Prevocational medical education and training

2020

This document outlines the AMA's position on the scope and structure of prevocational medical education, which encompasses the period between graduation and the commencement of vocational training. This includes the internship year (postgraduate year [PGY] 1) and post internship training (PGY2+). Doctors at this stage of their training are collectively referred to as prevocational doctors in this document.

1. Key points

1.1. The AMA supports a focus on generalist medical training, clinical skill development and medical professionalism in PGY 1 and 2, consistent with Medical Board of Australia (MBA) and Australian Medical Council (AMC) standards and guidelines.

1.2. General medical registration should be granted for doctors on satisfactory completion of the internship year (PGY1). Post internship, training should provide prevocational doctors with an increased level of responsibility for patient care with sufficient options to allow a vocational emphasis in training to occur.

1.3. All prevocational training places should be accredited against robust standards informed by a nationally consistent accreditation framework with respect to education and training. This will provide all prevocational doctors with a valid, safe, and well-structured training experience that facilitates entry into vocational training or the career path of their choice.

1.4. This framework is rigorously and appropriately developed by the Australian Medical Council (AMC), and implemented by state-based Postgraduate Medical Councils (PMCs or their equivalents). Employers should be accredited to agreed standards before being permitted to employ prevocational trainees and held accountable for complying with these standards.

1.5. The AMA encourages best practice in, and the implementation of, effective learning systems for prevocational doctors. Well-resourced supervision, feedback and assessment arrangements should foster clinical skill development, a personal understanding of areas for improvement and medical professionalism.

1.6. Supervisors should be adequately trained and supported to teach prevocational doctors.[1] Protected time must be available for more senior doctors to teach, supervise and assess prevocational doctors; and should have teaching responsibilities and non-clinical time built into their job descriptions and work schedules.

1.7. Employers must commit to building and sustaining a positive and respectful workplace culture and have appropriate workplace policies focussed on prevocational doctor health and wellbeing. This extends to adequate orientation, welfare and support, safe working hours and flexible work arrangements to facilitate health and wellbeing and an appropriate work-life balance.

1.8. Robust and independent workforce modelling and planning must inform the provision of an appropriate number of adequately funded undergraduate, prevocational, and vocational training places in line with projected community need. reater clarity on the supply and demand of prevocational and vocational training positions is also needed. Jurisdictions and employers should establish processes to collect and publicly report on the number of intern and prevocational positions available and unfilled each year to inform recruitment processes and workforce planning.

[1] This includes prevocational doctors who play a significant role in the delivery of clinical teaching to less experienced doctors and medical students.

1.9. The AMA supports evidence-based methods of prevocational training and assessment that leads to a greater generalist foundation of clinical experience for trainees. This should be underpinned by flexible and career-aligned options, while delivering excellent medical care to the community.

1.10. Systems that provide data on the quality and effectiveness of training are essential to drive evidence-based improvements to training. This will assist in preparing doctors for the transition from medical school to vocational training, support innovation in education and training, and align training with the health care needs of the community.

2. Aims and objectives

2.1. The aim of prevocational medical education is for medical graduates to consolidate and apply clinical knowledge while taking increasing responsibility for safe and high-quality patient care. Strengths of the current system include an experiential model of training, an emphasis on early clinical immersion, a willingness of senior doctors to provide workplace-based supervision and tuition and a flexible, innovative, and integrated approach to training.

2.2. It is important that prevocational doctors have a well-structured, balanced and generalist orientation to their practicing careers.[2,3] Exposure to a range of medical disciplines and clinical situations within a safe practicing environment will support the development of a generalist skill set in line with workforce and community needs It will build a firm foundation for specialist and generalist practice and enable prevocational doctors to make meaningful and informed decisions regarding career choice and vocational training.

2.3. Appropriate clinical contexts for prevocational exposure include experiences in resuscitation/urgent care, acute care, subacute care, and community/chronic illness care. While programs may focus on mandatory acute care terms, it is important that clinical experiences are also provided in non-acute settings (i.e., general practice and community settings) to enhance professional and personal growth, and to better align training requirements with the needs of the community.[4] These settings must be adequately funded, supported, and resourced to support teaching and training in these contexts.

2.4. Rural training terms fill an important workforce and educational need. Regional/rural placements should be incorporated into prevocational training to support the development of a generalist clinical skill set, encourage doctors to work in areas of workforce shortage and inspire regional and rural practice.

2.5. The AMA recognises that some prevocational doctors will have made a choice about their future specialty following internship. Sufficient options should be available to provide prevocational doctors with an opportunity to explore a particular discipline as part of an overall career development plan and to allow a vocational emphasis in their training to occur.[5] Flexible responses to individual circumstances are encouraged. These include College recognition of specific terms/experiences during the prevocational years as contributing to entry into vocational training.

[2] Gleason AJ, Oliver Daly J, Blackham RE. Prevocational medical training and the Australian Curriculum Framework for Junior Doctors: a junior doctor perspective. MJA 2007; 186 (3): 114-116.
[3] Prof John Collins. Foundation for Excellence. An Evaluation of the Foundation Programme. October 2010.
[4] Young L, Larkins SL, Sen Gupta TK, et al. Rural general practice placements: alignment with the Australian Curriculum Framework for Junior Doctors. Med J Aust 2013; 199 (11): 787-791.
[5] Some specialist medical colleges now offer a vocationally aligned prevocational curriculum to prepare prevocational doctors for vocational training.

3. Accreditation

3.1. Robust, profession-led accreditation arrangements are one of the strengths of medical education in Australia. The AMA believes that all prevocational training places should be accredited to ensure:

a) Prevocational doctors have access to structured education and training programs, organised clinical oversight, professional development, and support.
b) The entire continuum of medical education is accredited against agreed benchmarks to provide greater consistency and validity in the training experience for prevocational doctors.

3.2. The AMA supports the role of the Medical Board of Australia (MBA) and Australian Medical Council (AMC) in developing a nationally consistent framework for registration and accreditation of prevocational medical education, underpinned by the AMC accreditation of PMCs or their equivalents.

3.3. The AMA supports the role of the PMCs in accrediting prevocational training places using the standards developed by the AMC to assess clinical experience, quality, and safety. Providing a mandate and funding arrangements for PMCs to accredit all prevocational training places will provide continuity in the training and employment experience for prevocational doctors.

4. Internship PGY1 and PGY2

4.1. The internship year (PGY1) is a foundation year of work-based learning that culminates in general registration to practise medicine. It is a key part of the transition period between medical student education and career development in a chosen specialty.

4.2. The AMA supports an internship period that provides sufficient time in supervised clinical practice for the trainee to meet the requirements for general registration. Sufficient time for study and conference leave should be allocated as part of, and contribute to, this minimum time, in order to allow prevocational doctors to participate in continuous professional development.

4.3. There should be flexibility in the system to allow interns to meet training time requirements for general registration. Prevocational doctors who are unable to complete their internship within the time frames defined by the MBA should be able to apply for an extension to their provisional registration. General medical registration should be granted for doctors on satisfactory completion of internship.

4.4. Intern training programs must meet the requirements of the MBA registration standard for granting registration as a medical practitioner on completion of intern training and accompanying AMC accreditation standards and guidelines for intern/prevocational training. The curricula should be designed to achieve the AMC outcomes statements for intern/prevocational training and related capabilities.

4.5. It is important that training in PGY1 and 2 is well organised and properly supervised and provides prevocational doctors with adequate exposure to the appropriate depth and breadth of clinical experience, caseload and involvement in care to prepare them for increasingly independent practice. Using sub-specialty terms/experience is appropriate to the extent that it complements and does not impede a generalist experience and maintains the validity of training.

4.6. Assessment during internship should be consistent with the AMC national framework for prevocational training. The AMA supports an apprenticeship model of time-based prevocational training complemented by competency-based assessment.

4.7. There should be regular and comprehensive onsite supervision for interns at all times. Prevocational doctors should not be placed in a position where they are not adequately

supported by senior medical staff/registrars. While the overall term supervisor should be a consultant or senior medical practitioner with experience in the management of patients in the relevant discipline, the broad scope of practice of many supervisors in rural and regional areas should be taken into consideration to foster innovation of supervisor accreditation requirements in these centres.

5. PGY3+

5.1. The AMA supports the establishment of an accredited training pathway for prevocational doctors from PGY3+ that provides a valid, safe, and rewarding training experience, and a career pathway that values the different career preferences of doctors and recognises that these may change. Principles that should underpin this pathway include:

a) Recognition of prior learning for entry into vocational training.
b) Provision of safe and collaborative rostering.
c) A clear list of expected responsibilities.
d) Options for flexible work and training arrangements.
e) Safe supervision standards and training requirements met through accreditation by the relevant accrediting body.

6. Learning and assessment

6.1. Effective supervision, assessment and feedback is a critical element in practice-based learning as prevocational doctors acquire various knowledge and skills and behaviours throughout their training. Clinical skill development, a personal understanding of areas for improvement, and medical professionalism should underpin supervision, feedback, and assessment arrangements for prevocational doctors. Assessment of education and training should not be used for recruitment purpose.

6.2. The AMA supports the periodic review of current learning and assessment paradigms to ensure practice remains fit for purpose and continues to produce high quality doctors capable of increasingly independent practice.

6.3. Effective prevocational trainee feedback mechanisms must also be in place to aid providers in improving and strengthening prevocational education and training programs.

6.4. It is important that all prevocational doctors have clearly articulated educational goals and outcomes and that supervisors and assessors have clear criteria for determining progress and completion of prevocational training.

6.5. Wherever possible, there should be a clear delineation between supervisors and assessors performing direct term assessment to ensure that prevocational doctors feel confident to raise matters relating to training as they progress.

6.6. Supervisors, and doctors in training[6] who supervise more junior doctors and medical students, should have access to supervisor training and protected teaching and training time so that they can effectively perform their role.[7]

6.7. Prevocational doctors should not be asked to practice beyond their scope and without adequate supervision. Employers should ensure prevocational doctors are appropriately supervised and trained to perform the duties required prior to undertaking a particular clinical rotation or task.

[6] Prevocational doctors play a significant role in the delivery of clinical teaching to more junior doctors and medical students.
[7] Doctors should be allocated at least 20 per cent of their normal weekly hours to CST duties, consistent with medical college guidelines where relevant. AMA Victoria – Victorian Public Health Sector - Medical Specialists Enterprise Agreement 2018-2021.

7. Welfare and support

7.1. Employers must make a commitment to the teaching and welfare of prevocational doctors and maintain a balance between the demands of clinical service delivery, requirements for learning and health and wellbeing. This includes a commitment to building and sustaining a positive and respectful workplace culture and having in place appropriate workplace policies to support doctor health and wellbeing including mechanisms to address bullying and harassment, adequate orientation, safe working hours and flexible work arrangements. [8]

7.2. A comprehensive orientation program for prevocational doctors is important, particularly for doctors seconded to peripheral and/or isolated centres. Employers should utilise best practice in orientation programs to improve the transition to a new work environment for prevocational doctors.[9]

7.3. Appropriate and timely support must be available to prevocational doctors who encounter difficulties during training and/or are unable to meet and/or complete their training requirements. Prevocational doctors in difficulty should be supported via clear support/performance action plans to enable them to progress through training.

7.4. There should be supported opportunities for prevocational doctors to appeal assessment decisions via fair and transparent processes. Prevocational doctors should be aware of how to access complaints and remediation processes and have confidence that complaints will be handled in a timely and professional way. Where a prevocational doctor disagrees with a supervisor's assessment, a formal review process should follow.

7.5. Prevocational doctors should have access to both confidential personal and professional/career counselling and support services over the course of their training. Opportunities for early career planning, mentoring and support during training are appropriate to enable prevocational doctors to be more informed and confident in choosing a vocational pathway.[10]

7.6. There should be formal representative structures and mechanisms by which prevocational doctors can provide feedback on their training, at both an employer and professional level. This is an important mechanism to protect quality, transparency, and accountability.

See also:

Support for non-vocational trainees prior to entering a vocational training program – 2016

Employment processes for prevocational trainees - 2015

Building Capacity for Clinical Supervision in the Medical Workforce – 2017

Clinical support time - 2010. Revised 2019

Health and wellbeing of doctors and medical students - 2020

[8] This extends to the provision of adequate orientation, welfare and support, debriefing for vicarious trauma, safe working hours and flexible work arrangements that facilitate an appropriate work-life balance.
[9] Leeder S. Preparing interns for practice in the 21st century. Med J Aust 2007; 186 (7 Suppl): S6.
[10] MABEL Matters. Centre for Research Excellence in Medical Workforce Dynamics. No. 9 May 2014.