3 November 2020

Professor Brendan Crotty AM
Chair, National Intern Framework Review
Australian Medical Council
PO Box 4810
Kingston ACT 2604

Via email: prevac@amc.org.au
Cc: brendan.crotty@deakin.edu.au
philip.pigou@amc.org.au
d.ellwood@griffith.edu.au

Dear Brendan,

Re: Review of the AMC's Prevocational Framework

Thank you for inviting Medical Deans to provide feedback to the review of the AMC's Prevocational Framework. We also greatly value the opportunity to provide a representative on your Stakeholder Reference Group, Professor Stuart Carney, and E-Portfolio Specification Subgroup, Professor Jane Bleasel.

It is essential we continue to work together to enhance the support for graduates as they transition from medical student to medical professional. One of the positive experiences from the COVID-19 pandemic has been the strengthening of relationships between medical schools and health services, which enabled not only the vast majority of clinical training placements to be maintained, but also saw the co-design and development of meaningful workforce roles for students. A critical factor in these roles was the joint responsibility between medical schools and the health services for the student whilst working in a health workforce setting.

Anecdotal feedback from our members and health services has been that the Assistants in Medicine (AiM) roles in NSW have been welcomed and valued by all involved, and that they were only made possible because of this closer relationship. We believe the evaluation underway for the pilot would provide a rich source of information and insight about how to create a sustainable framework to support medical graduates as they transition into PGY1. We would welcome a Prevocational Framework that emphasised more shared responsibility for PGY1 doctors between health services and medical schools to improve students' transition from medical school to the workforce and leverage the gains made from this COVID-19 experience and AiM trial.

In regards to the proposed Prevocational Framework, our response attached focuses primarily on three key areas: defining the purpose of prevocational training; the role of prevocational training in developing a medical workforce ready and motivated to meet future population health needs; and developing improved and sustainable structures for the transition from medical school to the workforce.

Prevocational training should help consolidate a medical graduate's knowledge and skills as they enter the workforce and develop a clear path towards their specialty training of choice. We recommend the AMC's Prevocational Framework takes this opportunity to set out a clear vision on the purpose of this stage of medical training and how the Prevocational Framework will help providers and junior doctors achieve this purpose.

The recent National Medical Workforce Strategy Scoping Framework set out the critical pressures facing the medical workforce in Australia. Influencing and supporting the career choices of future doctors across the training continuum – from medical school, prevocational training, through to specialty training – is essential to addressing projected workforce under and over supply and maldistribution.

It is essential that each stage of the training continuum fosters and encourages interest in areas of workforce need – and recognises the central role that community-based care plays in the provision of health services. As such the importance of diverse training environments and experiences cannot be overstated. We welcome the proposed flexibility that aims for a more generalist and longitudinal experience across a range of settings, however we encourage more consideration is given to how an increased and sustained move to community-based prevocational training might be established.

We welcome the introduction of an e-Portfolio and would support the exploration of how this may be expanded into medical school. This could serve as a valuable tool for constructive discussions between recent medical graduates and their supervisors about their achievements and areas of relative weakness. This will better enable graduates to plan their learning during PGY1 and PGY2.

We know new doctors are vulnerable to burnout and the transition from medical school to prevocational training can be extremely stressful, often caused by the increased responsibility of making decisions and fear of making mistakes[1]. Easing this transition with appropriate supports is a priority for Medical Deans and to the sustainability of the junior doctor workforce, and we strongly recommend that this Framework take stronger account of the importance of this and consider how it could foster and drive a more connected, supportive and constructive approach to this transition.

We would welcome the opportunity for you and your team to discuss our feedback with our Executive or our extended networks with expertise in medical education, assessment, student health and professionalism. Should you wish to discuss any of the points we have raised in our submission, please contact Helen Craig, Medical Deans' CEO, at hcraig@medicaldeans.org.au to arrange a suitable time.

Yours sincerely,

Professor Richard Murray
President
Medical Deans Australia and New Zealand

[1] Beyond Blue (2013) National Mental Health Survey of Doctors and Medical Students, Table 88: Comparison of mental health status of students and doctors across stages of training and work.

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

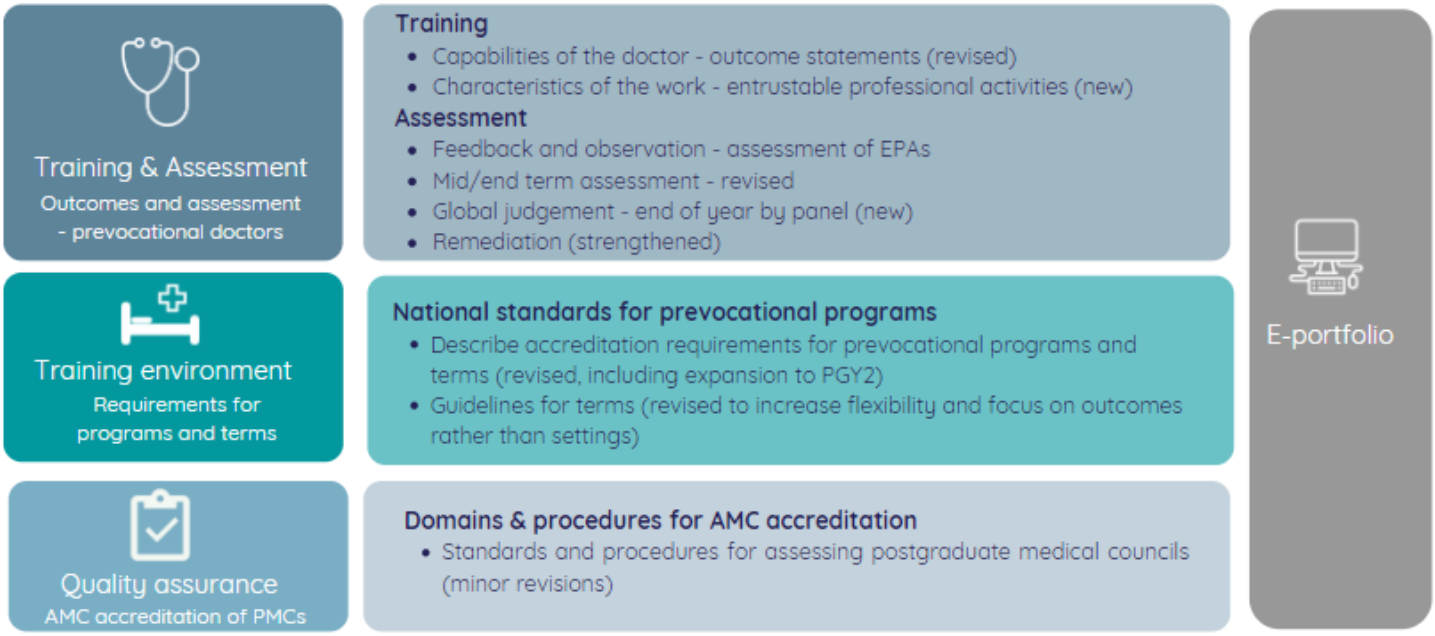
We recognise that all questions will not apply to all stakeholders, please only respond to those that are of relevance to you. There are also spaces for general comments.

Your information

Organisation (if relevant)	Medical Deans Australia and New Zealand
Name	Helen Craig
Position	CEO
Location (State/Territory)	NSW
Email	hcraig@medicaldeans.org.au
Telephone number	0449 109 721

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?

We support the suggestion to change the name of the framework. We note that the phrase does support the assumption that all doctors choose to progress into vocational training, which we know is not the case for a small number, and suggest that some time be spent considering whether there are alternatives that might be more suitable – for example, by looking internationally at terminology used – however we recognise there are likely to be some queries with whatever wording is chosen.

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?

No.

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

No

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:
	  ○ 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?

It is vital that the Intern Outcome Statements align with the expectations of the role of prevocational doctors, and we strongly support the work to ensure this is the case. However, we suggest it would be useful if the purpose of the prevocational training years were made more explicit. The review of the first year of training post-graduation by the Council of Australian Governments (COAG) identified three purposes to the training year:

- *To provide a transition to practice into the medical workforce in a system that is safe for patients and for graduates.*
- *To enable medical graduates to apply, consolidate and demonstrate capabilities and performance in the work environment as part of their progression towards independent practice.*
- *To provide exposure to different care settings and career paths as a guide to future practice and career choice[1].*

It is important that the new Framework takes the opportunity to clearly and deliberately articulate the purpose ofthis stage of training and how the Intern Outcome Statements focus on an experience that reflects that purpose. This would help ensure the revised Intern Outcome Statements are both fit for purpose and reflect the expectations of the role of prevocational doctors.

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?

We support the shift to a more flexible model based on EPAs which allows prevocational doctors to be assessed on their skills in different clinical settings and at different stages of the learning journey. It is important for the system to allow for prevocational doctors to progress through training at different paces and this new approach would be more conducive to recognising and supporting this. It would be useful to be more explicit in the Intern Outcome Statements about what level of entrustability is expected by the end of the two years, with some guidance reflecting the expected level of competence at different intervals during the two years. This would recognise the 'learning while working' context of prevocational training and the progressive nature of its process. It would also provide a useful guide for the prevocational doctors to orient and focus themselves whilst they are on this journey instead of solely focusing on competence at the end point.

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?

We support the introduction of an e-Portfolio to help manage the learning and achievement of outcomes of prevocational doctors. We strongly recommend that the approach taken is one that considers the e-Portfolio as a continuation of their medical school e-Portfolio; as this would support and encourage within the newly graduated doctor the desired culture of lifelong learning.

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?

No comment.

[1] Australian Health Ministers' Advisory Council, Council of Australian Governments (2015) Review of Medical Intern Training: Final Report, page 13

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

Whilst we acknowledge the Intern Outcome Statements are intended to be broad and applicable in a range of settings, it is essential to consider how they could be measured and how doctors will be assessed as having achieved them. Some are very broad, for example outcomes 2.5, 3.2, 3.3 and 4.1, and we suggest consideration be given to the Framework including some examples of how these might be interpreted and assessed in the context of a prevocational doctor.

The revised statements do not include specific mention of the mental health of prevocational doctors, either the knowledge, skills and habits to look after their own mental health or being aware of and responsive to signs of deteriorating health of their colleagues. We know the transition to prevocational training is extremely stressful and has an impact on their mental health. We believe this should be explicitly included.

Outcome 4.4 references "taking increasing responsibility" of patient care. However, this is a gradual process which will be evidenced by the EPAs and driven by the individual context, the patient, their skills and the supervision. It is not necessarily an outcome in itself and, if it is an outcome, then specificity about what aspects of patient care that are implied should be made explicit. Otherwise, this leaves a large area for ambiguity and mixed interpretations, leading to inconsistency of expectations between prevocational doctors, supervisors and colleagues.

We would encourage the AMC to make clearer connections about how the prevocational outcomes build on the capabilities and competencies demonstrated in the medical program. For example, considering more information about what clinical skills are expected during PGY1 and PGY2 and how this builds on the foundational skills acquired in the medical program. During the COVID-19 pandemic, a Taskforce under the auspices of the Medical Deans' Medical Education Collaborative Committee (MECC) developed a set of clinical practice core competencies. These competencies describe the foundational skills and knowledge required for medical graduates to be ready to step into internship and accept the responsibilities associated with being in the medical workforce. These competencies have been found to be very effective during a time of uncertainty as they clearly outline for all stakeholders the essential clinical skills and level of competency required in order to graduate. We would be happy to share our Clinical Practice Core Competencies document with you if that would be helpful, to support closer alignment of the outcomes demonstrated on completion of the medical program and those expected of prevocational doctors.

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[2] 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:

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

[2] 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)

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?**

No comment.

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

No comment.

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?**

No comment.

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?**

As noted in Attachment C, the supervisory scale to be used will be crucial – not only to clearly differentiate between the expectations for PGY1 and PGY2 doctors, but to support their learning journey to increased competency during each year. We look forward to contributing to this in the next stage of this consultation.

Whilst an integral part of the role and tasks of a prevocational doctor, the scenarios of EPAs 3 and 4 do not necessarily lend themselves well to an EPA approach. EPAs 3 and 4 also may be important subprocesses of another more complex clinical interaction or processes, for example prescribing fluids and oxygen as part of the treatment in the other 2 EPAs, and similarly for communication about patient care which would be a core part of many other complex processes. These are integral skills that are part of the day-to-day work of prevocational doctors and part of a range of other processes they will undertake.

EPA 3 on prescribing needs to more clearly account for the complex and broad range of medications and treatments, and the level of competence required to be involved in prescribing decisions. Whilst the "Not yet ready to perform" statement recognises the importance of scope of practice and experience, the "Ready to perform" statements do not. A PGY2 doctor assessed to be fully competent will still not be competent to make an assessment about a significant number of medicines, for example complex biologics.

We recommend the EPA scenarios be reviewed with a view to how doctors can progressively build on their skills in scenarios that require proficiency in a range of processes reflective of the context and role of prevocational doctors and decreasing levels of supervision proportionate to increasing levels of entrustability.

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?**

No comment.

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

No comment.

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

We have received feedback from some members that they feel the proposed EPAs are too broad and run the risk of being perceived as focused too much on the 'end point' (seen as a final exam). They suggest that having a larger number that are more specific and relevant to the tasks of a junior doctor might be more useful in terms of guiding and supporting the intern's learning, supervisors' targeted assessment and meaningful feedback, and more supportive of progressively developing competency and entrustability.

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

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?

e. The process for certifying completion of PGY2.

No comment.

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?)

No comment.

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)?

No comment.

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 transition to prevocational training and the first two years in the medical workforce is a period of potentially high stress. Medical Deans is exploring how medical schools and health services may be able to provide assistance through the exchange of appropriate information on student support and learning needs. There is a great deal of sensitivity around this issue for students, who are concerned that the provision of this information may have a negative effect on their career progression – i.e. that advice from a medical school to a potential employer that a student needs additional support for their mental or physical wellbeing during transition may stigmatise that student and retard their career opportunities. We believe it is important for the AMC to consider how the Prevocational Framework could enable and facilitate a constructive processes of information exchange that enables and facilitates better support for new doctors during this critical transition period and address the valid concerns noted above. We appreciate this is a significant challenge which would require broader cultural change. Given the AMC is the consistent organisation throughout the entirety of the medical training continuum, they have the opportunity to play a major role in this and foster a system of appropriate processes that are targeted at supporting doctors at each of these critical transition points.

One of the positive experiences from the COVID-19 pandemic has been the strengthening of relationships and collaborative work between medical schools and health services to enable clinical placements to be maintained and appropriate patient-care roles for students to be clarified. One such piece of work involved the development of meaningful workforce roles for students, with both medical schools and the health services having joint

responsibility for the student within a health workforce setting. We believe the evaluation underway for the Assistants in Medicine roles in NSW would provide a rich source of information about how to create sustainable and co-developed frameworks for medical schools and health services to partner in the co-development of a process and structure to better support medical graduates in their transition into PGY1 and the early months of their new role.

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

No comment.

3. Training environment

Current components	Summary of confirmed scope
National standards for programs	• 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
Guidelines for terms	
Registration standard	

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	Initial proposals for change to the national standards for programs in line with key themes discussed above, including strengthening standards for supervision.

programs	

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)?

We welcome the proposed flexibility that aims for a more generalist experience across a range of settings and with an increased focus on longitudinal experience by removing mandatory rotations. However, there are a few areas where we have identified risks to gaining the full benefit of these proposals.

Workforce pressures

The recent Australian government's National Medical Workforce Strategy Scoping Framework set out the critical workforce pressures facing the medical workforce in Australia. Influencing the career choices of future doctors in the early stages of the training continuum, both medical school and prevocational training, is essential to counter projected workforce shortages, oversupply, and maldistribution. Medical schools have invested heavily in fostering interest in their graduates for a career in areas of workforce need, specifically regional and rural areas, and the specialties needed to address future population health needs such as General Practice, psychiatry and other generalist specialties.

It is essential that each stage of the training continuum continues to foster and encourage interest in areas of workforce need, starting with diverse training environments and experiences. We fully agree with the comment in the consultation document that the current shape of prevocational training is misaligned to developing a medical workforce to meet these needs. Prevocational training in Australia over-emphasises hospital-based care and does not require graduates to consolidate and experience further learning in community settings. As such, it inappropriately emphasises certain sub-specialties and adds to the culture of promoting acute and sub-specialty careers.

Whilst we acknowledge that mandating increased experience in community-based clinical settings during the PGY1 and 2 years might not be currently feasible, we believe that this review should recognise that work is needed to enable this to be implemented in the future and indicate how this could be progressed. We would urge the AMC to consider the role they could play within prevocational training to encourage and enable the future progression of junior doctors into careers that are in the locations and specialties our communities need.

Quality of placements

The consultation documents appear to focus primarily on training environments and duration, with little reference to the quality of the training experience. From the work of medical schools in establishing and increasing regional medical education opportunities for their students, it is clear and widely recognised that a high-quality, stimulating, challenging, rewarding, and supported training experience is a key factor in influencing their learning and their future career choices. Places for regional medical education placements are routinely over-subscribed, and the Medical Schools Outcomes Database[3] reveals that it is now consistent for over a third of final-year students to state a preference for a future career based outside a capital city.

Any consideration of guidelines or parameters designed to introduce flexibility and work towards ameliorating workforce pressures need to provide clear guidance about the importance of the quality of experiences in those placements. For example, if a prevocational doctor only has an intense and high-pressure experience in an acute psychiatry ward, regardless of whether the rotation is short or long term, it should not be a surprise to hear they are unlikely to pursue a career in that specialty.

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:

[3] Medical Deans Australia and New Zealand (2020) Medical Schools Outcomes Database: National Data Report 2020. Available at: https://medicaldeans.org.au/md/2020/08/2020-MSOD-National-Data-Report_2015-2019-Full-report.pdf

- 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?

Whilst we will leave detailed comment on the above questions to those directly involved in postgraduate training, we are very supportive of the move to a competency-based approach, rather than one based on specific clinical settings or specialty rotations. Much could be learnt from the work of Rural Clinical Schools, where longer rotations of a more generalist nature are more commonplace and receive excellent feedback from students and supervisors on their ability to provide a wide range of training within this broader and longer form. This approach can still allow for substantial exposure to and learning in various specialties. For example, data shows that more than 50 per cent of general practice consultations are for a mental health issue, with workforce planning regularly highlighting the need for more community-based general psychiatrists. We need to progress from asking whether the current prevocational training in this clinical area is suitable to working on how prevocational training be adapted to better align the training needs of junior doctors with the needs of the community and ensure new doctors are provided with training that is more reflective of their likely future career. We strongly support this review in looking to address this.

Proposals for change to national standards for programs

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

No comment.

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

As noted above, there is an opportunity to use the EPAs structure to encourage doctors to work in areas of need and other settings. We welcome the flexibility of the EPAs to be applied in a range of settings. However, it is important to continue to foster interest in areas of need and the EPAs are one opportunity to leverage requirements to encourage doctors to explore other settings that are more aligned to future population health and community needs. For example, could a starting point be to require junior doctors to have least one of the EPAs completed outside of an acute or secondary care setting?

v. Do you have any suggestions about how supervision standards can be strengthened?

No comment.

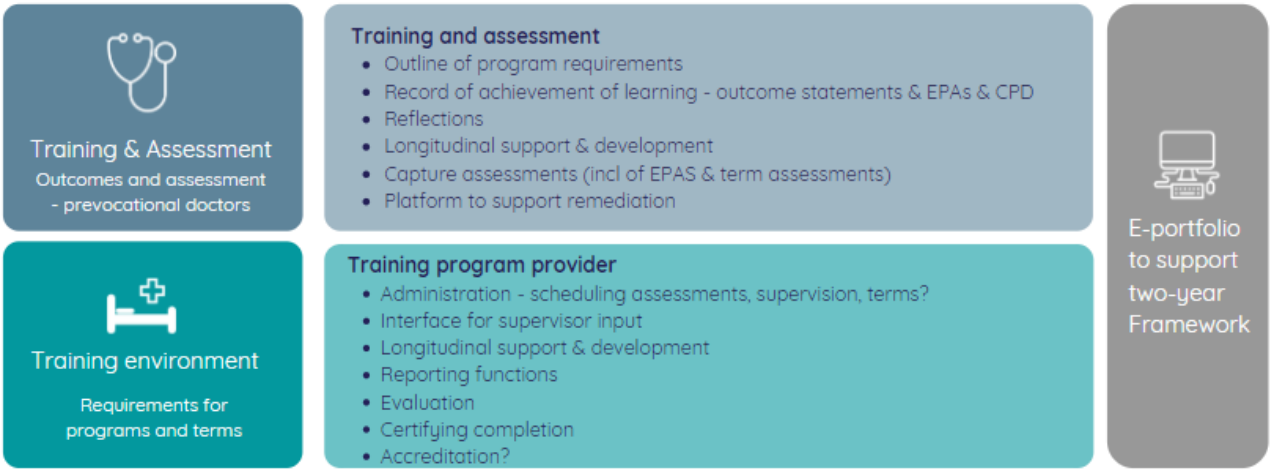
vi. Do you have any other comments or suggestions about the proposed revisions to guidelines for programs?

No comment.

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)?**

We support the approach for the proposed e-Portfolio specifications to be aligned with the record systems used by the penultimate and final year of the medical programs. As many medical programs have moved towards a competency framework and EPAs, this would prepare graduates for post-graduate training and enable a smoother transition between university and PGY1 and 2. It would also provide opportunities for alignment along the training continuum, for example allowing prevocational doctors to build on the EPA ratings assigned in their final year of medical school to move towards less supervision in PGY1 and PGY2 as their entrustability increases.

We would encourage the inclusion of feedback as well as more formal assessment outcomes. The inclusion of aspects such as results, progress dashboard report, expectations met/not met, marks, textual feedback, and rubrics, would allow junior doctors to measure their progress and reflect on areas for improvement.

In addition, alignment of an e-Portfolio with the final years of the medical program could serve as a valuable tool for constructive discussions between recent medical graduates and their supervisors about their achievements and areas of relative weakness. This will better enable graduates to plan their learning during PGY1 and PGY2

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

We agree the e-Portfolio is an opportunity for greater individual accountability for doctors and well-suited to tracking progression of prevocational doctors longitudinally throughout the two years of their prevocational training. The information in this consultation appears to suggest the e-Portfolio will have a broad range of functions such as, tracking attendance and progression through achievement of outcomes and EPAs, enabling sign off and certification, uploading training resources and student access to curate information to showcase their achievements. Whilst we welcome the extensive functionality proposed, the e-Portfolio appears to serve multiple purposes for different people which may add complexity to its design, development and implementation at different sites.

Another factor that is not clear is how it is envisaged that universities will be able to adopt the model if they choose, for example will it only be available from commercial providers, and if so from just the one or multiple providers? In addition, will there be the function to enable the data to be easily exported for universities to use or for doctors to use as part of their CV or applications?

We look forward to learning more detail about the specifications of the e-Portfolio and how this functionality aligns with the desired purpose(s) of the e-Portfolio, its role in prevocational training and plans for implementation in the different training environments.