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| Review of the National Framework for Medical Internship |

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| Part 2 | Consultation questions: Review and development work |

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| Your feedback |

We would like to hear your perspectives on the review and development work to date. We will consider all the feedback we receive when shaping our proposals for change. The AMC will communicate a summary of its consideration and response to the feedback provided.

The AMC’s primary responsibility is to ensure that standards of education, training and assessment of the medical profession promote and protect the health of the Australian community and the final content of the National Framework must reflect this. If you would like further information about how to engage with the review please visit the [AMC website](https://www.amc.org.au/accreditation-and-recognition/assessment-accreditation-prevocational-phase-medical-education/how-can-i-engage-in-the-national-framework-review/).

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| We are seeking feedback by **3 November 2020.**  To enable efficient evaluation of the feedback our preference is for responses to be provided in a **Word document** using this **template** to [prevac@amc.org.au](mailto:prevac@amc.org.au). If this is not possible, please provide a non-protected PDF. |

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| This template |

This template provides questions against each major component of the Framework for consultation, as follows:

1. Framework overall
2. Training and assessment
3. Training environment
4. E-portfolio specifications

This template should be read in conjunction with the **Part 1: Consultation Paper**, which outlines the background and review process. Relevant attachments include:

**ATTACHMENT A:** Training & assessment: Prevocational training outcome statements –Draft for consult Sept 20

**ATTACHMENT B**: Training & assessment: Prevocational entrustable professional activities – Draft for consult Sept 20

**ATTACHMENT C**: Training & assessment: Proposed revisions to prevocational assessment processes–for consult Sept

**ATTACHMENT D**: Proposed revisions to prevocational programs and terms – for consult Sept 20

**ATTACHMENT E**: High-level specifications for prevocational e-portfolio – Draft for consult Sept 20

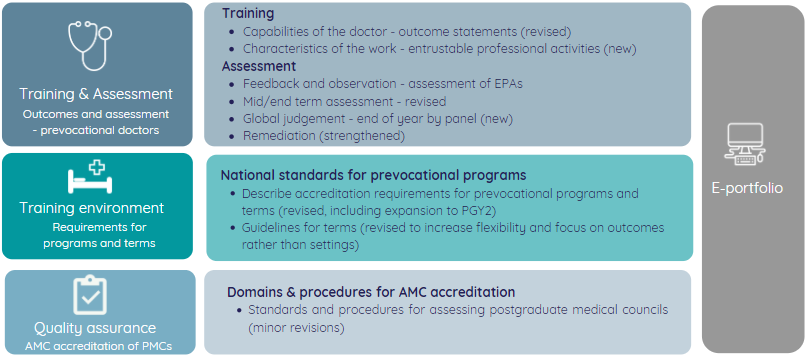
We recognise that all questions will not apply to all stakeholders, please only respond to those that are of relevance to you. There are also spaces for general comments.

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| Your information |

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| Organisation (if relevant) |  |
| Name |  |
| Position |  |
| Location (State/Territory) |  |
| Email |  |
| Telephone number |  |

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| 1. Framework overall |

A summary of the major components of the proposed framework, including the change from one to two years, is provided in the table. It is important to note that that while the National Framework will be expanded to include postgraduate year 2, the point of general registration will remain at the end of postgraduate year 1. The revised two-year framework builds on the existing National Framework with revisions and new developments. There are some significant changes proposed, in particular to assessment, program structure and the development of an e-portfolio. Details regarding these changes are outlined in the relevant sections below.



The Medical Board of Australia is in the final stages of developing a new Continuing Professional Development Registration Standard. PGY1 doctors in an accredited program will be exempt from the requirements, but they will apply to PGY2. The Board and the AMC will ensure that requirements for PGY2 are aligned and complementary.

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| Questions |
| The AMC is proposing to change the name of the framework from the National Framework for Medical Internship to the National Framework for Prevocational Training to reflect expansion to PGY2. Do you have any concerns or suggestions for alternatives?The Medical Board of Australia’s revised CPD requirements will apply to PGY2 doctors: a minimum of 50 hours of CPD per year that includes at least 25 per cent on activities that review performance, at least 25 per cent on activities that measure outcomes and at least 25 per cent on educational activities. The AMC is proposing that these activities are integrated into the National Framework. Do you have any concerns or suggestions?Do you have any other comments or suggestions about the overall Framework? |

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| 1. Training and assessment |

The AMC is proposing some significant changes to prevocational Training and Assessment. A summary of the review and development work to date is provided below.

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| Current components | Summary of confirmed scope |
| Outcomes: Key outcomes that interns should achieve by the end of their one-year program: [Intern outcome statements](https://www.amc.org.au/wp-content/uploads/accreditation_recognition/prevocational_standards_accreditation/national_internship_framework/intern-training-intern-outcome-statements-2014-09-24.pdf) | * Expand to PGY2 * Revise prevocational outcome statements * Develop entrustable professional activities (describing the key work of the PGY1/PGY2 doctor) * Revise assessment processes, including process for assessing EPAs, revising mid/end of term assessment and strengthening remediation |
| National assessment form and standards on assessment and remediation processes:   * [Assessment form](https://www.amc.org.au/wp-content/uploads/accreditation_recognition/prevocational_standards_accreditation/national_internship_framework/intern-training-term-assessment-form-2014-09-24-colour.pdf) * [Certifying completion](https://www.amc.org.au/wp-content/uploads/accreditation_recognition/prevocational_standards_accreditation/national_internship_framework/intern-training-assessing-and-certifying-2014-09-24.pdf) * Improving performance action plan |

**A. Prevocational outcome statements – characteristics of the prevocational doctor**

The Intern Training – Intern outcome statements state the broad and significant outcomes that interns should achieve by the end of their programs. The first revisions have been made to the outcome statements on the basis of the scoping and evaluation activities in 2019. Changes to the outcome statements will be iterative over the period of the review; they will continue to be revised as required alongside the changes to the Framework (including EPAs and the term assessment form).

The Intern outcome statements are aligned with the medical school graduate outcome statements. The AMC considers this alignment important. A review of the medical school accreditation standards has commenced and it is intended that the outcome statements for each phase of training will continue to be aligned.

It is considered that the current outcomes are applicable at completion of PGY1 and PGY2, acknowledging the level of responsibility, supervision, and entrustability will be different between the two years.

In revising the Framework, the AMC is also considering different methods of demonstrating and tracking achievement of the outcome statements across the two years in the e-portfolio.

The initial revisions to the outcome statements are at **ATTACHMENT A**. A summary of the revisions is provided below:

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| Area | Initial revisions to outcome statements for consultation |
| Overall | * Expansion to PGY2: Agreed not to make distinction between PGY1/PGY2 outcomes. * Areas relevant across all outcomes have been moved into the introduction:   + Importance of safety and quality   + Adherence to MBA’s Good Medical Practice – not an outcome but an expectation of practice * Paragraph to describe the ‘intent’ of the domains. |
| Domain 1: Scientist and scholar | * Revised wording of attributes 1.1 and 1.2 to improve clarity and relevance * Moved attribute 3.4 on quality assurance from Domain 3 |
| Domain 2: Practitioner | * Revised wording of attributes to improve clarity and relevance * Broadened 2.7 to focus on adapting to changing technology and systems |
| Domain 3: Health advocate | * Significant revisions in line with stakeholder feedback, attributes cover:   + Population health, whole of person care, Aboriginal and Torres Strait Islander Health, culturally reflective practice, patient journey in the broader system. |
| Domain 4: Professional and leader | * Revision to attribute 4.6 to include awareness of own rights, the rights of others, and responsibility to contribute to safe work environments |

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| Questions |
| The revisions to the outcome statements **(ATTACHMENT A)** have been made in response to evaluation and stakeholder feedback to better align them with contemporary expectations of the role of prevocational doctors and to clarify the relevance and wording to that role (in particular Domain 3). What are your views on the initial revisions to the outcome statements, including whether additional revisions are required?It is considered that the current outcomes are applicable at completion of PGY1 and PGY2, acknowledging the level of complexity, responsibility, supervision and entrustability, as well as context, will be different between the two years. It is not proposed to specifically distinguish outcomes between the years. What are your views on this? Are there any areas that should have specific outcomes for PGY1 or PGY2?The review is considering the role of the e-portfolio in demonstrating and tracking achievement against the outcome statements. In the current framework, this relies largely on the term assessment forms and it is apparent that some outcomes remain ‘not observed’ by the end of the year. It intended that in the revised Framework, the achievement of outcomes will be part of the prevocational doctor’s training portfolio and could be achieved by a combination of assessment and formal education. What are your views on this?The prevocational training component comprises outcome statements (describing the characteristics of the doctor) and the entrustable professional activities (describing the work performed by the prevocational doctor). The Australian Curriculum Framework for Junior Doctors was referenced in the initial version of the National Framework for Medical Internship but this document is now out of date and unlikely to be revised. Is there a need for any additional components in the National Framework for Prevocational Training?Do you have any other comments on the prevocational outcome statements? |

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**B. Entrustable professional activities – characteristics of the work of the PGY1 and PGY2 doctors**

The AMC has drafted four entrustable professional activities (EPAs) as part of the revised two-year framework. The EPAs aim to describe the key work of PGY1 and PGY2 doctors, providing clarity around the most important work and learning activities. Anchored to the prevocational outcome statements, the EPAs help to align the role, outcomes and assessment of PGY1 and PGY2 doctors. The assessment of EPAs will increase structured opportunities for observation, feedback and learning and inform global judgements at the end of terms/ years.

The draft EPAS have been developed using the [Royal Australasian College of Physician Basic Training Curriculum EPA](https://www.racp.edu.au/trainees/basic-training/curricula-renewal/standards/entrustable-professional-activities) structure and content, with permission.

The AMC’s thinking on the EPAs in the prevocational context is as follows:

* An EPA is a description of work: This contrasts with outcomes or capabilities which describe characteristics of the doctor.
* An EPA is not an assessment tool, but performance of an EPA can be assessed. The assessment of EPAs will include judgements about entrustability, the level of supervision required for the junior doctor to perform the work safely.
* While the same EPAs will be assessed for PGY1 and PGY2 doctors, they will be assessed at a higher level for PGY2 doctors based on the complexity, responsibility, level of supervision and entrustability, as well as the context, of PGY2 doctors’ work.

The AMC held workshop sessions in June to test the draft EPAs with small groups of stakeholders (including Directors of Clinical Training, Medical Education Officers, supervisors, registrars and interns) in each state/territory. Feedback from these groups was broadly positive, and supportive of the structure and content of the draft EPAs with some suggestions for revision. The AMC has also sought expert input from Dr Claire Touchie, Chief Medical Education Advisor, Medical Council of Canada, on the draft EPAs. Dr Touchie evaluated the EPAs using the EQual rubric[[1]](#footnote-1) and her feedback on the draft EPAs was that they were largely of good quality.

The draft EPAs are at **ATTACHMENT B**, a summary is provided below:

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| EPA | Summary |
| EPA 1: Clinical assessment | Conduct a clinical assessment of a patient incorporating history, examination, and formulation of a differential diagnosis and a management plan. (Based on RACP’s EPA 1) |
| EPA 2: Acutely unwell patients | Recognise, assess, escalate appropriately, and provide immediate management to deteriorating and acutely unwell patients. (Based on RACP’s EPA 7) |
| EPA 3: Prescribing | Appropriately prescribe therapies (drugs, fluids, blood products, inhalational therapies including oxygen) tailored to patients’ needs and conditions, either in response to a request by the treating team or self-initiated. (Based on RACP’s EPA 4) |
| EPA 4: Communicating about patient care | Communication about patient care, including accurate documentation and written and verbal information to facilitate high quality care at transition points and referral. (Based on combining RACP’s EPA 3 (documentation) and 5 (transfer of care)) |

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| Questions |
| Important note: the AMC’s initial thinking regarding the processes for assessing the EPAs is described in section C.  Content Do the EPAs describe the key work of the prevocational (PGY1 and PGY2) doctor?Is there anything included in the EPAs that is not appropriate for the work of the PGY1 or PGY2 doctor?Are any key components of the work of PGY and PGY2 doctors missing? Are there any specific areas that should be strengthened? Are there any specific areas that are emphasized too strongly?It is proposed that the same EPAs will be assessed for PGY1 and PGY2 doctors but at a higher level for PGY2 doctors based on the complexity, responsibility, level of supervision and entrustability, as well as the context, of PGY2 doctors’ work. This will be an important focus of supervisor training. Do you have any suggestions or concerns about this approach? Structure and clarity It is proposed that the EPAs will be included in an e-portfolio, which will enable their presentation in a more streamlined format with links to additional information as required by trainees and supervisors. Do you have any feedback on the structure or clarity of the EPAs?Do any providers have interest in trialling the EPAs in 2021?Do you have any other comments or suggestions about the draft EPAs? |

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**C. Proposals for revisions to assessment**

In line with the confirmed scope and evaluation feedback, the AMC has developed some initial proposals for revisions to assessment processes for PGY1 and PGY2 doctors.

There are three principles guiding the proposed changes to assessment:

* Strengthening the quality, consistency, relevance and longitudinal nature of assessment, including increasing opportunities for feedback.
* An e-portfolio will support the revised assessment process, including as a mechanism to facilitate a longitudinal approach to assessment and to streamline the process.
* Supervisor training and engagement will be critical. The AMC review is proposing that supervisor training requirements be strengthened, including development of online training materials and recognition of training completed for supervision of medical students or College trainees. This will include consideration of the role of and support for registrars.

A summary of the proposals for change to the assessment processes is provided in **ATTACHMENT C**. An outline is provided below:

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| Assessment components | Proposed change/ new development |
| Initial discussion | Strengthen the requirement for a beginning of term discussion between the prevocational doctor and the supervisor to outline the learning goals and assessment processes of the term. |
| Mid-term | Increased flexibility to enable registrars to contribute to/conduct mid-term assessments, with a process for formal sign off by the supervisor.  Revisions to streamline the mid-term assessment form. |
| Assessment of EPAs | A specified number of EPAs to be assessed each term by the term supervisor to increase opportunities for feedback based on observed clinical practice. Some assessments may be performed by registrars.  A draft EPA assessment form and proposed supervisory scale will be included in the next consultation. |
| End of term | Revisions to streamline the end of term assessment form. |
| Certifying completion | Global judgement by an assessment panel (rather than an individual) at the end of each year, taking account of EPA assessments and all end of term assessment forms. As is currently the case, satisfactory performance will be judged on attainment of the required standard by the end of the year rather than a requirement to pass a specified number of EPA or end of term assessments.  Satisfactory completion of PGY1 will continue to be a requirement for general registration. A certificate of completion will be issued at the end of PGY2. The AMC is proposing that this certificate should be a pre-requisite for entry into (or continuation of) vocational training. |
| Remediation | Strengthening remediation processes and guidance provided to trainees and supervisors. |

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| Questions |
| Do you have any feedback on the initial proposals for changes to the assessment processes **(ATTACHMENT C)**, including:  * 1. Strengthening the requirement for a beginning of term discussion   2. Changes to the mid-term assessment and flexibility to include registrars in the assessment, with appropriate sign off   3. The assessment processes for EPAS including the number, format and who should perform the assessment. The AMC is proposing:   + A minimum of 10 EPAs in total across the year and a minimum of 2 in each rotation.   + EPA 1 assessed in each rotation, and EPAs 2-4 assessed a minimum of two times each throughout the year.   + Opportunities to increase the EPAs for individuals with development needs.   Do you have any comments or suggestions about this proposal? Do you have any comments on registrars conducting some of the EPA assessments?   * 1. Decision by an assessment panel at the end of each year. What are your views on this, including any resource implications? Do you have any suggestions about the composition of this panel?  The process for certifying completion of PGY2.Feedback on the current National Framework indicates that the remediation processes need strengthening and additional guidance. It is hoped that the assessment of EPAs will help in earlier detection of those requiring additional support. What else would help with strengthening the current remediation processes? (e.g. a resource guide, supplementary assessments for remediation such as multi-source feedback or additional EPAs?)In line with feedback, the AMC is proposing strengthening the standards and requirements for supervisor training and engagement, acknowledging broader system issues, such as time and resource constraints. The AMC considers there are some common features of good supervision across the medical education continuum, (e.g. giving feedback), and sees opportunities for recognition of training completed for supervision of medical students or College trainees, and opportunities for sharing resources. What specific training or additional resources would be required or helpful for prevocational (PGY1/PGY2) supervisors (both supervisors and registrars)?The New Zealand prevocational model includes an educational supervisor (in addition to the term clinical supervisors and Directors of Clinical Training) who has oversight of a maximum of 10 prevocational doctors for one or two years. This person supports longitudinal development and monitoring of training and assessment requirements. The AMC recognizes that this would be challenging to achieve in the resource constrained environment of Australian prevocational training, particularly in health services with large numbers of prevocational trainees. What are your views on ways in which longitudinal support could be provided to prevocational doctors?Do you have any other comments or suggestions about the proposed revisions to assessment? |

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| 1. Training environment |

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| Current components | Summary of confirmed scope |
| National standards for programs | * Expand to PGY2 * Review term structures in relation to quality of learning, relevance and flexibility. Focus on outcomes/experience over setting * Support expanded settings * Strengthen national standards |
| [Guidelines for terms](https://www.amc.org.au/wp-content/uploads/accreditation_recognition/prevocational_standards_accreditation/national_internship_framework/Intern_training-Guidelines_for_terms_2013_12_18.pdf) |
| Registration standard |

The AMC is proposing some significant changes to prevocational program and term requirements. This is in line with stakeholder feedback received during the evaluation phase of the review. The AMC has commenced preliminary review and development work on these requirements.

One of the proposed changes is to discontinue the current mandatory term model. Feedback from stakeholders suggests the current model creates a number of challenges in the current healthcare environment, including that:

* The model is not reflective of community health needs, and limits opportunities for expanded settings
* The model restricts flexibility to explore and take advantage of valuable learning experiences in other settings
* Capacity constraints and changing models of care (e.g. high acuity, short stay, increasing specialisation) have resulted in significant variations in interns’ experience of mandatory terms. Health services report that they face challenges in providing enough terms that meet current requirements
* Defining the ‘setting’ does not necessarily ensure relevance, quality or consistency of learning experience

The revisions are aimed at improving the longitudinal nature and flexibility of the prevocational training programs and the quality and relevance of learning experiences. Important note: the removal of mandatory term requirements would not require an immediate change to the current program term structure.

A summary of proposed changes is provided at **ATTACHMENT D.** An outline is provided below.

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| Area | Initial revisions for consultation |
| Guidelines for terms (Based on National registration standard) | Initial proposals for change to program and term structures including removal of mandatory setting requirements, with introduction of other parameters to ensure the retention of important features such as the generalist experience and continuity. Parameters being considered include:   * Breadth of experiences * Min/max length of terms * Limits on the number or duration of relief or out of hours rotations each year   The AMC has commenced discussions with the Medical Board of Australia about aligning the National Framework for Prevocational Training with changes to the MBA’s registration standard and CPD requirements. |
| National standards for programs | Initial proposals for change to the national standards for programs in line with key themes discussed above, including strengthening standards for supervision. |

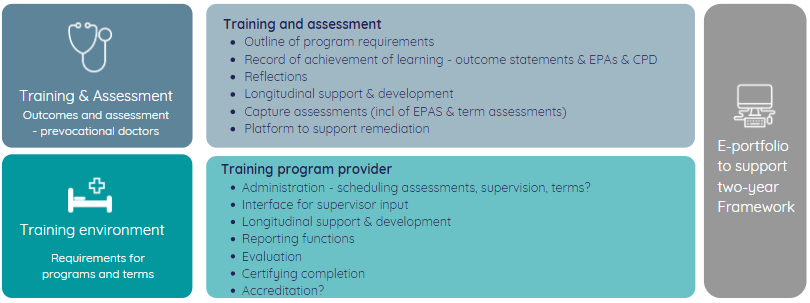
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| Questions |
| Proposals for change to guidelines for terms Do you have any feedback on the proposals for change to the guidelines to terms **(ATTACHMENT D)**?The AMC is proposing the introduction of parameters to maintain important features, such as generalist experience, in the absence of mandatory term requirements. In thinking about the parameters suggested:  * + What do you see as the most important (if any)? Why (rationale)?   + What are your thoughts about proposing minimum and maximum term lengths? Should there be differences for PGY1 and PGY2? What might be the impacts of this?   + What parameters might need to be in place to ensure a “generalist” experience or breadth of experience? (for example: by settings/environments? By patient profiles? By specialty exposure? Exposure to out of hours work? By exposure to ambulatory and inpatient care?   + How important is being part of a (medical) team (compared with ward-based terms) to the overall experience of prevocational trainees? How might this be addressed?  Are there any additional considerations required regarding term allocation/ rostering? Proposals for change to national standards for programs Feedback on the proposals for change to the national standards for programs **(ATTACHMENT D)**?How might the AMC support expanded settings (eg general practice, community health, drug and alcohol services) in the revisions to national standards?Do you have any suggestions about how supervision standards can be strengthened?Do you have any other comments or suggestions about the proposed revisions to guidelines for programs? |

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| 1. E-portfolio specifications |

The AMC has been appointed by the Australian Health Ministers’ Advisory Council to develop E-portfolio specifications to support the implementation of a two-year capability and performance framework.

The prevocational E-portfolio is a critical component of the revised Framework. It is intended to provide greater individual accountability for learning and support the assessment processes. It will also facilitate a longitudinal approach to prevocational training, providing a mechanism to support development across the two years and streamline administration of the program. A diagram illustrating possible functions of the e-portfolio is provided below.



The draft key functions at **ATTACHMENT E** have been developed by the AMC on the basis of other similar systems (for example the Medical Council of New Zealand’s E-Port) and stakeholder feedback to date.

Important note: The 2018 Health Ministers’ response to the 2015 Review of Medical Intern Training included a recommendation for national specifications for the e-portfolio with development and implementation at state and territory level. In consultations, the AMC has received strong feedback from stakeholders supporting a national approach to development and implementation of a prevocational e-portfolio. Reasons have included national consistency, efficiency and cost effectiveness. The AMC is engaging in discussions about the possibility of a national system with relevant stakeholders.

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| Questions |
| Feedback on e-portfolio specifications presented **(ATTACHMENT E)** including:  * + Is there anything missing or unnecessary in the key functions/ elements?  Does anything need to be reclassified (critical, desirable, for consideration)?Do you have any other comments or suggestions about the draft e-portfolio specifications? |

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1. Taylor DR, Park YS, Egan R, et al. EQual, a Novel Rubric to Evaluate Entrustable Professional Activities for Quality and Structure. Acad Med. 2017;92(11S Association of American Medical Colleges Learn Serve Lead: Proceedings of the 56th Annual Research in Medical Education Sessions) [↑](#footnote-ref-1)