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Mr Philip Pigou
Chief Executive Officer
Australian Medical Council
Email: prevac@amc.org.au

Dear Philip,

Thank you for inviting the AMA to provide feedback on the proposed scope of the review of the national framework for medical internship.

Our response to your consultation questions is attached. This was informed by the AMA Council of Doctors in Training.

I look forward to our ongoing involvement in the review as it progresses.

Please direct any questions pertaining to this response to Sally Cross, Workplace Policy at scross@ama.com.au.

Yours sincerely,

Dr Tony Bartone
President

## 1. Questions about proposed changes to the Framework overall

| Case for change | Proposed changes |
|---|---|
| × 2018 Health Ministers' agreed to changes in response to the COAG Review of Medical Intern Training, including development of a two-year capability and performance framework<br>× Internship is not functioning as a longitudinal program:<br>o difficult to identify and support interns across terms<br>o limited longitudinal development<br>o data not routinely collected | × Likely to result in significant changes, including to national standards, assessment and to accreditation of posts and programs.<br>× Consider the Health Ministers' 2018 response to the 2015 COAG Review of Medical Intern Training Recommendations in relation to the Framework.<br>× Expansion of the current National Framework to a two-year transition to practice model. Registration will remain at the end of PGY1. This will include consideration of differences in requirements for PGY1 and PGY2 and continuing capacity for entry to specialty training in PGY2.<br>× Consider mechanisms to support a longitudinal approach to internship. For example, strengthened standards on governance of the program, mechanisms for tracking development across terms or/and a longitudinal educational supervisor. |

### Questions

**Broad questions**

**A. Have we got the issues and proposed changes right? Are there other key issues to be addressed or other solutions? Are there areas you think are currently working well?**

The medical profession has a professional and social responsibility to provide prevocational trainees with a safe and educationally valid training experience that promotes specialist qualification within a realistic time frame, and delivers safe, efficient and effective patient care.

While the AMA believes the current model of intern training remains relevant and fit for purpose, we welcome the periodic review of medical training paradigms to support long-term quality improvement in medical training. This review is an opportunity to examine the structure of prevocational training across post graduate years (PGY) 1 and 2 to support the development a high-quality medical workforce well equipped to meet community need. Any proposals to change the current model of prevocational training are incremental and evidence based.

Data on the quality and effectiveness of training is essential to drive evidence based improvements to training, and to assist in preparing young 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.

The results of the MBA national medical training survey will provide valuable information about the quality of the training experience for interns and PGY2 doctors and will inform this review.

The AMA supports an ongoing focus on generalist medical training, clinical skill development and medical professionalism in the early postgraduate years.

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

A balanced and generalist orientation to their practicing careers will provide prevocational doctors with exposure to a range of medical disciplines and clinical situations within a safe practicing environment. This will support the development of a generalist skill set in line with workforce and

community need, build a firm foundation for specialist practice and enable prevocational doctors to make meaningful and informed decisions regarding career choice and vocational training.

The development of a two-year capability and performance framework affords the opportunity for all PGY 1 and 2 training places to be accredited. The AMA supports a nationally consistent framework for the accreditation of prevocational medical education, underpinned by Australian Medical Council (AMC) accreditation of PMCs or their equivalents. Employers should be accredited, to agreed standards, before being permitted to employ prevocational trainees.

The accreditation of all prevocational training places will provide prevocational doctors with a high quality, safe working environment, appropriate supervision, support and career guidance. While many post graduate medical councils (PMCs) already accredit PGY2 places, additional funding will be required to support PMCs to undertake this at a national level.

The intersection with the MBAs proposed continuing professional development (CPD) standards must be considered. The proposed CPD standards recommend that all prevocational trainees should have a CPD home; PMCs could potentially fill this role for PGY2 trainees who currently have no CPD home.

It is also important to link with the work being undertaken by the Medical Workforce Reform Advisory Committee (MWRAC) in respect of developing a National Medical Workforce Strategy. MWRAC are considering a range of issues and strategies relevant to this review including how to achieve a better balance of generalist versus subspecialist skills within the medical workforce, geographic maldistribution, a reliance on registrars for service delivery, management of end to end training and career pathways and doctor readiness; these are all relevant to the AMCs review.

Other points to consider include assessing:

- Whether there are any components of intern training that could be better redistributed within the health system. This includes consideration of what administrative tasks could be removed from the intern year to provide them with more time to focus on clinical skill development.
- The benefits, consequences and practical application of introducing intern rotations that last for a longer period.
- The feasibility of alternate categories for mandatory terms (e.g. acute, sub-acute and community care) and how appropriate such a reconfiguration of mandatory terms would be.
- The practical application of two-year contracts for PGY1 & 2 nationwide.[1] This could offer security of employment for prevocational trainees and an opportunity to focus on their training in a familiar environment. It also provides hospitals and health services with a known workforce to assist with workforce planning.

**What would be the impact of the expansion of the current National Framework to a two-year transition to practice model (with registration at the end of PGY1)? How could this better formalise the support and structure of PGY2, rather than to add significant additional requirements? What are the important points to consider here?**

National accreditation standards encompassing PGY1 and 2 would bring greater consistency to the early prevocational training experience across all states and territories, facilitate vertical integration between prevocational and specialist medical education, and enhance the quality of training by providing standardised assessment and progression processes. Important points to consider are how to maintain traditional elements of internship while allowing for flexibility, innovation and contextualisation of training.

Formalising existing arrangements for PMCs and jurisdictions to accredit PGY1 and 2 places will provide continuity in the training and employment experience for early prevocational doctors, as well as a structured education and training experience, clinical oversight, and access to professional development opportunities and professional support.

The AMA supports a role for PMCs or their equivalents to accredit prevocational training places using criteria developed by the AMC to assess clinical experience, quality and safety. It is vital that PMCs are properly resourced to allow them to fulfil their responsibilities in prevocational education.

[1] NSW offers two-year contracts for PGY 1 & 2. NSW DiTs believe it acknowledges the continuum of training, allows early prevocational to doctors build stronger networks within their hospital and offers a spread of terms/rotations of their choice across the two years.

The AMA supports the continuing existence of a national body responsible for coordinating and supporting prevocational medical education and training across jurisdictions to ensure quality and safety in medical training and patient care. The Confederation of Postgraduate Medical Council (CPMEC) previously fulfilled this role and enough funding should be reinstated to allow CPMEC or a similar body to continue this coordinating role in relation to prevocational medical training and support.

B. **What do you consider would be the most effective and efficient mechanism(s) for ensuring internship functions as a longitudinal program to support development, wellbeing, assessment and achievement of outcomes across the two years (e.g. standards on longitudinal governance of the program, technology to enable tracking of information, longitudinal educational supervisors.)?**

The AMA supports exploring the role of a longitudinal supervisor for prevocational doctors over the two-year period, inclusive of training for supervisors.

C. **Linked to the previous question, the Health Ministers' response to the 2015 COAG Review of Medical Intern Training agreed to the development of specifications for an e-portfolio, alongside the capability and performance framework, to provide greater individual accountability for learning and to support the assessment process. What are your views on an e-portfolio for the prevocational years? What are the most important opportunities and barriers to consider?**

The AMA supports a nationally funded e-portfolio, appropriately resourced so that it is a useful/intuitive tool for both trainees and supervisors without adding to the burden at either end. This must be portable between sites and should not result in additional costs to prevocational trainees or create an additional administrative burden which may compromise clinical learning. Governance and confidentiality arrangements concerning transfer of information must be considered.

The interplay with the proposed MBA CPD requirements should be considered.

D. **Other comments or questions:**

The AMA would not support a certificate of completion at the end of PGY2 being used as a selection tool for entry into specialist training.

**Specific questions** (These questions may not be applicable to all groups)

E. **In accordance with the Health Ministers' 2018 decision regarding a two-year transition to practice model, the AMC is proposing the National Framework be expanded to include PGY2 (this would include the accreditation requirements outlined in the *Intern training – National standards for programs*). The AMC is aware that all but one of the postgraduate medical councils are currently funded by their jurisdictions to accredit PGY2 (some on a voluntary basis), and using the same process and similar standards for accreditation. In this context, what do you consider would be the impact of expanding the Framework to include PGY2?**

As indicated, the AMA supports the role of PMCs in accrediting PGY1 and 2 training places, noting additional resources would be required to support them to do so.

Of note, in 2015 the Commonwealth Government discontinued funding for the CPMEC. The implementation of an integrated, two-year transition to practice model will require collaboration between the state and territory-based PMCs. Without a coordinating body, it is likely to be more difficult to implement sensible reforms that support the quality of prevocational training and that the process will end up being much less efficient as a result.

The CPMEC or a similar body would play a valuable role in coordinating and supporting prevocational medical education and training across jurisdictions to provide quality and safety in medical training and patient care. The AMA believes funding for such a body should be reinstated in the interests of national curriculum development, professional training and supervision, development of prevocational medical supervisors, and knowledge sharing amongst key constituents, particularly in rural, regional and major centres.

F. **The development of a two-year transition to practice program will require some further structure and support for PGY2. There are a range of important areas the AMC would like to explore regarding this, including how this relates to flexibility to enter into specialty training in PGY2, current college selection requirements and ensuring there is not a duplication of requirements. What are key issues to consider in this context?**

The AMA does not support any formalised process of early specialty streaming that would direct an intern/PGY2 doctor into a particular speciality/career. The current model of prevocational training

allows prevocational doctors to undertake several related rotations to explore a particular discipline as part of an overall career development plan in PGY2. In some cases, speciality training program permit entry into training in PGY2.

As part of this review the option of prevocational doctors being limited from entering vocational training to post PGY2 i.e. having to complete both PGY1 and PGY2 prior to getting on the program, could be explored in the interests of promoting generalism. The UK & NZ have moved to vocational training post completion of PGY2 and it would be useful to explore the validity of applying this to in the Australian context including consideration of any unintended consequences.

Also of concern to the AMA is the current phenomenon of CV buffing where prevocational doctors are doing higher degrees to improve their chances of gaining entry into vocational training. This does not necessarily make them better doctors or guarantee entry into training and is often undertaken at great personal and financial cost. Adjusting the levers to reduce the pressures associated with entry into specialty training for prevocational doctors would be of benefit.

Prevocational training should give doctors the requisite experience to commence vocational training. The AMA supports published explicit pre-requisites for vocational training programs where they are achievable by prevocational trainees during routine prevocational training. The AMA does not support pre-requisites that are unnecessarily onerous and/or extraneous to beginning practice as a vocational trainee, particularly those that are hidden or implicit, or are of high cost but not required by trainees for selection.

Sufficient options should be available to trainees to allow a vocational emphasis in their training to occur. The opportunity to undertake several related rotations to explore a particular discipline as part of an overall career development plan is appropriate.

**G. For colleges: If your college currently accepts entry to training in PGY2, would you be interested in discussions about whether PGY2 (or components of) could count towards training? What are key issues for the AMC to consider here?**

Not applicable to the AMA.

## 2. Questions about proposed changes to training and assessment

### Current components

**Outcomes:** Key outcomes that interns should achieve by the end of their one-year program: Intern outcome statements

**National assessment form** and **standards on assessment** and remediation processes:

- × Assessment form
- × Certifying completion

| Case for change | Possible changes |
|---|---|
| × Health Ministers' agreed a two-year capability and performance framework will be developed.<br>× Disconnect between current outcomes, teaching program and role expectations<br>× Some outcomes are routinely not observed (Domain 3)<br>× Assessment highly variable in quality, issues include:<br>o supervisor contact with interns limited<br>o minimal feedback, superficial and not multi-source<br>o supervisor training/ calibration challenging | × Likely to result in significant changes to national standards, intern outcome statements, assessment, and potentially supervision.<br>× Identify changes necessary to support the development of a two-year capability and performance framework, including review of the current outcomes and assessment processes.<br>× A comprehensive review of assessment processes and form, with particular focus on quality and variability, including consideration of:<br>o multi-source feedback<br>o longitudinal educational supervisor<br>o the role of the registrar<br>o supervisor training/ calibration<br>o different methods/models of assessment<br>Acknowledging solutions need to be proportionate and practical. |

### Questions

**Broad questions**

**A. Have we got the issues and proposed changes right? Are there other key issues to be addressed or other solutions? Are there areas you think are currently working well?**

The AMA supports a comprehensive review of assessment processes and forms, with a focus on quality and variability, including consideration of:

- ) anonymous, multi-source feedback
- ) longitudinal educational supervisor
- ) the role of a mentor
- ) Ensuring protected clinical support time is available time for trainees and supervisors; supervisors must have teaching responsibilities and non-clinical time built into their job descriptions and work schedules.
- ) preserving the role of the doctor in training in teaching
- ) supervisor training/calibration
- ) improving supervisor training in assessment, and giving and receiving feedback
- ) different methods/models of assessment

- the timing of assessments e.g. mid-term/end of term
- discussing career progression with prevocational doctors early on

**B. In 2018, Health Ministers' accepted the 2015 COAG Review of Medical Intern Training recommendation for 'the development of a detailed and measurable two-year capability and performance framework that builds on existing curriculum frameworks'.**

- **Is there a resource that exists that could be used to develop the basis for the prevocational capability framework (e.g. the *Intern training – Intern outcome statements*)?**

It is vital that all prevocational doctors have clearly articulated educational goals and outcomes. The Australian Curriculum Framework for Junior Doctors (ACFJD) was developed by the Confederation of Postgraduate Medical Education Councils (CPMEC) to provide an academic foundation for prevocational doctors in PGY1 and 2.

The ACFJD outlines the knowledge, skills and behaviours that prevocational doctors should aim to acquire in PGY1 and PGY2 and is recognised as a useful tool to improve the training of prevocational doctors in different locations and clinical settings. It is used to implement effective learning systems for prevocational doctors, including mid-term appraisal, end-of-term assessment and review of learning opportunities.

While this has not been updated for some years due to the cessation of funding to support the CPMEC, it remains a significant and important piece of work from which to develop of a two-year capability and performance framework.

**C. What are important factors to ensure the framework is deliverable across a range of settings and helps to align role expectations and learning and development opportunities (e.g. the level of detail, key areas to include, system changes required)?**

The framework must facilitate vertical integration between undergraduate, prevocational and vocational training, and enhance the quality of prevocational training by providing standardised assessment and progression processes. The framework should combine the traditional elements of internship such as work-based training with flexibility, innovation and contextualisation of training.

It is also important to ensure that the scope of capabilities assessed in the framework are valid so that the framework does not become simply a 'tick & flick' exercise due to excessive numbers of capabilities being required.

**D. Are the current *Intern training – Intern outcome statements* (these outcomes form the basis of the term assessment form) in alignment with expectations and role of interns? For example, the AMC has received feedback that Domain 3: Health Advocate is routinely 'Not observed'. Of the areas that appear to be 'out of alignment' or not adequately assessed, should these be addressed in the intern program through experience, formal education programs or assessment?**

The AMA has no feedback to provide currently.

**E. The review will include evaluation of the assessment processes. Review feedback suggests assessment is superficial and variable. There is also feedback against increasing assessment requirements. What do you consider is a proportionate response, and what are the key things that would make the greatest improvement (e.g. multi source feedback, supervisor training, supervised learning events, registrar involvement)?**

The AMA has no feedback to provide currently.

**F. The review will include evaluation of the current term assessment form (acknowledging the content of any term assessment process will be aligned with the curriculum/capability framework). Note: there has also been local level adaptation of the forms in each State and Territory. In its focus group discussions, the AMC identified issues with the form length, rating scales, identifying and assessing domain 3. What do you consider are the strengths and challenges of the current term assessment form? If you made changes to the form, what did you change and why?**

The AMA has no feedback to provide currently.

**G. What is your view on the requirements for remediation and support of interns experiencing difficulty? Are the current processes sufficient, if not, what could be improved?**

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. Feedback should be given early and often. Multisource feedback should be anonymous and provides an opportunity to identify interns who require help early. Self-assessment is also important. Prevocational doctors should have access to confidential counselling and support services over the course of their training.

Opportunities for early career planning, mentoring and support during prevocational training should also be available to enable prevocational doctors to be more informed and confident in choosing a vocational pathway.

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.

Prevocational doctors should have to access training in interprofessional/personal communication and how to deal with difficult situations that may arise in the workplace, including how to deal with training disputes, discrimination, bullying and sexual harassment, and how to access support services as part of their professional development program.

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. External to their hospital, prevocational doctors must be represented in a way that protects their interests and is independent of the PMCs and employers.

The AMA would also like to see further strengthening of the accreditation standard on wellbeing/welfare. Employers must make a commitment to the teaching and welfare of prevocational doctors and maintain a balance between the demands of clinical service, the requirements for learning and their own health and wellbeing. They must commit to building and sustaining a positive and respectful workplace culture and have appropriate workplace policies focused on doctor health and wellbeing. This extends to the provision of adequate orientation, welfare and support, debriefing for vicarious trauma, safe working hours and flexible work arrangements that facilitate doctor health and wellbeing and an appropriate work-life balance.

A comprehensive orientation program for prevocational doctors is important, particularly for doctors seconded to peripheral and/or isolated centres. Employers should consider best practice in orientation programs, where buddy systems and resilience training have been shown to improve the transition to a new work environment for early postgraduate doctors.

**H. Are you aware of any innovations, examples of good practice or evaluations that have been conducted to improve intern training or assessment? We would be interested to hear about them.**

In 2015 AMA Queensland's Council of Doctors in Training researched and developed a Resilience on the Run pilot program. The pilot program aimed to provide young doctors with the resilience and coping skills needed to survive and thrive in medicine and was successfully delivered for Interns at Rockhampton Base Hospital in October 2015. Since then the program has been expanded across Queensland public hospitals and focuses on developing techniques for resilience, mindfulness, better managing interpersonal relationships, navigating difficult scenarios on the job and practical steps for asking for help. The delivery of Resilience on the Run can play an integral part of an intern's training at the vulnerable time of their entry into the workforce. In 2020 the program will be reviewed and rebranded as Wellbeing at Work.

**I. Other comments or questions:**

The AMA has no feedback to provide currently.

**Specific questions** (These questions may not be applicable to all groups)

**J. If you have implemented a capability/competency and outcomes-based assessment framework, what have been the key learnings?**

The AMA has no feedback to provide currently.

## 3. Questions about proposed changes to the training environment

### Current components

**National standards for programs and terms** - Requirements for processes, systems and resources for quality intern training:

- × National standards for programs
- × Guidelines for terms

| Case for change | Possible changes |
|---|---|
| × Variable and limited clinical experience<br>× Structure not reflective of community health needs/ modern healthcare<br>× Constant turnover impacts education, is resource intensive and disruptive to care | × Likely to result in significant changes to experience and term requirements, including accreditation of terms and programs.<br>× Review of current term structures in relation to quality of learning, relevance and flexibility. Consider a change to focus on outcomes/experience over setting.<br>× In line with AMC strategic aims to ensure medical education meets community health needs, consider how the AMC can support expanded settings. |

### Questions

**Broad questions**

**A. Have we got the issues and proposed changes right? Are there other key issues to be addressed or other solutions? Are there areas you think are currently working well?**

The AMAs view is that the current model of internship remains fit for purpose with room to explore incremental, evidence-based changes focusing on improving supervision, assessment processes and expanding prevocational experience in non-traditional settings such as the community and private settings

It is critical that the review of the current internship framework focuses on maintenance of quality, rather than seeking cost shifting or savings, and is informed by appropriate and considered consultation and a robust review of the available evidence on medical training and practice in Australia.

**B. The AMC is proposing to review the current term structures (mandatory terms). Review feedback suggests that there is a range of issues with the current structure including significant variation in the quality of learning experiences, its relevance and flexibility to be applied across different settings. This is further influenced by changes to care delivery and capacity constraints, which change the intern experience. The AMC considers that setting is not necessarily a determining factor in the quality of the intern experience. In line with the development of a two-year capability and performance framework, the AMC is interested in exploring a change in focus to that of outcomes/experience over setting (as has been achieved in the United Kingdom and New Zealand).**

**What do you think are the key issues to consider regarding this change and the impact to you, your organisation and/or the delivery and quality assurance of care and training?**

The AMA acknowledges there are international models of intern training that are competency based. While the flexibility associated with such models may be attractive, the AMA's position is that outcomes/competency-based assessment should complement, but not replace, the current apprenticeship model of time-based internship training.

The AMA considers that time and experience is a necessary part of training, and that specific competency in a procedure is not in itself sufficient evidence of competence to practice. Medical training to date has included the completion of a minimum number and type of clinical placements and rotations and the AMA supports the continuation of this model.

The AMAs current position is that all interns should undertake well-organised and properly supervised placements in medicine, surgery and emergency medical care as these disciplines provide experiences that are essential to the professional development of doctors. These terms provide an essential combination of experience during the intern year and any shift away from this model should be informed by a strong evidence base before being considered as practicable for implementation.

Accredited terms in general practice and expanded private and community settings should be actively pursued, noting however that the current primary care environment is not resourced to support this.

General medical registration should continue to be granted for doctors on satisfactory completion of the intern year.

Further work to explore the validity of any changes to the current training model should be evidence-based and could include assessing:

- Whether there are any components of intern training that could be better redistributed within the health system i.e. transferring responsibility for paperwork and red tape to clerical staff.
- The benefits, consequences and practical application of introducing intern rotations that last for a longer period.
- The feasibility of alternate categories for mandatory terms (e.g. acute, sub-acute and community care) and how appropriate such a reconfiguration of mandatory terms would be.
- The risks and benefits of the practical application of two year contracts for PGY1 and 2 nationwide.
- The educational validity of community based rotations. Should community based rotations be considered, then a careful pilot should be conducted to ensure there are no negative impacts on the educational quality of internships.
- The introduction of nationally coordinated prevocational employment processes via a centralised system of offer and acceptance.

**C. Do you consider that the current guidelines permit sufficient flexibility in intern training? How could the AMC support expanded settings?**

Training in expanded settings is now recognised as an important adjunct to the public teaching hospital model, benefiting both the trainee and the setting in which the training occurs. It enables clinical training relevant to future practice that may not otherwise be available in traditional settings. The AMA acknowledges the significant increase in the number of Government-funded prevocational training places in recent years, including growth in the private sector which has contributed to increased intern training capacity.

Despite Government funding for training in expanded settings, there is a complex interplay of factors affecting the ability of settings to provide ongoing training. Significant costs are incurred with medical training from the actual provision of training and from lost efficiencies relating to the training process. Current funding does not always cover the entire cost of the training position, and the fee-for-service funding model in private settings does not always easily accommodate the provision of medical education. These factors significantly impact on the willingness of institutions and private practitioners to provide training.

Equitable access to significant, dedicated and reliable funding for training positions in expanded settings is essential if positions are to be established with no financial detriment to the institution, supervisor and trainee. Funding must provide for full cost-recovery of providing high quality medical training and must be indexed to guarantee the long-term sustainability of placements in expanded settings. The institution and practitioner must be compensated for the complete cost of participating in training.

The AMA supports the provision of intern training in general practice, private and community settings for prevocational terms, subject to them meeting relevant accreditation standards. These settings must be adequately supported and resourced to ensure that teaching remains a viable and sustainable proposition. In particular, alternative funding models and incentives to support general practice training are urgently required to ensure the pool of supervisors and training infrastructure meets demand for current and future training requirements.

The viability of community-based internships has been the topic of discussion in recent years. The AMA agrees in principle that this model has the potential to offer general practice and community health exposure to interns that could enhance professional and personal growth, and better integrate training requirements with the needs of the community.

However, positions must be adequately resourced and supported, meet accreditation standards, and afford the doctor in training the same qualification as a public teaching hospital counterpart.

**D. The preliminary results of this review and the findings of the 2015 COAG Review of Medical Intern Training, indicate that variable supervisor engagement and training is impacting on the training and assessment of interns. The AMC proposes strengthening the standards and requirements in this area while acknowledging broader system issues, such as time and resource constraints and value placed on training. The AMC considers there are some common principles of good supervision across the medical education continuum (e.g. giving feedback), so sees opportunities for recognition and sharing of current resources, with identification of areas that are specific to the different stages of training (e.g. the level of assessment).**

**What are your views on strengthening standards and requirements for supervisor training, and/or opportunities for sharing resources? Are you aware of specific resources that would be applicable across the training continuum? Would you be interested in further discussions about this?**

Despite clear-cut requirements for doctors who supervise, feedback from supervisors and trainees shows that clinical support time in the public hospital system is not being adequately recognised or supported. This includes doctors being actively discouraged from quarantining time for teaching and training activities. Inadequate clinical support time arrangements is also increasing the risk of burn-out among the supervisors who are endeavouring to cope with the time pressures of supervision and medical practice.

Stronger standards are required to support access to clinical support time during training so that supervising doctors can properly supervise, assess and provide feedback, and doctors in training can learn in a supported environment.

Though AMC accreditation standards for specialist education programs and workplace-based assessment for providers acknowledge the importance of adequate resourcing and support for medical training and education, the AMA believes these standards should be strengthened to ensure that public and private health care institutions and services provide the resources to enable sufficient time for teaching and supervision.

Supervision is a skill that requires training and development. The AMA supports developing professional standards and competencies for clinical supervision to the extent that they teach broad educational principles and the skills to apply these into the workplace. They should include skills in broader responsibilities for supervisors such as giving and receiving feedback, mentoring and personal development. Standards and competencies should not be overly prescriptive. The AMA also supports funding for professional development to develop the supervisory skills of senior clinicians and doctors in training.

**E. What are your views on the role of registrars in supervising and assessing interns, including how these contributions could be/ are recognised in college training programs?**

The AMA supports the role of registrars in supervising and assessing interns; this is seen as an important feedback source of feedback. Registrars and other prevocational doctors play a significant role in the delivery of clinical teaching to less experienced trainees. It is essential that they have access to protected clinical support time so that they can properly supervise, assess and provide feedback, and so that less experienced doctors can learn in a supported environment. Training in performance management, unconscious bias training, giving and receiving feedback, and cultural safety should be provided to registrars and prevocational doctors as part of their professional development program so that they can teach and supervise other trainees effectively and respectfully.

**F. Are there any other changes you think would be important to consider to support the two-year capability and performance framework (e.g. term length)?**

It is not unreasonable that the optimum length of terms in the intern year should be explored. A survey of close to 500 Western Australian doctors in training in 2015 found that 70% of surveyed doctors preferred five terms a year during their pre-vocational stage. 20% supported four terms a year, 7% supported six terms a year, and 3% supported three terms a year and none supported two terms a year. The reasons provided for these preferences centred on adequate broad exposure to multiple specialties over pre-vocational years. Longer terms were seen as an unnecessary extension of training time for the skill levels expected of a pre-vocational trainee. Longer terms were considered positively when provided in the context of a thematic year. For example, residents were satisfied with a shift to four terms a year if the year was structured as a “critical care” year, with

dedicated exposure to specialties and educational opportunities related to the broader theme of critical care.

**G. Other comments or questions:**

The AMA has no further comment to make currently.

**Specific questions** (These questions may not be applicable to all groups)

**H. What are current emerging issues or patterns you have observed in prevocational accreditation? Are the issues different for PGY 1 and PGY2? What are the differences in your accreditation standards and requirements for PGY2?**

The AMA has no further comment to make currently.

**I. What would be the impact of PGY2 accreditation on rural and general practice placements?**

Rural placements

Rural terms fill an important workforce, service and educational need. Provided it is consistent with the development of appropriate clinical skills, the AMA supports the inclusion a regional/rural medical service component in postgraduate medical training programs. Mandatory return-of-service obligations in rural areas are inappropriate for prevocational doctors; they are not likely to lead to long-term recruitment of doctors to areas of workforce shortage and stigmatise regional and rural practice.

The AMA also believes that a system of generalist prevocational training in the early postgraduate years produces a more flexible and adaptable medical workforce. PGY1 and 2 doctors can be assigned to and trained in smaller hospitals which do not provide a wide range of specialist services but may be well equipped to provide generalist medical training with strong mentoring in the intern and prevocational years.

Historically, there has been a gap in the educational infrastructure and oversight of prevocational doctors in rural areas and this has implications for patient safety and for the educational validity of placements. Clinical supervision gaps at a local level could be supplemented by supervision from medical practitioners at tertiary centres, using facilities now in place for telehealth, to create a supervision team.

Examples of excellent practice that have been successful in expanding opportunities for junior doctor teaching, supervision and learning in rural and remote areas, and in locations that have had difficulty in providing sufficient educational oversight, should be identified and promoted.

Other mechanisms include specific preparation and training prior to the placement, briefing on the likely clinical problems and situations trainees will encounter, use of telehealth to communicate with senior doctors and other members of the supervising team, regular debriefing and mentoring.

Systems should also be in place to incentivise and support training in regional and rural centres. This includes policies to ensure trainees are not disadvantaged by undertaking regional/rural training such enabling portability of entitlements and providing housing and financial assistance to undertake rotations that require a move away from the usual place of residence.

General practice placements

The AMA recognises the value of prevocational exposure to accredited terms in general practice, private and community settings to enhance professional and personal growth, and to better integrate training requirements with the needs of the community.

These settings must be adequately funded, supported and resourced to ensure that prevocational doctors continue to have access to clinical training opportunities in these areas, that teaching remains a viable and sustainable proposition, and that the pool of supervisors and training infrastructure meets the demand for current and future training requirements.

The AMA supports ongoing funding to support high quality placements in general practice for prevocational doctors as part of their training. This must be new funding and not funding taken away from pre-existing programs or funding commitments, such as extra intern places in the private sector.

J. **What has been your experience in applying the national standards to expanded settings and what challenges have arisen in this context?**

The AMA has no further comment to make currently.

K. **The AMC also sets National Standards that outline at a high level the requirements for processes, systems and resources that contribute to good quality intern training. The intern training accreditation authorities (postgraduate medical councils) in each State and Territory map their accreditation standards to these standards (noting in some states/territories there is local adaptation of the standards).**

**In general, do you consider the accreditation standards and requirements clear, fair and reasonable? Do you consider there are any gaps or areas that should be strengthened? Is further guidance required? What (if anything) did you change in adopting the national standards and why? Has there been any subsequent evaluation of areas that are unclear for teams/committees/providers?**

The AMA has no further comment to make currently.