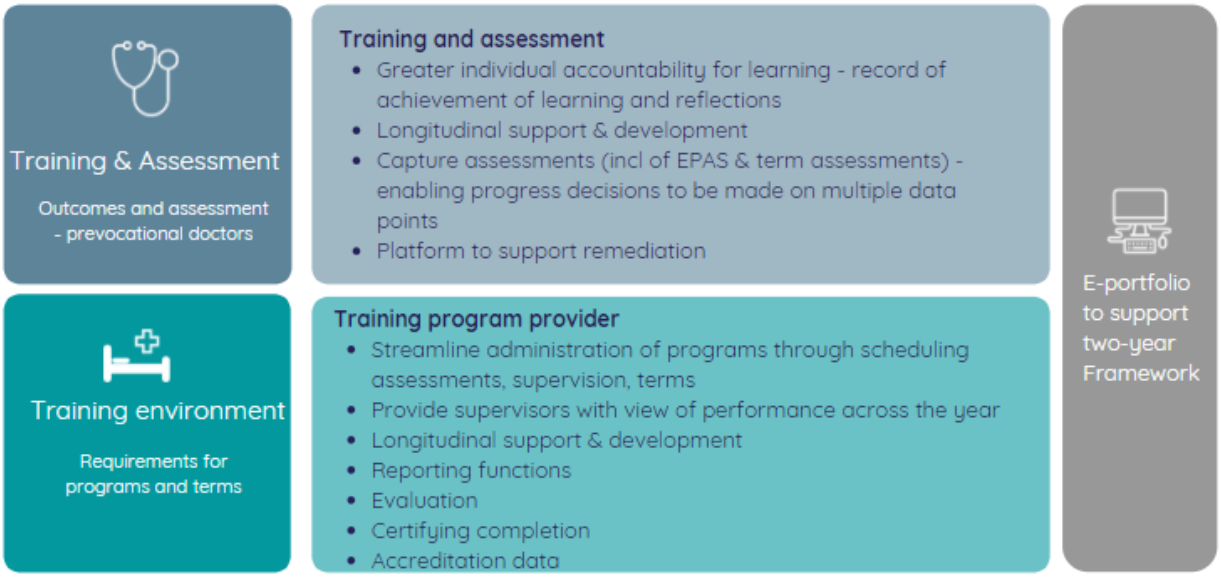
ii. In line with evaluation and stakeholder feedback, the AMC has determined that major change is not required to the procedures for accrediting the accreditation authorities (postgraduate medical councils). From your perspective, are there additional areas that require clarification or strengthening?

No

5. 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 C** 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. The high-level specifications were sent out for consultation in Sep-Nov 2020. Stakeholder feedback was supportive of the specifications proposed. Further detail has been added to the revised key functions document.

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 has put forward a proposal and is engaging in discussions about the possibility of a national system with relevant stakeholders.

Questions

i. Feedback on e-portfolio specifications presented (**ATTACHMENT C**) including:
   - Is there anything missing or unnecessary in the key functions/ elements?
     - Ability of the e-portfolio to flag incomplete work or work to be undertaken to ensure satisfactory completion of program
     - Sec 3.1 Interact Directly with the system – for the supervisors/assessors as opposed to a link possibility of the system generating a QR code for the supervisor to scan on mobile device
     - Sec 3.2 Receive reports from the system – consider adding Health Ombudsman and medical schools, medical schools my use aggregate reports for intern preparedness
     - Sec 4.2 Detailed Requirements – Assessment – Will there be a mechanism for the PGY1/2 doctor to appeal or request a review of information that has been entered such as mid/end term assessments?
     - Sec 4.2 Detailed Requirements – Assessment – What will the process be for alerting a PGY1 doctor of an uploaded assessment? Consideration for timing of the alert – it may not be advisable for a junior doctor to receive a less than favourable assessment whilst they are actively working in a clinical role.
     - Agree that the e-portfolio is not the appropriate medium for seeking PGY1/2 feedback about their educational experience
   - Are there any possible users/ roles that need to be included?

- Regarding the Question - Should the e-portfolio include capacity to extract data from other external systems (in addition to exporting) e.g. Ahpra numbers?
    - Agreed to have capacity to circulate to external bodies – consider Specialty Medical Colleges as they may seek to access the e-portfolio of an applicant to review training/experiences for consideration of entry into vocational training
- Does anything need to be reclassified (critical, desirable, for consideration)?

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