Prevocational medical education and training

2011

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. In the case of most trainees, it includes postgraduate year 1 (PGY1), also known as internship, and postgraduate year 2 (PGY2). Doctors at this stage of their training are collectively referred to as junior medical officers (JMOs).

1. Introduction

1.1. Australia enjoys an enviable reputation as a provider of high quality medical education and training. Particular strengths of the system include an experiential model of training, an emphasis on early clinical immersion and willingness of senior practitioners to provide workplace-based supervision and tuition.

1.2. A significant increase in numbers of medical students enrolled in Australian medical schools has created additional pressures on the system to provide clinical training for medical students and junior doctors. The quality of medical training may be eroded if investments in supervision and supporting infrastructure do not match the growth in trainee numbers.

1.3. Robust workforce modelling and planning must inform the provision of an appropriate number of adequately funded undergraduate, prevocational and vocational training places. The development of innovative teaching and training methods (including expansion beyond traditional public hospital settings into rural environments, the private sector and community settings) and new technologies (such as simulated learning environments) will also help to improve teaching and training capacity.

2. Aims and objectives

2.1. It is important that junior medical officers have a balanced and generalist orientation to their practicing careers. This allows them to build a firm foundation for specialist practice and assists with the transition to vocational training.

2.2. 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. Diagnostic skills, communications skills, therapeutic and procedural skills and professionalism are developed under appropriate supervision. This is consistent with the Medical Board of Australia’s guidance, as well as the multiple roles of a medical practitioner identified and defined in the CanMEDS 2000 project and the Australian Curriculum Framework for Junior Doctors.

2.3. Prevocational training should expose JMOs to a range of medical disciplines and clinical situations in order to provide a firm foundation for future practice in any medical specialty. This approach will also enable trainees to make meaningful and informed decisions regarding career choice and vocational training. The AMA supports a balanced and generalist orientation during the first two postgraduate years that prepares trainees to access further vocational training provide by medical colleges. In PGY2, trainees should be offered more...
flexibility in terms and encouragement to accept greater responsibility in their workplace, including in patient care.  

2.4. It is recognised that some junior medical officers have made a choice about their future specialty by the commencement of their PGY2 year. In these instances, 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.

2.5. With increasing numbers of medical trainees, health services need to ensure that JMOs receive adequate exposure to a variety of quality clinical experiences within a safe practising environment. Subject to appropriate funding and support, private sector and community settings should be utilised to build the capacity of Australia’s medical training system. Such arrangements should be in addition to training in the public sector.

2.6. The AMA recognises the value of prevocational exposure to general practice. Prevocational doctors should have the opportunity to undertake a term in general practice if desired. These placements should be appropriately resourced to support participation and teaching in this area. The AMA supports the Prevocational General Practice Placements program (PGPPP), which provides professional and well-supervised general practice placements for JMOs as part of their 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 in PGY1 and 2 should be accredited.

3.2. Accreditation standards developed by the Postgraduate Medical Councils (or their equivalents) should underpin the delivery of quality prevocational medical education. These should be derived from the National Training and Assessment Guidelines for Junior Medical Doctors PGY 1 and 2, and from the Standards for the Supervision of Prevocational Doctors in General Practice in the case of general practice. It is important that Postgraduate Medical Councils (PMCs) are properly resourced to fulfil their responsibilities in prevocational education.

3.3. Accreditation visits should be undertaken by trained peer reviewers and teams should include at least one prevocational trainee from another health service. The significant contribution of junior doctors, college fellows and medical educators who act as accreditors of prevocational training positions should be recognised. Doctors should be supported to participate in accreditation visits.

3.4. The AMA supports a nationally consistent framework for the accreditation of prevocational medical education, underpinned by Australian Medical Council (AMC) accreditation of PMCs. This will ensure the entire continuum of medical education is accredited against agreed benchmarks.

3.5. At the hospital level, there should be formal representative structures by which JMOs can provide feedback on their training. This is an important mechanism to protect quality.

---

9 Australian Medical Council Submission To The Australian Commission On Safety And Quality In Healthcare. 18 September 2009.
3.6. External to their hospital, JMOs must be represented in a way that protects their interests and is independent of the PMCs and employers. State AMA Doctor-in-Training committees are the only groups that meet these requirements.

4. Curricula

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

4.2. The Australian Curriculum Framework for Junior Doctors (ACFJD) outlines the knowledge, skills and behaviours that prevocational doctors should aim to acquire in PGY1 and PGY2.  

4.3. The AMA believes that the ACFJD is a useful tool to improve the training of prevocational doctors in different regions and clinical settings to the extent that it does not result in onerous assessment. It should be used to implement effective learning systems for prevocational doctors, including mid-term appraisal and end-of-term assessment and to review learning opportunities.

4.4. Continual review of the ACFJD is essential if it is to remain practical and relevant to prevocational trainees and their supervisors. Mechanisms must be put in place to update required competencies, content and teaching and learning resources as the need arises. To enable this to occur, the ACFJD must be adequately funded on an ongoing basis.

5. Internship

5.1. 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. In the absence of exceptional circumstances, an internship should be completed within two years of commencement.

5.2. The AMA supports compulsory core terms in emergency medicine, surgery and medicine, of at least eight weeks duration, in the intern year. These core terms provide an essential combination of experience during the intern year and must be well organised and properly supervised.

5.3. General medical registration should be granted for doctors on satisfactory completion of internship. Completion should be signed off by the Director of Clinical Training and a senior health service administrator.

5.4. Prevocational trainees who fail to complete their internship within the timeframes defined by the Medical Board of Australia should be able to apply for an extension to their provisional registration.

6. Supervision

6.1. The AMA recognises that most learning that occurs in the work place is progressive and relies on effective supervision and feedback. Effective supervision is a critical element in practice-based learning as JMOs acquire various knowledge and skills and behaviours throughout their training.

6.2. To give senior clinicians the time they need to train the next generation of medical practitioners, health services need to improve access to protected time for teaching and training. The AMA's benchmark is that at least 30 per cent of a public hospital senior

12 http://curriculum.cpme.org.au/background.cfm
clinician’s time should be set aside for clinical support work. Specific funding must be made available to support the provision of protected training time in Australia’s public hospital system.

6.3. Prevocational doctors should not be asked to practice beyond their competence and without adequate supervision. Employers should ensure JMOs are appropriately trained to perform the duties required prior to undertaking a particular rotation.

6.4. The significant role that junior doctors play in the delivery of clinical teaching to less experienced trainees must be recognised, developed and supported. The provision of appropriate professional development programs, such as Teaching on the Run, will give junior doctors the skills they need to help teach and train medical students and other junior doctors.

6.5. Simulated-based training and structured off-the-floor teaching can play a positive role in improving the quality of teaching and enhancing available teaching capacity and should serve as an adjunct to, rather than replacement of, supervised hands-on clinical experience.

7. Feedback and assessment

7.1. 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 only 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, a formal review process should follow.

7.2. There may be a role for prevocational assessment arrangements that foster clinical skill development, a personal understanding of areas for improvement, and medical professionalism. These principles should underpin feedback and assessment arrangements in the early postgraduate years. The AMA does not support formal centralised or standardised examinations for prevocational trainees.

8. Competency-based training and assessment

8.1. The AMA believes that competency-based training can be an effective component of medical education and training programs. However, the limitations of this approach must be recognised and respected. There must be safeguards that ensure high standards of medical education and training are maintained and that the achievement of excellence continues to be promoted. This view is further expressed in the AMA Position Statement on competency-based training in medical education.

9. Welfare

9.1. The AMA expects employers of prevocational trainees to have appropriate workplace policies focussed on junior doctor health and wellbeing. This extends to safe working hours, fatigue management and flexible work arrangements so that an appropriate work-life balance can be obtained.

9.2. JMOs should have access to confidential counselling and support services over the course of their prevocational training. Opportunities for early career planning, advice and support during prevocational training should be made available to enable JMOs to be more informed and confident in choosing a vocational pathway.

16 Andrew W Dent et al. Learning opportunities for Australian prevocational hospital doctors: exposure, perceived quality and desired methods of learning. MJA 2006; 184 (9): 436-440
9.3. Prevocational doctors are often required to relocate temporarily to undertake a clinical rotation as part of their employment. The AMA believes that junior doctors should be reimbursed for the costs of relocation to ensure that personal or financial disadvantage is negated when relocating. 19

10. Key points

10.1. Quality clinical teaching and training in public hospitals and general practice underpins medical education in Australia. It is vital that work-place based teaching remains central in the early postgraduate period for doctors, even as the pressures on public hospitals increase. Employers must have a commitment to the teaching and welfare of doctors-in-training and maintain a balance between the demands of clinical service and the requirements for learning.

10.2. The AMA supports a focus during the early postgraduate years on clinical skills development and medical professionalism, consistent with Medical Board of Australian guidance and the multiple roles of a medical practitioner identified and defined in the CanMEDS 2000 project and in the Australian Curriculum Framework for Junior Doctors.

10.3. All interns should undertake well-organised and properly supervised placements in Emergency Medicine, Surgery and General Medicine as these are critical disciplines in the professional development of doctors. General medical registration should be granted for doctors on satisfactory completion of the intern year.

10.4. All PGY1 and 2 places should be accredited against standards developed by the PMCs (or their equivalents). Employers should be accredited, to agreed standards, before being permitted to employ prevocational trainees.

10.5. The AMA supports a nationally consistent framework for the accreditation of prevocational medical education, underpinned by Australian Medical Council (AMC) accreditation of PMCs.

10.6. JMOs should be able to provide feedback on their prevocational training through formal representative structures.

10.7. The ACFJD has an important role to play in providing an academic foundation for the prevocational years. It should be used to implement effective learning systems for prevocational doctors. 20

10.8. The AMA supports prevocational assessment arrangements that foster clinical skill development, a personal understanding of areas for improvement, and medical professionalism. These principles should underpin feedback and assessment arrangements in the early postgraduate years.

10.9. Protected time must be available for teaching and professional development of JMOs; senior clinicians should have teaching responsibilities and non-clinical time built into their job descriptions and work schedules.

10.10. The AMA expects employers of prevocational trainees to have appropriate workplace policies focussed on junior doctor health and wellbeing. This extends to safe working hours, fatigue management and flexible work arrangements so that an appropriate work-life balance can be obtained.


AMA Position Statement

See also: