

## Prevocational medical education and training

### 2011. Revised 2017

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 1) and post internship training (postgraduate year 2+). 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 the early postgraduate years, consistent with Medical Board of Australia (MBA) and Australian Medical Council (AMC) standards and guidelines, and the curricula outlined in the Australian Curriculum Framework for Junior Doctors (ACFJD).
- 1.2. The current model of internship is relevant and fit for purpose. 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. Accredited terms in general practice and expanded private and community settings should be actively pursued. General medical registration should continue to be granted for doctors on satisfactory completion of the intern year.
- 1.3. Post internship training should provide prevocational doctors with an increased level of responsibility for patient care, and provide sufficient options to allow a vocational emphasis in training to occur. The AMA does not support direct/formal streaming into vocational training immediately after the internship year.
- 1.4. All prevocational training places should be accredited against standards developed by the PMCs (or their equivalents). The AMA supports a nationally consistent framework for the accreditation of prevocational medical education, underpinned by Australian Medical Council (AMC) accreditation of PMCs. Employers should be accredited, to agreed standards, before being permitted to employ prevocational trainees.
- 1.5. The ACFJD plays an important role in providing an academic foundation for prevocational training and implementing effective learning systems for prevocational doctors.<sup>1</sup> Supervision, feedback and assessment arrangements in the early postgraduate years should foster clinical skill development, a personal understanding of areas for improvement and medical professionalism.
- 1.6. Supervisors should be adequately trained to teach prevocational doctors. Protected time must be available for senior clinicians to teach, supervise and assess prevocational doctors; senior clinicians 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 doctors' health and wellbeing. This extends to adequate orientation, welfare and support, safe working hours and flexible work arrangements to facilitate doctor 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.
- 1.9. The AMA supports a nationally consistent prevocational employment process, and greater

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<sup>1</sup> Confederation of Postgraduate Medical Education Councils (2012). Australian Curriculum Framework for Junior Doctors. Version 3.1.

clarity on the supply and demand of prevocational and vocational training positions on an ongoing basis. Jurisdictions and employers should establish processes to collect and report on the number of intern and prevocational positions available and unfilled each year to inform recruitment processes and workforce planning.

- 1.10. Any changes to the current model of prevocational training in Australia must be incremental and evidence-based. 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 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.

## 2. Aims and objectives

- 2.1. The specific aim of prevocational medical education is for graduates to consolidate and apply clinical knowledge while taking increasing responsibility for the safe and high quality patient care. Particular strengths of the 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.
- 2.2. It is important that prevocational doctors have a balanced and generalist orientation to their practicing careers.<sup>2,3</sup> 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 need, build a firm foundation for specialist practice and enable prevocational doctors to make meaningful and informed decisions regarding career choice and vocational training.
- 2.3. The AMA recognises that some prevocational doctors will have made a choice about their future specialty following internship. In these instances, 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.<sup>4</sup>
- 2.4. The AMA does not support mandatory, direct streaming into speciality training from medical school or the intern year. While flexible and sensible responses to individual circumstances are encouraged, and include College recognition of specific terms post-internship, this should not undermine the current approach of having a period of generalist training and experience before entering speciality training.
- 2.5. 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.<sup>5</sup> 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.
- 2.6. In particular 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.

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<sup>2</sup> 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.

<sup>3</sup> Prof John Collins. Foundation for Excellence. An Evaluation of the Foundation Programme. October 2010.

<sup>4</sup> Some specialist medical colleges now offer a vocationally aligned prevocational curriculum to prepare prevocational doctors for vocational training.

<sup>5</sup> 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.

- 2.7. Rural training terms fill an important workforce, service and educational need. The AMA supports the inclusion of regional/rural placements in prevocational training consistent with the development of appropriate clinical skills. 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.

### 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 prevocational doctors have access to structured education and training programs, organised clinical oversight, professional development and support. This will assure the entire continuum of medical education is accredited against agreed benchmarks, and 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 postgraduate medical councils (PMCs) or their equivalents.
- 3.3. The AMA supports the role of the PMCs in accrediting prevocational training places using the 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.
- 3.4. The AMA supports the continuing existence of a national body who is 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 sufficient funding should be reinstated to allow CPMEC or similar to continue this coordinating role in relation to prevocational medical training and support.

### 4. Internship training

- 4.1. The internship 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 of 47 weeks equivalent full time experience (excluding annual leave provisions) in supervised clinical practice. Sufficient time for study and conference leave should be allocated as part of, and contribute to, this minimum time period, in order to allow prevocational doctors to participate in continuous professional development.
- 4.3. There should be flexibility in the system to allow for part time training. Prevocational doctors who are unable to complete their internship within the time frames defined by the MBA<sup>6</sup> 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 - Granting registration as a medical practitioner on completion of intern training* and accompanying AMC *National Internship Framework accreditation standards and guidelines for intern training*. The curricula should be designed to achieve the AMC global outcomes statements for intern training and the competencies outlined in the ACFJD.

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<sup>6</sup> This equates to 12 months for full time internship, three years for part time internship. MBA Registration standard. Granting general registration as a medical practitioner to Australian and New Zealand medical graduates on completion of intern training. 2014

- 4.5. An accredited internship should comprise of accredited core terms in medicine, surgery and emergency medical care of at least eight weeks duration, with the remaining time comprised of other accredited terms. 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.
- 4.6. It is important that core terms adhere to AMC Guidelines for Intern Rotations, are well organised and properly supervised, and provide interns with adequate exposure to the appropriate depth and breadth of clinical experience, caseload and involvement in care. Using sub-specialty terms inappropriately as core medical/surgical terms puts at risk the generalist experience and risks diluting the validity of the training experience.
- 4.7. The AMA supports chronological block learning for core terms. Block learning provides interns with exposure to continuity of care, and provides for consistent supervision, assessment and constructive feedback. Exceptions to this principle should only occur if there is sound educational justification.
- 4.8. Assessment during internship should be limited to end-of-term assessments consistent with the AMC *National Internship Framework*. Competency-based assessments should complement, but not replace, the apprenticeship model of time-based internship training.
- 4.9. There should be complete onsite supervision for interns at all times. Interns should not be placed in a position where they are not adequately supported by senior medical staff and registrars. Consistent with the relevant AMC documents, the overall term supervisor should be “a consultant or senior medical practitioner with experience in the management of patients in the relevant discipline”.

## 5. Learning and assessment

- 5.1. The AMA supports an apprenticeship model of experiential time-based prevocational training. 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 in the early postgraduate years.
- 5.2. It is vital that all prevocational doctors have clearly articulated educational goals and outcomes. The ACFJD outlines the knowledge, skills and behaviours that prevocational doctors should aim to acquire in PGY1 and PGY2 and is a useful tool to improve the training of prevocational doctors in different locations and clinical settings. It should be used to implement effective learning systems for prevocational doctors, including mid-term appraisal, end-of-term assessment and review of learning opportunities.<sup>1</sup>
- 5.3. Supervisors should have access to appropriate training to allow them to perform their role. Protected time must be available for teaching prevocational doctors. Senior clinicians should have teaching responsibilities and non-clinical time built into their job descriptions and work schedules, with at least 30 per cent of a public hospital senior clinician’s time set aside for clinical support work.<sup>7</sup>
- 5.4. Prevocational doctors should not be asked to practice beyond their competence 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.
- 5.5. Prevocational doctors play a significant role in the delivery of clinical teaching to less experienced trainees. Training in performance management, unconscious bias training, giving and receiving feedback, and cultural safety should be provided to prevocational

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<sup>7</sup> The AMA consulted with the medical colleges in 2008 and received broad support for an overall benchmark of 30 per cent for clinical support time.

doctors as part of their professional development program so that they can teach and supervise other trainees effectively and respectfully.

## 6. Welfare and support

- 6.1. 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 focussed 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.
- 6.2. 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.<sup>8</sup>
- 6.3. 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. Doctors in training should have access to confidential counselling and support services over the course of their prevocational 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.<sup>9</sup>
- 6.4. 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 inter-professional/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.
- 6.5. 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.

## Related AMA content

*AMA Position Statement on Pre-Internships in medical school – 2017.*

*AMA Position Statement on Support for non-vocational trainees prior to entering a vocational training program – 2016.*

*AMA Position Statement on Employment processes for prevocational trainees – 2015.*

*AMA Position Statement on Competency-based training in medical education – 2010.*

*AMA submissions to the Review of Medical Intern Training 2015.*

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<sup>8</sup> Leeder S. Preparing interns for practice in the 21st century. *Med J Aust* 2007; 186 (7 Suppl): S6.

<sup>9</sup> MABEL Matters. Centre for Research Excellence in Medical Workforce Dynamics. No. 9 May 2014.