
PREVOCATIONAL MEDICAL EDUCATION AND TRAINING

2005

Preamble

The early postgraduate years represent an important phase in the training of doctors to the high standards that have been a hallmark of medical practice in Australia. Employing hospitals and senior clinicians have always accepted an obligation to provide supervised training and development for doctors in these early postgraduate years as they progressively increased their professional skills and their contribution to patient care.

There has been an erosion of the teaching environment stemming from fiscal constraints in an overloaded health system, changes in health funding models and changes in health care delivery. Our traditional training institutions (ie public hospitals) are less able and inclined to value and support teaching, yet that is fundamental to the education and training of doctors. It is vital that teaching remain central in the early postgraduate period, even as the pressures on public hospitals increase. This holds true for other training settings that may be developed in the private sector.

Employing hospitals must have a commitment to the teaching and welfare of doctors-in-training. The hospital must recognise and reward quality clinical teaching and provide protected time for such roles. Hospitals must be funded and encouraged to develop an appropriate balance between short term service demands and the training and professional development of their medical staff.

Aims and objectives of the early postgraduate years

The AMA acknowledges the challenges of training doctors in their early postgraduate years, with a need to clarify the key skills and knowledge required for prevocational medical training. Consistent with the multiple roles of a medical practitioner identified and defined in the CanMEDS 2000 project, the AMA supports a focus during the early postgraduate years on clinical skills development and medical professionalism.

Induction into professional practice and development of those attributes/skills not specifically addressed during undergraduate medical training should provide a focus for the curriculum during this phase of doctors' professional careers. Training should be an apprenticeship which is patient focused and skills based. The apprenticeship model remains the most effective one for training doctors; it requires the direct engagement of senior clinicians and recognition by hospital employers.

The AMA supports the Medical Training Review Panel (MTRP) recommendation for medical practitioners to have balanced and generalist orientation to their first two postgraduate years which would allow them to access vocational training offered by medical colleges.

At the same time the AMA acknowledges the needs of those doctors-in-training who have made a choice regarding their ultimate vocational training program and encourages hospitals to facilitate placements accordingly. The AMA strongly supports the need to ensure that such early career decisions do not compromise any subsequent changes in vocational career choice and that recognition of prior learning exists.

The fact that some doctors seek to enter vocational training programs at the end of the Intern year makes it all the more important that all Interns undertake rotations in Emergency Medicine, Surgery and General Medicine. These are critical disciplines in the postgraduate training and development of doctors and should be compulsory for Interns. It is not enough for doctors simply to work in these areas; placements must be well organised and properly supervised.

The grant of full medical registration for doctors should continue to occur on satisfactory completion of the Intern year.

Accreditation of postgraduate training programs

Hospitals should continue to be accredited before being permitted to employ Interns. Accreditation standards should be derived from the *National Training and Assessment Guidelines for Junior Medical Doctors PGY 1 and 2*, which were produced by the Confederation of Postgraduate Medical Councils (CPMEC) in 2001. They are published on the internet and are widely available. Once standards are set in a manner consistent with the guidelines, compliance should be enforced in each state by the Postgraduate Medical Council.

The AMA supports regular on-site assessment of hospitals by professional and trained peer review teams. Membership of accreditation teams should include doctors-in-training.

Workforce shortages and administrative pressures should not influence the accreditation process. Failure to meet accreditation standards should be a realistic possibility, and must preclude the employment of Interns in that hospital. The process should be overseen by the state PMCs with the accreditation process approved by the Australian Medical Council.

If extended periods of accreditation are granted, there must be a formal mechanism to monitor standards and resolve training issues in between formal visits.

Furthermore, in between site visits, reporting mechanisms must exist for affected doctors to notify deficits in hospital training programs to state PMCs, particularly in those circumstances where trainees are on secondment to a secondary allocation hospital. This process should be facilitated by Directors of Clinical Training, the PMCs and the state AMA Doctors-in-Training (DIT) committees as independent representatives of affected doctors.

Assistance should be provided through the PMC network to assist hospitals to meet accreditation requirements or remedy identified deficiencies.

Representation of doctors-in-training is a critical part of the accreditation process. A loose, informal arrangement is ineffective. Formal structures must exist for seeking feedback from PGY 1 and 2 doctors on their prevocational training. These doctors must be represented in a way which is truly representative of their interests, is independent of the PMCs and hospital employers and has funding and organisational support for their activities. State AMA Doctors-in-Training committees are the only DIT bodies which meet these requirements.

Properly structured DIT representation would facilitate feedback from hospitals and allow junior doctors a non-threatening means of raising concerns about prevocational training in particular centres. Furthermore, the AMA in each state could progress concerns with underperforming PMCs in each state.

Curriculum development for prevocational training

The AMA views with caution any attempt to develop prescriptive medical school-style curricula for this period of prevocational training, including the implementation of training portfolios. As a principle, the AMA resists any attempt to become overly prescriptive with respect to prevocational training in PGY 1 and 2. Current work on a national core curriculum should result in a guide for development and assessment, not a set of assessable requirements which would effectively create another formal hurdle for doctors-in-training without necessarily adding any value to their professional development and skills as medical practitioners. The intent should remain the creation of useful learning opportunities and outcomes through direct patient care and clinical experience.

This still requires goals and standards to be set in the areas of medical skills, knowledge, tasks and behaviour that constitute the agreed education and development program and outcomes for doctors in the early postgraduate years. It also requires hospitals to recognise and set aside time for both the trainees and for the senior clinicians and registrars who actually deliver the teaching.

Assessment

The AMA does not support formal written assessment or other centralised examinations for postgraduate prevocational trainees. Such measures would not be in the spirit of clinical skills

development and fostering of medical professionalism which should remain the focus of the early postgraduate years.

Supervisor reports should continue to be a key element of assessment, but they need to be supported by structured feedback sessions during the term, not just at the end. The process should incorporate self-assessment by doctors-in-training as the basis for discussion. Where a doctor disagrees with a supervisor's assessment, or it is inconsistent with reports from other supervisors, there should be access to a formal review process.

The AMA supports the concept of "performance management plans" for doctors in PGY 1 and 2, provided that the emphasis is on setting and achievement of professional development goals based on CanMEDS criteria. Using such a process for setting agreed goals and providing feedback on progress towards them can be valuable, provided it is done consistently and well. It can provide clarity and reinforcement for those who are going well and, for those who are struggling to meet the requirements, it can help to identify problems at an early stage and develop measures to overcome them.

Performance management plans should involve the trainees, Director of Clinical Training and term supervisor and should establish the details of training required within a defined timeline agreed upon by all parties. They need to be set within a performance management scheme that ensures a fair and consistent process for all.

Competency Based Training & Assessment

There is an increasing push towards competency based training (CBT) and assessment in the medical workforce. The implementation of CBT in Australia has progressed rapidly since the 1990s and CBT is widely accepted. However, one of the criticisms of CBT is that strategies are needed to bridge the gap between competence and excellence. Medical education should not be about simply "falling across the line".

Concern has also been expressed that CBT can encourage fragmented learning and a checklist approach that ignores the holistic assessment of competence and assessment of underpinning knowledge.

The implementation of competency-based frameworks must recognise and address these limitations. In addition, a competency based training framework can only work when there is:

- Organisational support for learning and development
- Clearly articulated competencies
- Appropriate infrastructure to support a quality learning environment and experience
- Access to training opportunities and appropriately qualified supervisors
- Assessment by appropriately qualified assessors

Educational environment and the employer hospital

The employer hospital must have a commitment to the teaching and welfare of doctors in the early postgraduate years. It should be the aim of hospitals to establish and maintain a teaching culture. The hospital must recognise and reward quality clinical teaching, and provide protected time for such roles, both for the trainees and the more senior medical staff who provide the teaching and mentoring.

Each hospital employing interns and PGY 2 doctors must have a clinician in a Director of Clinical Training (DCT) role with time to undertake it and adequate administrative support. Appointments of Directors of Clinical Training should occur in conjunction with state PMCs, and there should be PMC representation on hospital appointment committees.

Clear reporting/communication mechanisms should exist between hospital DCTs and the PMC. There must be regular contact between the DCT, the PGY 1 and 2 doctors and the more senior medical staff, including registrars, who supervise and teach them. An education committee or other formal structure with representation of doctors-in-training can help in this regard.

All doctors in PGY 1 and 2 should be made aware of local and national training guidelines and how to access them.

Protected time must be available for teaching and professional development. This means that senior clinicians should have teaching responsibilities and non-clinical time built into their job descriptions and work schedules. The AMA supports a benchmark of five hours per week of pager-free quarantined education time for doctors in PGY 1 and 2, with a strong expectation that they will attend education and training activities in that time.

Hospitals must develop mechanisms which do not allow service pressures to encroach on the professional development of their medical staff. For example, educational sessions should be scheduled at times where they are least likely to conflict with times of high service demands. When rostering medical staff, hospitals should aim to ensure that opportunity is provided for staff to attend sessions

Junior doctors should be encouraged to engage with the formal and informal learning processes that are made available to them in the work environment. They should have access to professional development leave to attend courses and take up other learning opportunities outside the hospital workplace.

The AMA recognises the importance of appropriate orientation for junior medical staff, particularly for those doctors seconded to peripheral centres.

Junior doctor requests for specific terms should be accommodated wherever possible, recognising the importance of facilitating exposure to disciplines in which they have vocational training interests.

Rural or community terms are encouraged where they meet PMC/AMC requirements and do not detract from experience in core clinical areas such as general medicine, surgery and emergency medicine.

Summary of Key Points

1. It is vital that teaching remain central in the early postgraduate period for doctors, even as the pressures on public hospitals increase. Employing hospitals must have a commitment to the teaching and welfare of doctors-in-training.
2. Consistent with the multiple roles of a medical practitioner identified and defined in the CanMEDS 2000 project, the AMA supports a focus during the early postgraduate years on clinical skills development and medical professionalism.
3. All Interns should undertake well organised and properly supervised placements in Emergency Medicine, Surgery and General Medicine as these are critical disciplines in the postgraduate training and development of doctors. Full medical registration should continue to be granted for doctors on satisfactory completion of the Intern year.
4. Hospitals should continue to be accredited before being permitted to employ Interns, with accreditation standards to be derived from the *National Training and Assessment Guidelines for Junior Medical Doctors PGY 1 and 2*.
5. Doctors-in-training should be directly involved, through formal representative structures, in accreditation of employing hospitals and in reporting mechanisms to ensure employing hospitals are complying with the terms of their accreditation.
6. The AMA is opposed to any attempt to develop prescriptive medical school-style curricula for this period of prevocational training; the focus should be on clinical skills development and fostering of medical professionalism.
7. The AMA does not support formal written assessment or other centralised examinations for postgraduate prevocational trainees because these measures shift the focus away from direct patient care and clinical experience.
8. Any move to competency-based training and assessment of doctors must recognise its limitations and the prerequisites for it to work at all.
9. Protected time must be available for teaching and professional development of doctors-in-training; senior clinicians should have teaching responsibilities and non-clinical time built into their job descriptions and work schedules.
10. Employing hospitals must develop mechanisms which do not allow service pressures to encroach on the professional development of their medical staff.