NATIONAL FRAMEWORK FOR PREVOCATIONAL (PGY1 AND PGY2) MEDICAL TRAINING

Australian Medical Council Limited

Training and assessment

Training and assessment requirements for prevocational (PGY1 and PGY2) training programs

CONTENTS

Acknowledgement of country

The Australian Medical Council acknowledges Aboriginal, Torres Strait Islander Peoples and Māori Peoples as the Traditional Custodians of the lands the AMC works upon.

We pay respects to Elders past, present and emerging and acknowledge the ongoing contributions that Indigenous Peoples make to all communities. We acknowledge the government policies and practices that impact on the health and wellbeing of Indigenous Peoples and commit to working together to support healing and positive health outcomes.

The AMC is committed to improving outcomes for Aboriginal, Torres Strait Islander and Māori Peoples through its assessment and accreditation processes including equitable access to health services for First Nations Peoples.

National Framework for Prevocational Medical Training

The National Framework for Prevocational Medical Training describes the standards for the first two post graduate years for prevocational doctors in Australia. The AMC acknowledges and appreciates the Aboriginal and Torres Strait Islander individuals and organisations that provided feedback and contributed to the development of the National Framework for Prevocational Medical Training.

The National Framework for Prevocational Medical Training review and development work was supported by the AMC Aboriginal, Torres Strait Islander and Māori Committee. The AMC has strengthened the requirements for Aboriginal and Torres Strait Islander health content across the Framework to better support Aboriginal and Torres Strait Islander patients and doctors. The AMC will ensure continuous improvement of the education and accreditation standards to ensure the domestic and international medical graduates registered to practice in Australia are contributing to a culturally safe workforce for Aboriginal, Torres Strait Islander and Māori colleagues and clients. The AMC is committed to future strengthening of these requirements within the Framework.

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About this document

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About this document

This document describes the training and assessment requirements for prevocational (PGY1 and PGY2) training programs. It contains two stand-alone sections:

SECTION 1 **Prevocational training**	2A	Prevocational outcome statements
	2B	Entrustable professional activities (EPAs)
	2C	Record of learning
SECTION 2 **Prevocational assessment**	3A	Assessment approach
	3B	Improving performance
	3C	Certifying completion of PGY1 and PGY2 training
	3D	National assessment forms

These training and assessment requirements are part of the National Framework for Prevocational (PGY1 and PYG2) Medical Training, which describes how doctors are trained and assessed in their first two years after medical school, and sets standards that contribute to good quality training. The complete National Framework components and their relevant documents are:

- **Training and assessment** – *Training and assessment requirements for prevocational (PGY1 and PGY2) training programs* (**this document**)
- **Training environment** – *National standards and requirements for prevocational (PGY1 and PGY2) training programs and terms*
- **Quality assurance** – *AMC domains and procedures for assessing and accrediting prevocational (PGY1 and PGY2) training accreditation authorities*

Figure 1 summarises the National Framework, showing its structure and how the components interact with each other.

Figure 2 depicts how the training and assessment components described in Section 2 and 3 of this document are interconnected and support each other.

Figure 1 – Overview of the National Framework for prevocational medical training

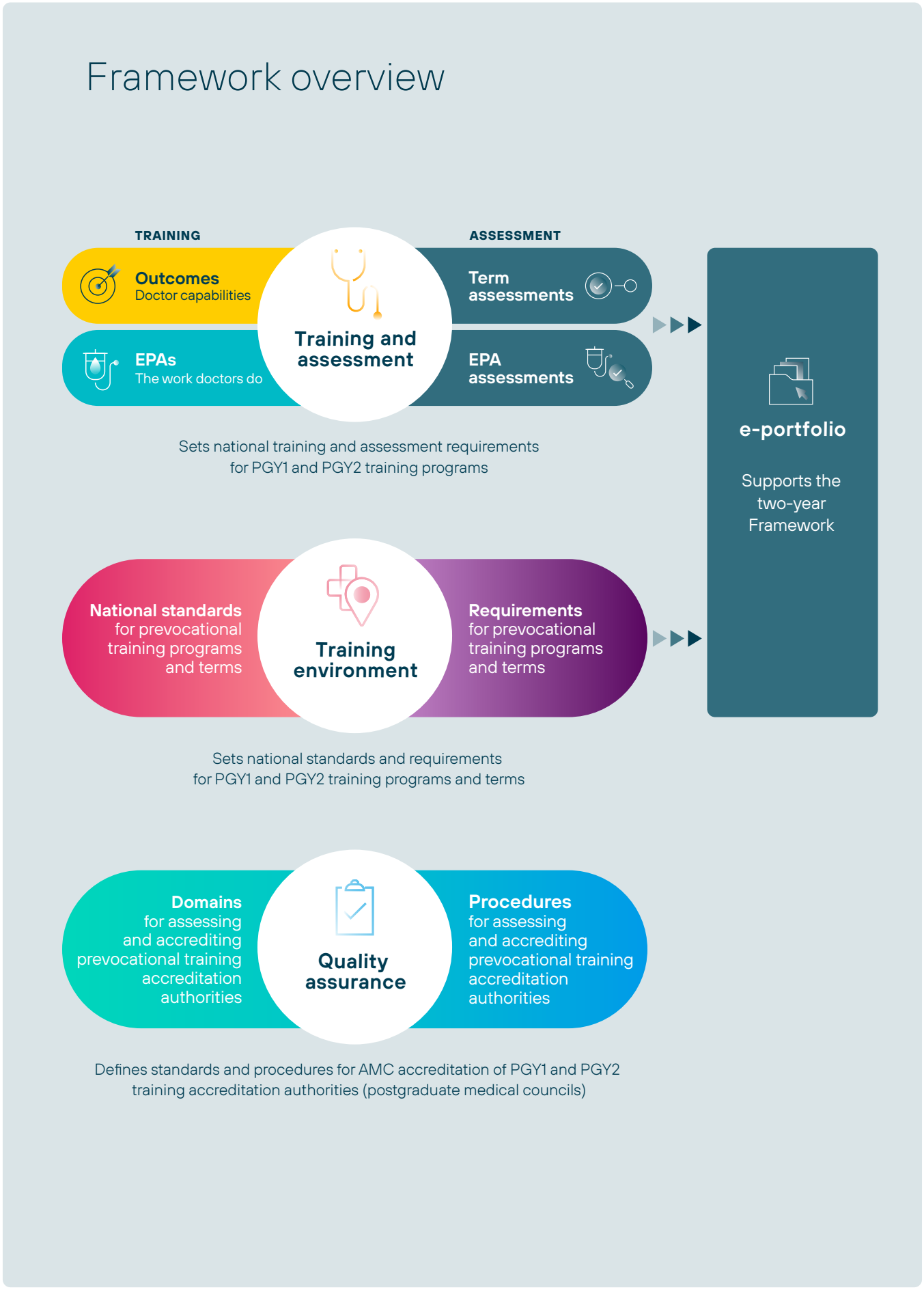
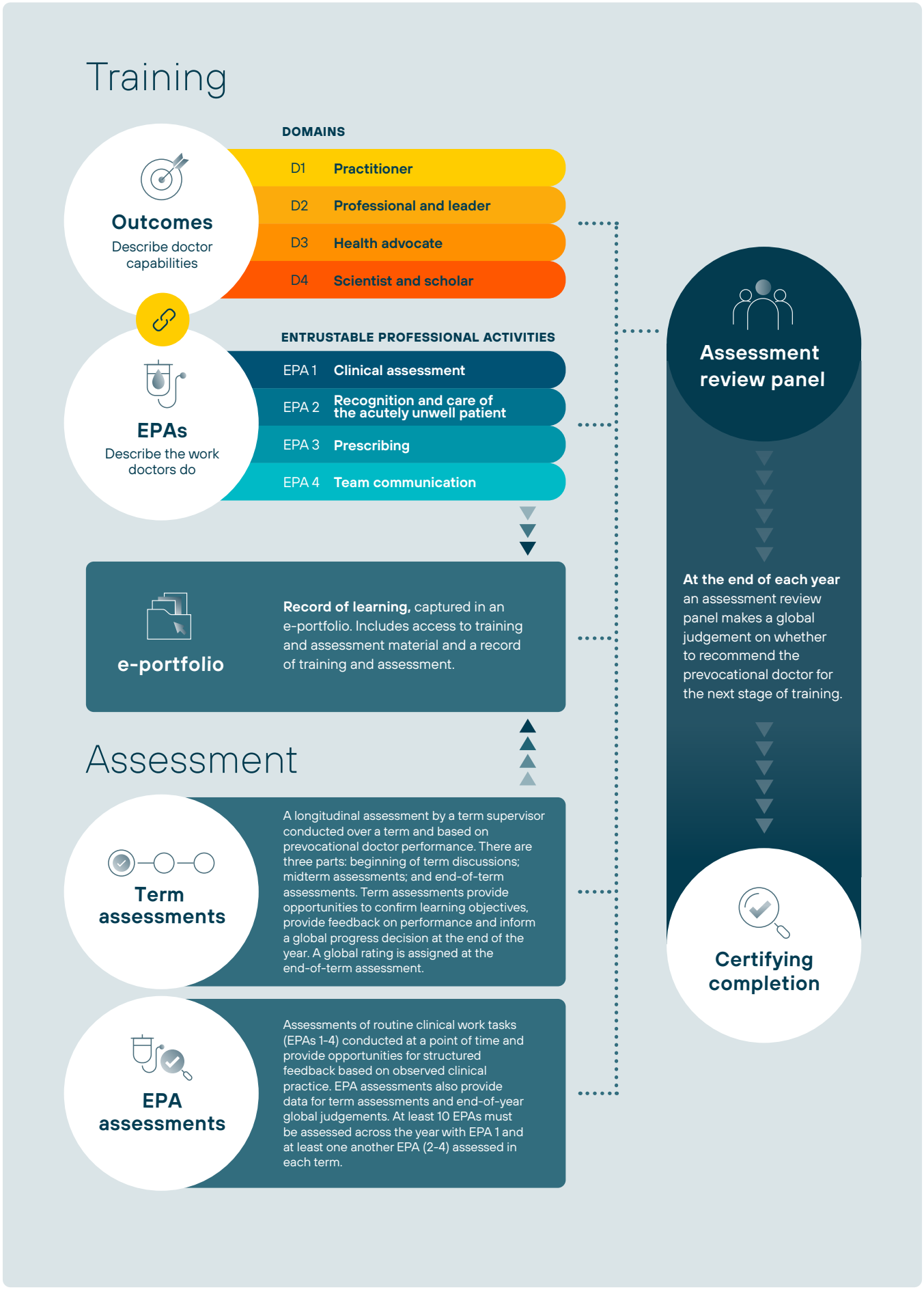


Figure 2 – Overview of the training and assessment components of the National Framework



2

Prevocational training

2A

PREVOCATIONAL TRAINING

Prevocational outcome statements

Introduction

The prevocational outcome statements describe the broad and significant capabilities that prevocational doctors should achieve by the end of their postgraduate year 1 (PGY1) and postgraduate year 2 (PGY2) programs. The high-level statements apply at completion of both PGY1 and PGY2, though the level of expectation, responsibility, supervision, and entrustability of the outcomes will be different between the two years.

The outcome statements form part of 'Prevocational training' (Section 2 of *Training and assessment requirements for prevocational (PGY1 and PGY2) programs*). The statements describe the capabilities of a prevocational doctor and are complemented with entrustable professional activities (EPAs), which describe common essential tasks that prevocational doctors undertake as part of providing health care.

Prevocational doctors must ensure they understand the two-year prevocational training and assessment requirements, monitor their progress against those requirements, and proactively work with their supervisors and training providers to address any areas needing improvement to meet the requirements.

Prevocational training providers must design learning and assessment programs that will enable prevocational doctors to achieve these outcomes. The outcome statements provide clinical supervisors and training directors with clear criteria for determining progress and completion. Achieving the outcomes is a requirement for general registration at the end PGY1.

The outcome statements and the training and assessment requirements assume that prevocational doctors work within their scope of practice. Delivering safe and high-quality health care is an overarching expectation on all practitioners, at all stages of training, in all healthcare settings, and in the programs developed by training providers. Accordingly, prevocational training programs and prevocational doctors should take account of:

- the work of the Australian Commission on Safety and Quality in Health Care
- the National Safety and Quality Health Service (NSQHS) Standards
- the NSQHS Standards *User guide for Aboriginal and Torres Strait Islander health*[1].

All doctors should practice according to the Medical Board of Australia's *Good medical practice: a code of conduct for doctors in Australia*[2].

The outcome statements are:

Set within four domains[3]

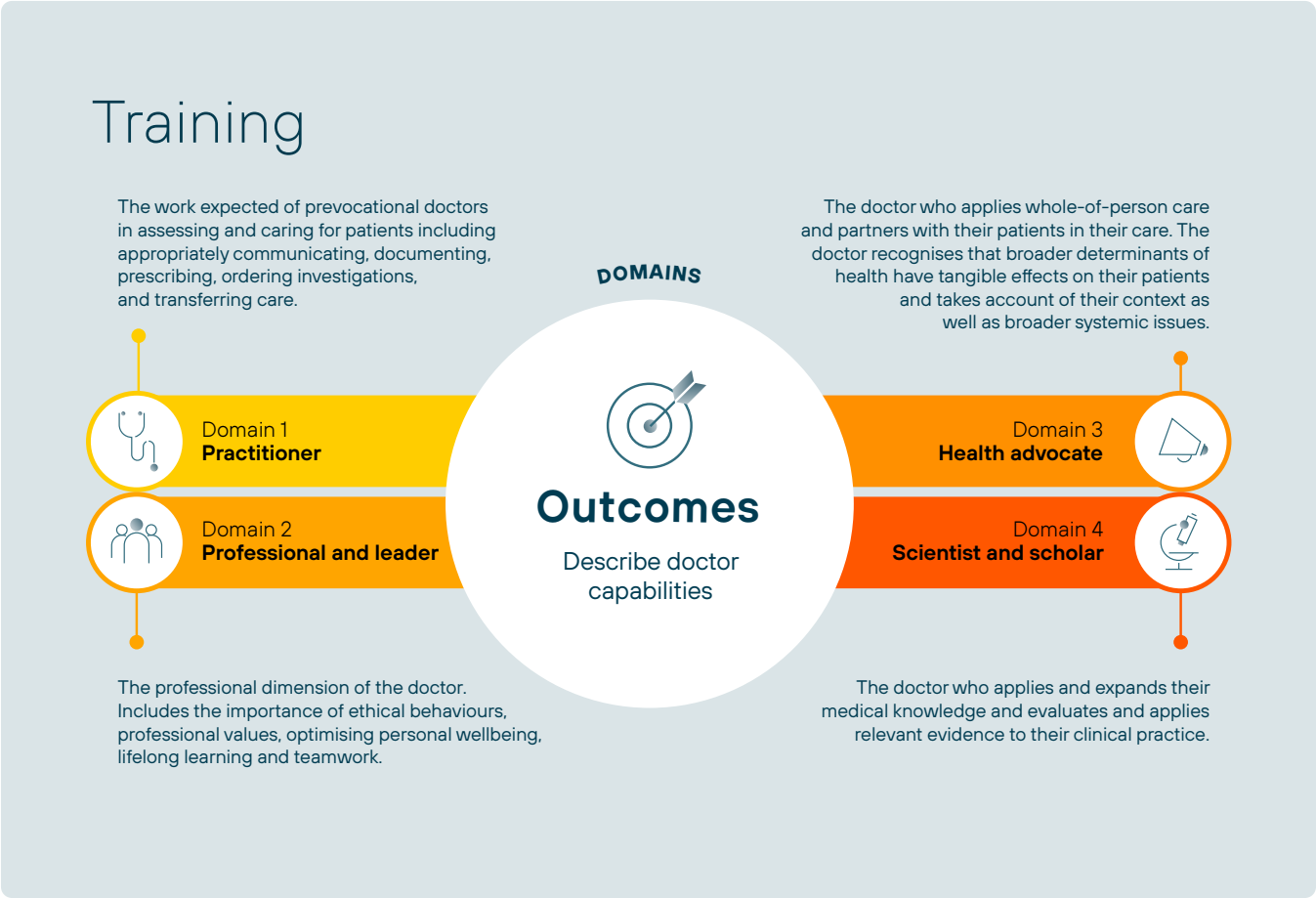
To be achieved by the end of each prevocational year (PGY1 and PGY2)

Work-based, person-centred, and take account of the prevocational doctor's increasing responsibility for patient care under supervision

Designed to be sufficiently generic to cover a range of learning environments

1. Australian Commission on Safety and Quality in Health Care, *NSQHS standards user guide for Aboriginal and Torres Strait Islander health*, ACSQHC website, 2017, accessed 22 April 2022.
2. The Medical Board of Australia (MBA), Good medical practice: a code of conduct for doctors in Australia, MBA website, 2021, accessed 22 April 2022.
3. The same four domains are used in the graduate outcome statements for medical students, and can be found in Australian Medical Council (AMC), Standards for assessment and accreditation of primary medical programs by the Australian Medical Council 2012, AMC website, 2012, accessed 22 April 2022.

Figure 3 – Overview of the prevocational outcome statements



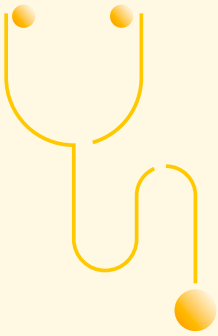
2A

The prevocational doctor as practitioner

DOMAIN 1

2A

D1 Practitioner



Domain 1 describes the work expected of prevocational doctors in assessing and caring for patients including appropriately communicating, documenting, prescribing, ordering investigations, and transferring care. It is expected that prevocational training will equip doctors with the broad skills they need to continue their education and practice in a range of settings.

On completing training, Australian prevocational doctors are able to:

1.1 Place the needs and safety of patients at the centre of the care process, working within statutory and regulatory requirements and guidelines. Demonstrate skills including effective clinical handover, graded assertiveness, delegation and escalation, infection control, and adverse event reporting.

1.2 Communicate sensitively and effectively with patients, their family and carers, and health professionals, applying the principles of shared decision-making and informed consent.

1.3 Demonstrate effective, culturally safe interpersonal skills, empathetic communication and respect within an ethical framework inclusive of Indigenous knowledges of wellbeing and health models to support Aboriginal and Torres Strait Islander patient care.

1.4 Perform and document patient assessments, incorporating a problem-focused medical history with a relevant physical examination, and generate a valid differential diagnosis and/or summary of the patient's health and other relevant issues.

1.5 Request and accurately interpret common and relevant investigations using evidence-informed knowledge and principles of sustainability and cost-effectiveness.

1.6 Safely perform a range of common procedural skills required for work as a PGY1 or PGY2 doctor.

1.7 Make evidence-informed management decisions and referrals using principles of shared decision-making with patients, carers and the health care team.

1.8 Prescribe therapies and other products including drugs, fluids, electrolytes, and blood products safely, effectively and economically.

1.9 Recognise, assess, communicate and escalate as required, and provide immediate management to deteriorating and critically unwell patients.

1.10 Appropriately use and adapt to dynamic systems and technology to facilitate practice, including for documentation, communication, information management and supporting decision-making.

2A

The prevocational doctor as a professional and leader

DOMAIN 2

D2 Professional and leader

Domain 2 describes the professional dimension of the doctor. It includes the importance of ethical behaviours, professional values, optimising personal wellbeing, lifelong learning and teamwork. Responsibilities of the doctor also include supporting the health and wellbeing of individuals, communities and populations now and for future generations, teaching, and promoting the environmental and financial sustainability of the healthcare system.

On completing training, Australian prevocational doctors are able to:

2.1 Demonstrate ethical behaviours and professional values including integrity, compassion, self-awareness, empathy, patient confidentiality and respect for all.

2.2 Identify factors and optimise personal wellbeing and professional practice, including responding to fatigue, and recognising and respecting one's own limitations to mitigate risks associated with professional practice.

2.3 Demonstrate lifelong learning behaviours and participate in, and contribute to, teaching, supervision and feedback.

2.4 Take increasing responsibility for patient care, while recognising the limits of their expertise and involving other professionals as needed to contribute to patient care.

2.5 Respect the roles and expertise of healthcare professionals, and learn and work collaboratively as a member of an inter-professional team.

2.6 Contribute to safe and supportive work environments, including being aware of professional standards and institutional policies and processes regarding bullying, harassment and discrimination for themselves and others.

2.7 Critically evaluate cultural safety and clinical competencies to improve culturally safe practice and create culturally safe environments for Aboriginal and Torres Strait Islander communities. Incorporate into the learning plan strategies to address any identified gaps in knowledge, skills, or behaviours that impact Aboriginal and Torres Strait Islander patient care.

2.8 Effectively manage time and workload demands, be punctual, and show ability to prioritise workload to manage patient outcomes and health service functions.

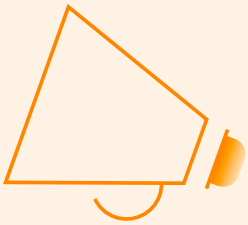
2A

The prevocational doctor as a health advocate

DOMAIN 3

2A

D3 Health advocate



Domain 3 describes the doctor who applies whole-of-person care[4] and partners with their patients in their care. The doctor recognises that broader determinants of health[5] have tangible effects on their patients and takes account of their context as well as broader systemic issues. The doctor considers how these factors influence a patient's presentation, symptoms, interpretation, and behaviours. Acting as an advocate occurs as a response to acknowledgment of the disempowerment that patients may experience as they access the health system. As a health practitioner, the prevocational doctor considers their own biases and reflects on their impact on their practice.

On completing training, Australian prevocational doctors are able to:

3.1 Incorporate disease prevention, relevant health promotion and health surveillance into interactions with individual patients, including screening for common diseases, chronic conditions, and discussions of healthcare behaviours with patients.

3.2 Apply whole-of-person care principles to clinical practice, including consideration of a patient's physical, emotional, social, economic, cultural and spiritual needs and their geographical location, acknowledging that these factors can influence a patient's description of symptoms, presentation of illness, healthcare behaviours and access to health services or resources.

3.3 Demonstrate culturally safe practice with ongoing critical reflection of the impact of a health practitioner's knowledge, skills, attitudes, practising behaviours and power differentials in delivering safe, accessible and responsive healthcare free of racism and discrimination.

3.4 Demonstrate knowledge of the systemic and clinician biases in the health system that impact on the service delivery for Aboriginal and Torres Strait Islander peoples. This includes understanding current evidence around systemic racism as a determinant of health and how racism maintains health inequity.

3.5 Demonstrate knowledge of the ongoing impact of colonisation, intergenerational trauma and racism on the health and wellbeing of Aboriginal and Torres Strait Islander peoples.

3.6 Partner with the patient in their healthcare journey, recognising the importance of interaction with and connection to the broader healthcare system. Where relevant, this should include culturally appropriate communication with caregivers and extended family members while also including and working collaboratively with other health professionals (including Aboriginal Health Workers, practitioners and Liaison Officers).

4. Whole-of-person care includes consideration of all dimensions that can affect a person's overall health. These dimensions include but are not limited to an individual's geographical location, culture, sexual orientation, gender identity and any disabilities.
5. Social, economic, cultural, historical and environmental (including climate change).

2A

The prevocational doctor as a scientist and scholar

DOMAIN 4

D4 Scientist and scholar

Domain 4 describes the doctor who applies and expands their medical knowledge and evaluates and applies relevant evidence to their clinical practice. The doctor recognises that research, and quality improvement and assurance underpin continuous improvement of clinical practice and the broader healthcare system, and conscientiously supports these activities.

On completing training, Australian prevocational doctors are able to:

4.1 Consolidate, expand and apply knowledge of the aetiology, pathology, clinical features, natural history and prognosis of common and important presentations in a variety of stages of life and settings.

4.2 Access, critically appraise and apply evidence from the medical and scientific literature to clinical and professional practice.

4.3 Participate in quality assurance and quality improvement activities such as peer review of performance, clinical audit, risk management, incident reporting and reflective practice.

4.4 Demonstrate a knowledge of evidence-informed medicine and models of care that support and advance Aboriginal and Torres Strait Islander health.

2B

PREVOCATIONAL TRAINING

Entrustable professional activities (EPAs)

2B

SUMMARY

EPAs

The four EPAs describe essential work undertaken by PGY1 and PGY2 doctors. They are anchored to the prevocational outcome statements in the same domains and thus help align PGY1 and PGY2 doctors' roles with both training activities, and assessment and achievement of prevocational outcomes (see Figure 4 for an overview, and Table 1 for structure). Assessment of EPAs provides structured opportunities for observation, feedback and learning, and informs global judgements at the end of terms and the end of each prevocational year.

The following are important points about EPAs in the prevocational context:

- An EPA is a description of essential work. This contrasts with outcomes or capabilities, which describe characteristics of a prevocational doctor.
- An EPA is not an assessment tool, but performance of an EPA can be assessed. Assessment of EPAs will include judgements about entrustability, that is, the level of supervision required for the doctor to perform this work safely.
- While PGY1 and PGY2 doctors will be assessed using the same EPAs, PGY2 doctors will be assessed to a higher level based on the complexity, responsibility, level of supervision and entrustability, as well as the context, of PGY2 doctors' work.

Information about assessing EPAs is detailed in 'Prevocational assessment' (Section 3 of *Training and assessment requirements for prevocational (PGY1 and PGY2) training programs*).

Figure 4 – Overview of the entrustable professional activities (EPAs)

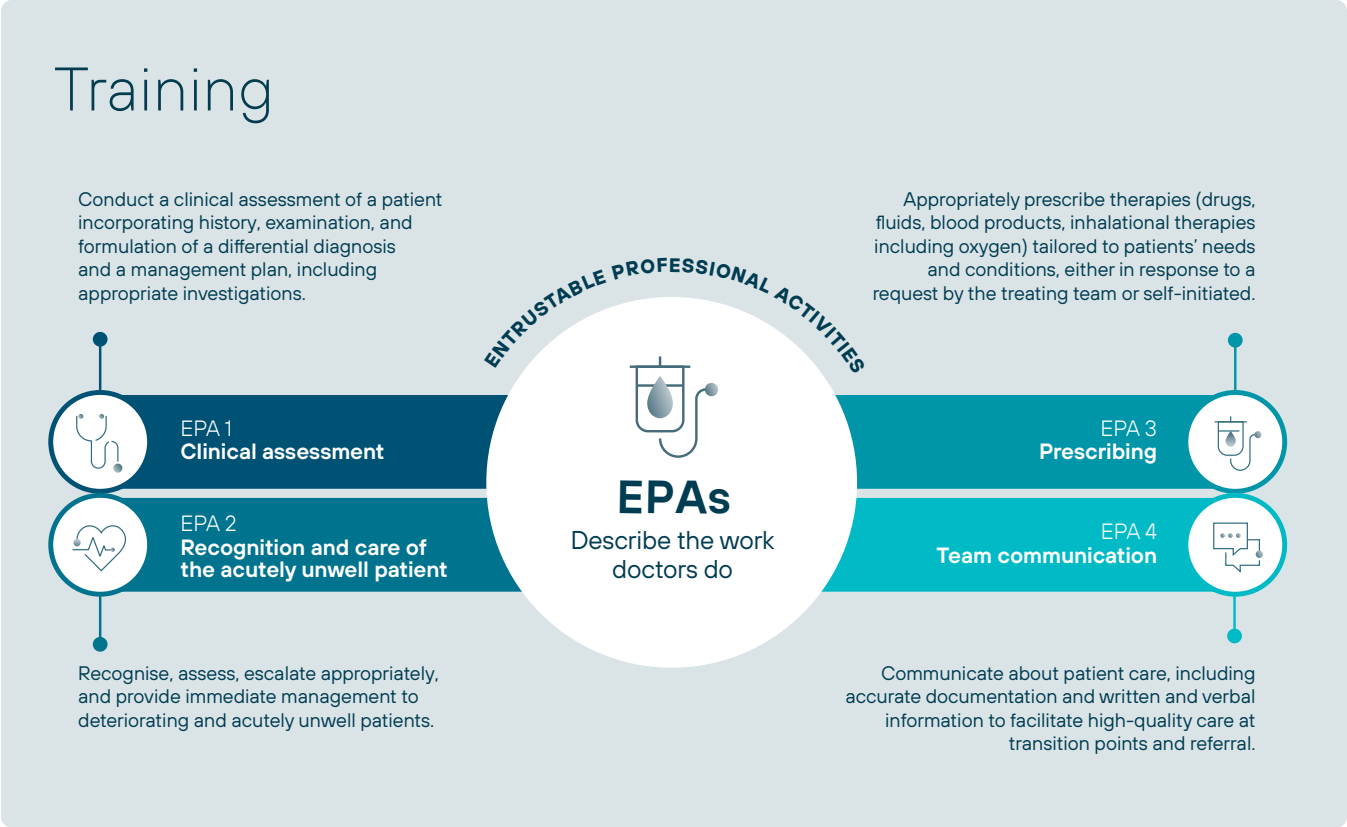


Table 1 – Structure of the EPAs

COMPONENT	DESCRIPTION
THEME	Identifies the activity.
TITLE	Provides a brief summary of the activity.
FOCUS AND CONTEXT	Describes central aspects of the activity and in what clinical context it might apply.
DESCRIPTION	Provides an overview of the key tasks involved in the activity.
BEHAVIOURS	Describes behaviours that could be observed and would support the supervisor's judgements about the level of performance. The behaviours are anchored to the prevocational outcome statements. Subpoints are included to provide further detail where required; in an electronic format these could be minimised.

Acknowledgements

These EPAs have been developed using the Royal Australasian College of Physician Basic Training Curriculum EPA structure and content, with permission. The EPAs are informed by material presented at Ins and Outs of Entrustable Professional Activities: An International Course of EPAs – Utretch. March 21-23, 2019. This course was directed by Professor Olle ten Cate PhD, with contributions from faculty: H. Carrie Chen, MD PhD; Reiner Hoff, MD PhD; Claire Touchie, MD MPHE; and Josephine Boland, MSc EdD. The EPAs have been critically appraised by Associate Professor Claire Touchie, Faculty of Medicine, University of Ottawa and Chief Medical Education Officer Medical Council of Canada. There has been extensive consultation with Australian stakeholders as drafts have been iterated, and feedback received has been considered and incorporated. The AMC is grateful to all for their willingness to contribute.

Clinical assessment

EPA 1

TITLE

Conduct a clinical assessment of a patient incorporating history, examination, and formulation of a differential diagnosis and a management plan, including appropriate investigations (based on RACP's EPA 1).

FOCUS AND CONTEXT

This EPA applies in admission, reviewing a patient in response to a particular concern, ward-call tasks, ward rounds, lower acuity emergency department presentations, general practice consultations or outpatient clinical attendances.

Perform this activity in multiple settings, including inpatient and ambulatory (including community) care settings or in emergency departments and in the care of different populations (for example children, adults and the elderly).

DESCRIPTION

This activity requires the ability to, where appropriate or possible:

1. if the clinical assessment has been requested by a team member, clarify the concern(s) with them
2. identify relevant information in the patient record
3. obtain consent from the patient
4. obtain a history
5. examine the patient
6. consider and integrate information from the patient record, clinical assessments, and relevant ward protocols, guidelines or literature
7. develop provisional and differential diagnoses and/or problem lists
8. produce a management plan, confirm as appropriate with a senior colleague, and communicate with relevant team members and the patient
9. implement the management plan, initiate or perform appropriate investigations and procedures, and document the assessment and next steps, including indications for follow-up.

2B

EPA 1

Clinical assessment

BEHAVIOURS

Outcome	Requires minimal supervision	Requires direct supervision
	I trust the prevocational doctor to complete the task; I need to be contactable / in the building and able to provide a general overview of work. Examples of behaviours of a prevocational doctor who can perform this activity with **minimal supervision.**	*I need to be there to observe the interactions and review the work.* Examples of behaviours of a prevocational doctor who **requires direct supervision** to perform this activity.
DOMAIN 1 Practitioner	**Patient assessment – history** • Obtains person-centred histories tailored to the clinical situation in a culturally safe and appropriate way. Subpoints • Reviews and identifies relevant information in the patient's record to locate the problem in that patient journey. • Identifies and uses collateral sources of information to obtain history when needed, such as family members, carers, and other health professionals.	**Patient assessment – history** • Exhaustively gathers information not relevant to the presenting problem while missing necessary points. • Uses jargon and/or inappropriate acronyms. • Does not listen to the patient effectively or give them space to speak.
	Aboriginal and Torres Strait Islander health • Demonstrates cultural safety in working alongside Aboriginal and Torres Strait Islander peoples (patients and colleagues), and actively supports cultural safety within the clinical environment. • Demonstrates effective, culturally safe inter-personal skills, empathetic communication, and respect within an ethical framework inclusive of holistic social and emotional wellbeing models to support equity in Aboriginal and Torres Strait Islander peoples' patient care.	**Aboriginal and Torres Strait Islander health** • Does not yet demonstrate their ability to: follow processes to routinely ask patients if they identify as being of Aboriginal and/or Torres Strait Islander origin; and include current Indigenous health evidence-based medicine, inclusive of social and emotional wellbeing, within their practice. • Does not yet demonstrate effective, culturally safe interpersonal skills, empathetic communication, and respect, within an ethical framework inclusive of holistic social and emotional wellbeing models to support equity in Aboriginal and Torres Strait Islander peoples' patient care.
	Patient assessment – physical examination • Performs an accurate, appropriate and person-centred physical and/or mental state examination.	**Patient assessment – physical examination** • Performs inadequate physical examinations. • Does not respect patient privacy, comfort and safety.
	Patient assessment – clinical reasoning • Filters, prioritises, and synthesises relevant information for clinical problem-solving. Subpoints • Recognises and correctly interprets normal and abnormal findings. • Formulates appropriate problem lists or differential diagnoses.	**Patient assessment – clinical reasoning** • Reaches conclusions unsupported by data or evidence such as history and examination findings. • Unable to synthesise relevant information. • Differential diagnosis is unsafe, unprioritised and/or not contextualised. • Develops a minimal list of potential problems with relevant, major problems missed.

EPA 1 Clinical assessment

DOMAIN 1 **Practitioner**

Patient management

- Produces and implements an appropriate management plan.
- Initiates appropriate, focused and basic investigations.
- Safely performs common procedures where relevant.

Subpoints

- Identifies patients' preferences regarding management and assesses the role of families in decision-making.

Patient management

- Unable to produce a basic management plan.
- Produces a management plan which does not address issues relevant to the patient.
- Does not confirm management plan with supervisor when appropriate.

Communication

- Communicates accurately and effectively with the patient, carers and team members.

Subpoints

- Clarifies the task or problem with the team member/s.
- Communication includes anticipating, reading, and responding to verbal and non-verbal cues.
- Demonstrates active listening skills.

Communication

- When communicating with patient, carers or team members may do one or more of the following:
  - › does not introduce themselves
  - › does not listen carefully
  - › does not clarify
  - › uses jargon
  - › does not summarise to ensure shared understanding.

DOMAIN 2 **Professional and leader**

Professionalism

- Demonstrates professional conduct, honesty and integrity.
- Recognises their own limitations and seeks help when required in an appropriate way.

Subpoints

- Maintains patient privacy and confidentiality.
- Displays respect and sensitivity towards patients.
- Maximises patient autonomy and supports patients' decision-making.
- Takes responsibility and is accountable for patient care.

Professionalism

- Displays lapses in professional conduct, such as acting disrespectfully or providing inaccurate or incomplete information.
- Has an incomplete understanding of their own limitations that may result in overestimation of ability and dismissal of other health care team member concerns, or delay in responding to or asking for help for patients in need of urgent care.
- Lacks insight into learning needs and does not seek or act on feedback.
- Inadequately maintains confidentiality, for example, displaying or discussing confidential information on patients in public.

Aboriginal and Torres Strait Islander health

- Demonstrates ability to identify and address racism.
- Takes actions and knows how to support those who experience racism.

Teamwork

- Works effectively as a member or leader of the interprofessional team and positively influences team dynamics.

Teamwork

- Works in a way that disrupts effective functioning of the interprofessional team.

EPA 1 Clinical assessment

DOMAIN 3
Health advocate

Whole-of-person care

- Recognises and takes precautions where the patient may be vulnerable.
- Incorporates psychosocial considerations and stage in illness journey into assessment, acknowledging these factors can influence a patient's experience of illness and healthcare behaviours.

Whole-of-person care

- Disregards the social history and the patient's goals of care/treatment in assessment and management.

Population health

- Incorporates disease prevention, health promotion and health surveillance into interactions with individual patients.

Population health

- Does not consider population-based risk factors.
- Does not take opportunities to discuss healthcare behaviours.

Cultural safety for all communities

- Is respectful of patients' cultures and beliefs.
- Appropriately accesses interpretive or culturally-focused services.
- Identifies and considers culturally safe and appropriate means of obtaining patient histories and/or performing physical examination.

Cultural safety for all communities

- Does not take account of relevant cultural or religious beliefs and practices such as diet, burial practices or processes for decision-making.
- Demonstrates an inadequate awareness of, or difficulty accepting and understanding, the cultures of others.

Aboriginal and Torres Strait Islander health

[Based on Ahpra definition of cultural safety][6]

- Demonstrates critical reflection of health practitioner knowledge, skills, attitudes, practising behaviours and power differentials in delivering safe, accessible and responsive healthcare free of racism.
- Acknowledges colonisation and systemic racism and the social, cultural, behavioural and economic factors that impact individual and community health.
- Acknowledges and addresses individual racism, their own biases, assumptions, stereotypes and prejudices and provides care that is holistic, and free of bias and racism.
- Recognises the importance of self-determined decision-making, partnership and collaboration in healthcare which is driven by the individual, family and community.
- Fosters a safe working environment through leadership to support the rights and dignity of Aboriginal and Torres Strait Islander people and colleagues.

Aboriginal and Torres Strait Islander health

- Requires further development of knowledge and skills to effectively advocate for health advancement alongside Aboriginal and Torres Strait Islander peoples (patients and colleagues).

6. Australian Health Practitioner Regulation Agency (Ahpra), *National Scheme's Aboriginal and Torres Strait Islander Health and Cultural Safety Strategy 2020–2025*, Ahpra website, 2021, accessed 22 April 2022.

2B

EPA 1

Clinical assessment

DOMAIN 4

Scientist and scholar

Knowledge

- Makes use of local service protocols and guidelines to inform clinical decision-making.
- Draws on medical literature to assist in clinical assessments, when required.
- Demonstrates the ability to manage uncertainty in clinical decision-making.

Knowledge

- Demonstrates poorly formed approaches to identifying local service resources to support clinical decision-making.
- Cannot implement strategies to respond to clinical ambiguity and uncertainty such as ensuring patients and team members are clear about what to do if things change.

Quality assurance

- Performs hand hygiene and takes infection control precautions at appropriate moments.
- Advocates for and actively participates in quality improvement activities including incident reporting.

Quality assurance

- Demonstrates an undisciplined approach to hand hygiene and infection control.

Aboriginal and Torres Strait Islander health

- Demonstrates a clear understanding of how colonisation impacts Aboriginal and Torres Strait Islander health outcomes, and is able to map this to current evidence on systemic racism as a determinant of health and how racism maintains health inequity.

Aboriginal and Torres Strait Islander health

- Does not yet demonstrate a clear understanding of how colonisation impacts Aboriginal and Torres Strait Islander health outcomes, and is not yet able to map this to current evidence on systemic racism as a determinant of health and how racism maintains health inequity.

2B

Recognition and care of the acutely unwell patient

EPA 2

TITLE

Recognise, assess, escalate appropriately, and provide immediate management to deteriorating and acutely unwell patients. (This EPA recognises that PGY1 and PGY2 doctors are often called after-hours to assess patients whose situation has acutely changed.)

FOCUS AND CONTEXT

This EPA applies in any clinical context but the critical aspects that differentiate it from EPA 1 are for the PGY1/PGY2 doctor to:

1. recognise the acutely unwell and/or deteriorating patient (including deterioration in mental health)
2. act immediately, demonstrating a timely approach to management
3. escalate appropriately.

Perform this activity in multiple settings, including inpatient and ambulatory (including community) care settings or in emergency departments, in- and after-hours, and in the care of different populations (for example children, adults and the elderly).

DESCRIPTION

This activity requires the ability to, as appropriate and where possible:

1. recognise clinical deterioration or acutely unwell patients
2. respond by initiating immediate management, including basic life support if required
3. seek appropriate assistance, including following local processes for escalation of care
4. communicate critical information in a concise, accurate and timely manner to facilitate decision-making
5. lead the resuscitation initially, and involve other necessary services, such as intensive care or retrieval services.

2B

EPA 2

Recognition and care of the acutely unwell patient

BEHAVIOURS

Outcome	Requires minimal supervision	Requires direct supervision
	I trust the prevocational doctor to complete the task; I need to be contactable / in the building and able to provide a general overview of work. Examples of behaviours of a prevocational doctor who can perform this activity with **minimal supervision.**	*I need to be there to observe the interactions and review the work.* Examples of behaviours of a prevocational doctor who **requires direct supervision** to perform this activity.
DOMAIN 1 Practitioner	**Patient assessment – history** • Identifies deteriorating or acutely unwell patients.	**Patient assessment – history** • Does not identify deteriorating or acutely unwell patients. • Has difficulty gathering, filtering and prioritising the critical data.
	Patient management • Initiates a timely structured approach to management, actively anticipates additional requirements and seeks appropriate assistance. • Identifies, where possible, patients' wishes and preferences about care, including CPR and other life-sustaining treatments (such as intubation and ventilation). • Demonstrates and applies knowledge of relevant anatomy, physiology, indications and potential risks and complications of resuscitation, if appropriate to the case. Subpoints • Where appropriate, has discussions with patients about their rights to refuse medical therapy, including life-sustaining treatment. • Where appropriate, has discussions with patients about their goals of care and/or advance care plans. • Involves patients or substitute decision makers, where appropriate, in discussions regarding treatment and end-of-life care.	**Patient management** • Does not initiate timely basic management correctly. • Does not seek appropriate assistance, including inappropriate delay in escalating. • Applies skills inconsistently, resulting in an inability to reliably complete procedures, such as inconsistent use of universal precautions and aseptic techniques.
	Communication • Recognises the need for timely escalation of care and escalates to appropriate staff or service, following escalation in care policies and procedures. • Communicates accurately and effectively with the health care team. • As appropriate, explains the situation to patients and/or carers in a sensitive and supportive manner, avoiding unnecessary jargon and confirming their understanding. • Performs succinct, accurate and complete handover of care of patients, including ongoing care requirements.	**Communication** • Inadequately escalates to senior colleagues. • Communicates in an unclear manner with other team members regarding management. • Explains the situation to patients and/or carers in an unclear or insensitive manner. • Handover is inaccurate and/or incomplete and/or missing critical information, including ongoing care requirements.

2B

EPA 2

Recognition and care of the acutely unwell patient

DOMAIN 1
Practitioner

Aboriginal and Torres Strait Islander health

- Demonstrates cultural safety in working alongside Aboriginal and Torres Strait Islander peoples (patients and colleagues), and actively supports cultural safety within the clinical environment, in the context of an acutely unwell patient.
- Demonstrates effective, culturally safe interpersonal skills, empathetic communication, and respect, within an ethical framework inclusive of holistic social and emotional wellbeing models to support equity in Aboriginal and Torres Strait Islander peoples' patient care in the context of an acutely unwell patient.

Aboriginal and Torres Strait Islander health

- Does not yet demonstrate their ability to: follow processes to routinely ask patients if they identify as being of Aboriginal and/or Torres Strait Islander origin; and include current Indigenous health evidence-based medicine, inclusive of social and emotional wellbeing, within their practice, in the context of an acutely unwell patient.
- Does not yet demonstrate effective, culturally safe interpersonal skills, empathetic communication, and respect, within an ethical framework inclusive of holistic social and emotional wellbeing models to support equity in Aboriginal and Torres Strait Islander peoples' patient care in the context of an acutely unwell patient.

DOMAIN 2
Professional and leader

Professionalism

- Demonstrates professional conduct.
- Recognises their own limitations and seeks help when required in an appropriate way.

Subpoints

- Maintains patient privacy and confidentiality.
- Displays respect and sensitivity towards patients.
- Maximises patient autonomy and supports patients' decision-making.
- Demonstrates graded assertiveness.

Professionalism

- Has an incomplete understanding of their own limitations that may result in overestimation of ability and dismissal of other health care team member concerns, or delay in responding to or asking for help for patients in need of urgent care.
- Displays lapses in professional conduct, such as acting disrespectfully or providing inaccurate or incomplete information.

Teamwork

- Works effectively as a member of a team and uses other team members, based on knowledge of their roles and skills, as required.

Teamwork

- Avoids playing a leading role in the management of patients.
- Demonstrates inadequate teamwork.

Self-education

- Seeks guidance and feedback from the health. care team to reflect on the encounter and improve future patient care.
- Participates in debrief sessions.

Self-education

- Lacks insight into learning needs.
- Does not seek or act on feedback on areas for improvement.

DOMAIN 3
Health advocate

Cultural safety for all communities

- Accesses interpretive or culturally-focused services and considers relevant cultural or religious beliefs and practices.

Cultural safety for all communities

- Does not take account of relevant cultural or religious beliefs and practices.

EPA 2 Recognition and care of the acutely unwell patient

DOMAIN 3 Health advocate

Aboriginal and Torres Strait Islander health

- Demonstrates an ability to advocate for health advancement alongside Aboriginal and Torres Strait Islander peoples (patients and colleagues), in the context of an acutely unwell patient.

[Based on Ahpra definition of cultural safety][7]

- Demonstrates critical reflection of health practitioner knowledge, skills, attitudes, practising behaviours and power differentials in delivering safe, accessible and responsive healthcare free of racism.
- Acknowledges colonisation and systemic racism, and the social, cultural, behavioural and economic factors that impact individual and community health.
- Acknowledges and addresses individual racism, their own biases, assumptions, stereotypes and prejudices and provides care that is holistic and free of bias and racism.
- Recognises the importance of self-determined decision-making, partnership and collaboration in healthcare which is driven by the individual, family and community.
- Fosters a safe working environment through leadership to support the rights and dignity of Aboriginal and Torres Strait Islander people and colleagues.

Aboriginal and Torres Strait Islander health

- Requires further development of knowledge and skills to effectively advocate for health advancement alongside Aboriginal and Torres Strait Islander peoples (patients and colleagues), in the context of an acutely unwell patient.

DOMAIN 4 Scientist and scholar

Quality assurance

- Complies with escalation protocols and maintains up-to-date certification in advanced life support appropriate to the level of training.
- Performs hand hygiene and takes infection control precautions at appropriate moments.
- Raises appropriate issues for review in quality assurance processes (such as at morbidity and mortality meetings).

Quality assurance

- Demonstrates an undisciplined approach to hand hygiene and infection control.

Knowledge

- Observes local service protocols and guidelines on acutely unwell patients.

Knowledge

- Demonstrates poorly formed approaches to identifying local service resources to support clinical decision-making relating to acutely unwell patients.

Aboriginal and Torres Strait Islander health

- Demonstrates a clear understanding of how colonisation impacts Aboriginal and Torres Strait Islander health outcomes, and is able to map this to current evidence on systemic racism as a determinant of health and how racism maintains health inequity in the context of an acutely unwell patient.

Aboriginal and Torres Strait Islander health

- Does not yet demonstrate a clear understanding of how colonisation impacts Aboriginal and Torres Strait Islander health outcomes, and is not yet able to map this to current evidence on systemic racism as a determinant of health and how racism maintains health inequity in the context of an acutely unwell patient.

7. Australian Health Practitioner Regulation Agency (Ahpra), *National Scheme's Aboriginal and Torres Strait Islander Health and Cultural Safety Strategy 2020–2025*, Ahpra website, 2021, accessed 22 April 2022.

Prescribing

EPA 3

TITLE

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.

FOCUS AND CONTEXT

This EPA applies in any clinical context but the critical aspects are to:

1. prescribe autonomously when appropriate, taking account of registration, health service policies, and individual confidence and experience with that drug or product
2. prescribe as directed by a senior team member, taking responsibility for completion of the order to ensure it is both accurate and appropriate for the patient.

Perform this activity in multiple settings, including inpatient and ambulatory (including community) care settings or in emergency departments and in the care of different populations (for example children, adults and the elderly).

DESCRIPTION

This activity requires the ability to, as appropriate and where possible:

1. obtain and interpret medication histories
2. respond to requests from team members to prescribe medications
3. consider whether a prescription is appropriate
4. choose appropriate medications
5. where appropriate, clarify with the senior medical officers, pharmacists, nursing staff, family members or clinical resources the drug, including name, dose, frequency and duration
6. actively consider drug—drug interactions and/or allergies and if identified check whether to proceed
7. provide instruction on medication administration, effects and adverse effects using appropriate resources
8. elicit any patient concerns about benefits and risks, and, as appropriate, seek advice and support to address those concerns
9. write or enter accurate and clear prescriptions or medication charts
10. monitor medications for efficacy, safety, adverse reactions and concordance
11. review medications and interactions, and cease medications where indicated, in consultation with senior team members, including a pharmacist.

2B

EPA 3 Prescribing

BEHAVIOURS

Outcome	Requires minimal supervision	Requires direct supervision
	I trust the prevocational doctor to complete the task; I need to be contactable / in the building and able to provide a general overview of work. Examples of behaviours of a prevocational doctor who can perform this activity with **minimal supervision**.	*I need to be there to observe the interactions and review the work.* Examples of behaviours of a prevocational doctor who **requires direct supervision** to perform this activity.
DOMAIN 1 Practitioner	**Prescribing** • Appropriately, safely and accurately prescribes therapies (drugs, fluids, blood products, oxygen), and demonstrates an understanding of the rationale, risks and benefits, contraindications, adverse effects, drug interactions, dosage and routes of administration. • Initiates, modifies or ceases therapies (drugs, fluids, blood products, oxygen) safely, adheres to all relevant protocols and monitors patient reactions, reporting when relevant.	**Prescribing** • Makes frequent and/or critical prescribing errors. • Initiates, modifies or ceases therapies (drugs, fluids, blood products, oxygen) beyond scope of practice (registration), health service protocols or their experience. Subpoints • Demonstrates an inadequate understanding of the rationale behind the choice of therapy. • Prescribes when it is not appropriate. • Does not take into account the following for all therapies: › risk–benefit analysis › contraindications › adverse effects › interactions › routes of administration › cost to patients, families and the community › the need for medication monitoring › funding and regulatory considerations › generic versus brand medicines. • Unable to source suitable dosing guidelines or implement dose modifications based on organ function, or patient age or size. • Demonstrates an inadequate understanding of fluid requirements and the compatibility of medications with intravenous fluids.

Prescribing

DOMAIN 1
Practitioner

Aboriginal and Torres Strait Islander health

- Demonstrates cultural safety in working alongside Aboriginal and Torres Strait Islander peoples (patients and colleagues), and actively supports cultural safety within the clinical environment, in the context of prescribing.
- Demonstrates an understanding of the different Medicare and PBS criteria for prescribing for Aboriginal and Torres Strait Islander patients.
- Demonstrates effective, culturally safe interpersonal skills, empathetic communication, and respect, within an ethical framework inclusive of holistic social and emotional wellbeing models to support equity in Aboriginal and Torres Strait Islander peoples' patient care in the context of prescribing.

Aboriginal and Torres Strait Islander health

- Requires further opportunities to demonstrate their ability to: follow processes to routinely ask patients if they identify as being of Aboriginal and/or Torres Strait Islander origin; and include current Indigenous health evidence-based medicine, inclusive of social and emotional wellbeing, within their practice, in the context of prescribing.
- Requires further opportunities to demonstrate effective, culturally safe interpersonal skills, empathetic communication, and respect, within an ethical framework inclusive of holistic social and emotional wellbeing models to support equity in Aboriginal and Torres Strait Islander peoples' patient care in the context of prescribing.

Patient management

- As appropriate, monitors and adjusts medications.
- Identifies and manages potential and actual adverse events.

Patient management

- Does not follow up monitoring instructions or relevant test results.
- Does not identify or manage adverse events.

Communication

- Ensures the patient understands the rationale and requirements of the treatment.
- Writes clearly legible prescriptions or charts using generic names.
- Understands the principles and is able to safely electronic prescribe and document medications.
- Advises patients of possible adverse effects.
- Advises patients of the costs of medication and checks this is acceptable.
- Informs the treating team of changes to prescriptions.

Communication

- Fails to explain the rationale for the treatment and other relevant information including the practical aspects of administration, the importance of adherence, follow-up and monitoring for adverse effects.
- Produces incomplete or inaccurate prescriptions or medication charts.
- Writes illegible prescriptions or drug orders or makes incorrect entries into electronic prescribing systems.
- Inadequately consults with the multidisciplinary team (including the clinical supervisor and/or allied health professionals).

DOMAIN 2
Professional and leader

Professionalism

- Demonstrates professional conduct, honesty and integrity.
- Recognises their own limitations and seeks help when required in an appropriate way.
- Demonstrates an understanding of the regulatory and legal requirements and limitations regarding prescribing.

Subpoints

- Demonstrates an understanding of the ethical implications of pharmaceutical industry–funded research and marketing.
- Maintains patient privacy and confidentiality.
- Maximises patient autonomy and supports patients' decision-making.

Professionalism

- Has an incomplete understanding of their own limitations that may result in overestimation of ability and dismissal of other health care team member concerns, or delay in responding or asking for help.

2B

EPA 3 Prescribing

DOMAIN 2 Professional and leader

Clinical responsibility

- Reports adverse events related to medications.

Teamwork

- Works collaboratively with the multidisciplinary team, including pharmacists and nursing staff.
- Participates in medication safety meetings and morbidity and mortality meetings.

DOMAIN 3 Health advocate

Cultural safety for all communities

- Acknowledges and respects patients' cultural and religious background, attitude and beliefs, and how these might influence the acceptability of pharmacological and non-pharmacological management approaches.

Cultural safety for all communities

- Does not consider patients' cultural and religious background, attitude and beliefs, and how these might influence the acceptability of pharmacological and non-pharmacological management approaches.

Population health

- Considers population-level constraints on prescribing, including:
  - economic costs to community
  - environmental cost to community
  - antimicrobial resistance.

Population health

- Does not consider population-level constraints on prescribing, including:
  - economic costs to community
  - environmental cost to community
  - antimicrobial resistance.

Aboriginal and Torres Strait Islander health

- Demonstrates an ability to advocate for health advancement alongside Aboriginal and Torres Strait Islander peoples (patients and colleagues), in the context of prescribing.

[Based on Ahpra definition of cultural safety][8]

- Demonstrates critical reflection of health practitioner knowledge, skills, attitudes, practising behaviours and power differentials in delivering safe, accessible and responsive healthcare free of racism.
- Acknowledges colonisation and systemic racism, and the social, cultural, behavioural and economic factors that impact individual and community health.
- Acknowledges and addresses individual racism, their own biases, assumptions, stereotypes and prejudices and provides care that is holistic, and free of bias and racism.
- Recognises the importance of self-determined decision-making, partnership and collaboration in healthcare which is driven by the individual, family and community.
- Fosters a safe working environment through leadership to support the rights and dignity of Aboriginal and Torres Strait Islander people and colleagues.

Aboriginal and Torres Strait Islander health

- Requires further development of knowledge and skills to effectively advocate for health advancement alongside Aboriginal and Torres Strait Islander peoples (patients and colleagues) in the context of prescribing.

8. Australian Health Practitioner Regulation Agency (Ahpra), *National Scheme's Aboriginal and Torres Strait Islander Health and Cultural Safety Strategy 2020–2025*, Ahpra website, 2021, accessed 22 April 2022.

EPA 3 Prescribing

DOMAIN 4
Scientist and scholar

Knowledge

- Demonstrates knowledge of clinical pharmacology, including adverse effects and drug interactions, of the drugs they are prescribing.
- Makes use of local service protocols and guidelines to ensure decision-making is evidence-based and applies guidelines to individual patients appropriately.

Quality Assurance

- Applies the principles of safe prescribing, particularly for drugs with a risk of significant adverse effects, using evidence-based prescribing resources, as appropriate.
- Prescribes in accordance with institutional policies, including policies on antibiotic stewardship.
- Safely uses electronic prescribing systems as appropriate.

Subpoints

- Applies information regarding side-effects and monitoring requirements of medications.
- Identifies medication errors and institutes appropriate measures.
- Uses electronic prescribing systems safely.

Quality Assurance

- Does not apply the principles of prescribing and/or consider the use of evidence-based prescribing resources.
- Does not prescribes in accordance with institutional policies.
- Displays inadequate knowledge of the monitoring requirements or potential adverse effects of the medications they are prescribing.

Aboriginal and Torres Strait Islander health

- Demonstrates a clear understanding of how colonisation impacts Aboriginal and Torres Strait Islander health outcomes, and is able to map this current evidence on systemic racism as a determinant of health and how racism maintains health inequity marginalisation in the context of prescribing.

Aboriginal and Torres Strait Islander health

- Does not yet demonstrate a clear understanding of how colonisation impacts Aboriginal and Torres Strait Islander health outcomes, and is not yet able to map this to current evidence on systemic racism as a determinant of health and how racism maintains health inequity in the context of prescribing.

Team communication – documentation, handover and referrals

EPA 4

TITLE

Communicate about patient care, including accurate documentation and written and verbal information to facilitate high-quality care at transition points and referral.

FOCUS AND CONTEXT

This EPA applies in any clinical context but the critical aspects are to:

1. communicate timely, accurate and concise information to facilitate transfer of care across various health sector boundaries including:
   - at referral from ambulatory and community care
   - at admission
   - between clinical services and multidisciplinary teams
   - at changes of shift
   - at discharge to ambulatory and community care.
2. produce timely, accurate and concise documentation of episodes of clinical care.

Perform this activity in multiple settings, including inpatient and ambulatory (including community) care settings or in emergency departments and in the care of different populations (for example children, adults and the elderly).

DESCRIPTION

This activity requires the ability to:

1. communicate effectively to:
   - facilitate high-quality care at any transition point
   - ensure continuity of care
   - share patient information with other health care providers and multidisciplinary teams in conjunction with referral or the transfer of responsibility for patient care
   - use local agreed modes of information transfer, including oral, electronic and written formats to communicate (at least):
     - patient demographics
     - a concise medical history and relevant physical examination findings
     - current problems and issues
     - details of relevant and pending investigation results
     - medical and multidisciplinary care plans
     - planned outcomes and indications for follow-up.
2. document effectively to:
   - enable other health professionals to understand the issues and continue care
   - produce written summaries of care, including admission and progress notes, team referrals, discharge summaries, and transfer documentation
   - produce accurate records appropriate for secondary purposes
   - complete accurate medical certificates, death certificates and cremation certificates
   - enable the appropriate use of clinical handover tools.

2B

EPA 4 Team communication

BEHAVIOURS

Outcome

✓ Requires minimal supervision	! Requires direct supervision
I trust the prevocational doctor to complete the task; I need to be contactable / in the building and able to provide a general overview of work.	*I need to be there to observe the interactions and review the work.*
Examples of behaviours of a prevocational doctor who can perform this activity with **minimal supervision**.	Examples of behaviours of a prevocational doctor who **requires direct supervision** to perform this activity.

DOMAIN 1 Practitioner

✓ Information management	! Information management
• Produces medical record entries that are timely, accurate, concise and understandable. • Documents and prioritises the most important issues for the patient.	• Produces incomplete and/or inaccurate records that: › omit clinically significant history, examination findings, investigation results, clinical issues or management plans; and/or › do not include identification details, entry date and time, signature, printed name, designation or contact details. • Does not produce records or updates to documentation in a timeframe appropriate to the clinical situation. • Creates an unstructured medical record. • Makes illegible notes, or uses jargon and/or inappropriate acronyms.
✓ Patient management	! Patient management
• Displays understanding of the details of the patient's condition, illness severity, comorbidities and potential emerging issues, summarising planned management including indications for follow-up. Subpoints • Uses a structured approach to documenting and prioritising patients' issues.	• The medical record lacks an overall impression or plan. Subpoints • Does not use an appropriate structure for the clinical context (for example, a traditional presenting problem history or systems-based structure).
✓ Communication	! Communication
• Creates verbal or written summaries of information that are timely, accurate, appropriate, relevant and understandable for patients, carers and/or other health professionals. Sub-points: • Accurately identifies key problems or issues. • Ensures a suitable environment and adequate time for handover. • Communicates clearly with patients, team members and other caregivers. • Confirms information has been received and understood, and seeks questions and feedback.	• Creates verbal or written summaries of information that are not timely, appropriate, relevant or understandable for patients, carers and/or other health professionals. • Uses language that may be offensive or distressing to patients or other health professionals. • Does not mitigate the risks associated with changing care teams or environments. • Inadequately summarises the active medical problems. • Has an unstructured approach in transferring oral or written information. • Includes unnecessary or irrelevant information. • Omits significant problems. • Inadequately clarifies treatment changes and clinical reasoning. • Omits ongoing management plans, discharge medications, pending tests at discharge, or patient counselling. • Communicates in an inappropriate environment, such as handover in a public place.

2B

EPA 4

Team communication

DOMAIN 1
Practitioner

Aboriginal and Torres Strait Islander health

- Demonstrates cultural safety in working alongside Aboriginal and Torres Strait Islander peoples (patients and colleagues), and actively supports cultural safety within the clinical environment, in the context of team communication.
- Demonstrates effective, culturally safe interpersonal skills, empathetic communication, and respect, within an ethical framework inclusive of holistic social and emotional wellbeing models to support equity in Aboriginal and Torres Strait Islander peoples' patient care in the context of team communication.

Aboriginal and Torres Strait Islander health

- Does not yet demonstrate their ability to: follow processes to routinely ask patients if they identify as being of Aboriginal and/or Torres Strait Islander origin; and include current Indigenous health evidence-based medicine, inclusive of the social and emotional wellbeing, within their practice, in the context of team communication.
- Does not yet demonstrate effective, culturally safe interpersonal skills, empathetic communication, and respect, within an ethical framework inclusive of holistic social and emotional wellbeing models to support equity in Aboriginal and Torres Strait Islander peoples' patient care in the context of team communication.

DOMAIN 2
Professional and leader

Professionalism

- Demonstrates professional conduct, honesty and integrity.
- Appropriately prioritises the creation of medical record entries.
- Informs patients that handover of care will take place and to which team, service, or clinician as appropriate.
- Maintains respect for patients, families, carers, and other health professionals, including respecting privacy and confidentiality.

Subpoints

- Complies with the legal requirements for preparing and managing documentation.
- Provides honest and accurate medical certification where required.
- Maintains confidentiality of documentation and stores clinical notes appropriately.
- Uses appropriately secure methods of clinical communication.
- Maximises patient autonomy and supports patients' decision-making.
- Takes responsibility and is accountable for their actions.

Professionalism

- Assigns a low priority to the creation of medical record entries when ordering daily tasks, such as deferring it to the end of the day or clinic leading to delays that may affect patient care or the quality of the record.
- Inappropriately delays preparing transfer documentation and/or undertaking transfer communications.
- Inadequately maintains confidentiality, for example, gathering and displaying confidential patient information, such as information displayed on a list that the patient's relatives could access, or sharing information that is not relevant to patient care.
- Displays lapses in professional conduct, such as providing inaccurate or incomplete information.

Teamwork

- Does not engage with nursing staff and/or other relevant allied health practitioners.
- Omits or disregards key information from other team members in handover.

Team communication

DOMAIN 3
Health advocate

Whole person care

- Considers social/economic context, for example:
  - factors transport issues and costs to patients into arrangements for transferring patients to other settings
  - appropriately prioritises social history and cultural factors.

Whole person care

- Disregards social history or cultural factors and their management in transfer-of-care documentation.

Cultural safety for all communities

- Includes relevant information regarding patients' cultural or ethnic background in the handover and whether an interpreter is required.

Cultural safety for all communities

- Demonstrates insensitivity or lack of awareness of relevant cultural issues, such as not specifying when an interpreter is required.
- Uses language that may be offensive or distressing to patients or other health professionals.

Aboriginal and Torres Strait Islander health

- Demonstrates an ability to advocate for health advancement alongside Aboriginal and Torres Strait Islander peoples (patients and colleagues), including an understanding of what services are available and discussing with the patient/family/community to find out their preferences around accessing these services.

[Based on Ahpra definition of cultural safety][9]

- Demonstrates critical reflection of health practitioner knowledge, skills, attitudes, practising behaviours and power differentials in delivering safe, accessible and responsive healthcare free of racism.
- Acknowledges colonisation and systemic racism, and the social, cultural, behavioural and economic factors which impact individual and community health.
- Acknowledges and addresses individual racism, their own biases, assumptions, stereotypes and prejudices and provides care that is holistic, and free of bias and racism.
- Recognises the importance of self-determined decision-making, partnership and collaboration in healthcare which is driven by the individual, family and community.
- Fosters a safe working environment through leadership to support the rights and dignity of Aboriginal and Torres Strait Islander people and colleagues.

Aboriginal and Torres Strait Islander health

- Requires further development of knowledge and skills to effectively advocate for health advancement alongside Aboriginal and Torres Strait Islander peoples (patients and colleagues), including an understanding of what services are available and discussing with the patient/family/community to find out their preferences around accessing these services.

9. Australian Health Practitioner Regulation Agency (Ahpra), *National Scheme's Aboriginal and Torres Strait Islander Health and Cultural Safety Strategy 2020–2025*, Ahpra website, 2021, accessed 22 April 2022.

EPA 4

Team communication

DOMAIN 4

Scientist and scholar

Quality Assurance

- Maintains records to enable optimal patient care and secondary use of the document for relevant activities such as adequate coding, incident review, research or medico-legal proceedings.
- Ensures all outstanding investigations, results or procedures will be followed up by receiving units and clinicians.

Subpoints

- Provides and receives feedback to and from team members regarding handovers and any errors that occurred, including inaccurate information transmission.
- Communicates accurately and in a timely fashion to ensure an effective transition between settings, and continuity and quality of care.

Quality Assurance

- Does not maintain records adequately.
- Produces records lacking key information regarding episodes of care.
- Uses ambiguous or inappropriate acronyms.
- Performs incomplete handover.
- Makes omissions and/or errors in transfer-of-care communications.
- Does not complete transfer-of-care communications in a timely manner.

Aboriginal and Torres Strait Islander health

- Demonstrates a clear understanding of how colonisation impacts Aboriginal and Torres Strait Islander health outcomes, and is able to map this to current evidence on systemic racism as a determinant of health and how racism maintains health inequity in the context of team communication.

Aboriginal and Torres Strait Islander health

- Does not yet demonstrate a clear understanding of how colonisation impacts Aboriginal and Torres Strait Islander health outcomes, and is not yet able to map this to current evidence on systemic racism as a determinant of health and how racism maintains health inequity in the context of team communication.

2C

PREVOCATIONAL TRAINING

Record of learning

NATIONAL FRAMEWORK FOR PREVOCATIONAL (PGY1 AND PGY2) MEDICAL TRAINING

2C

SUMMARY

Record of learning

The revised National Framework includes a record of learning, which is captured in an e-portfolio. The e-portfolio will include at least the following components:

1. Access to training and assessment material:

- outline of and access to training requirements (outcome statements and EPAs).

2. Record of training and assessment:

- record of longitudinal achievement/progress against outcome statements and EPAs.
- record of assessments.
- record of additional education training (export/import) – for example, completion of basic life support, hand hygiene or cultural safety modules or courses.
- record of procedures performed – for the prevocational doctor to document procedures performed. There is no prescribed list of procedures.
- space to record prevocational doctors' goals and reflections

Note: this section will be further developed as the detailed requirements for the e-portfolio are developed. For further details, see the e-portfolio specifications in 'National assessment forms' (Sections 3DI and 3DII of *Training and assessment requirements*) .

3

Prevocational assessment

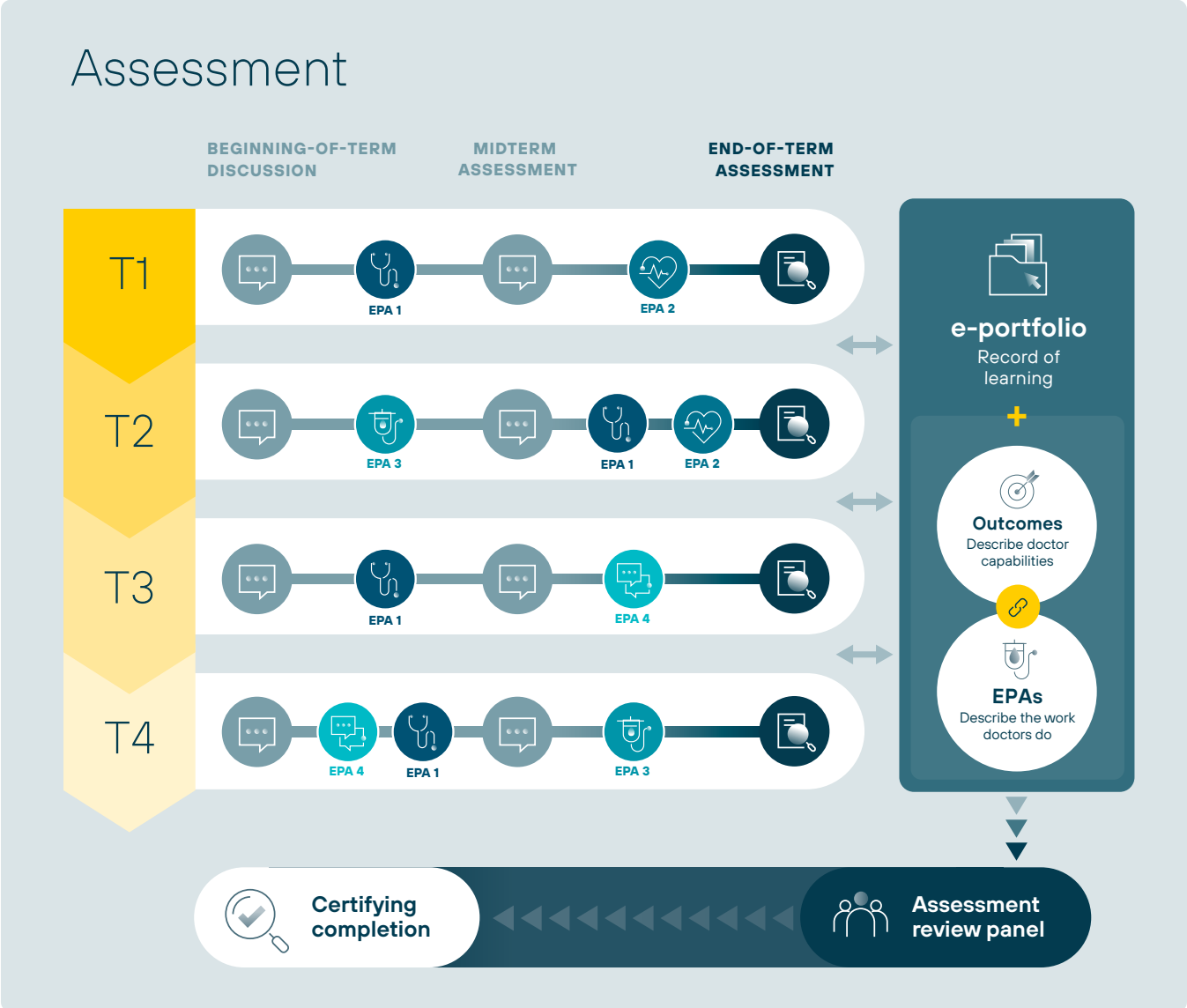
INTRODUCTION

Prevocational assessment

Prevocational assessment lays out the requirements for assessing PGY1 and PGY2 doctors participating in accredited training programs, and for certifying the completion of each year. This document should be read in conjunction with:

- *Registration standard – Granting general registration as a medical practitioner to Australian and New Zealand medical graduates on completion of intern training*[10]
- *National standards and requirements for prevocational (PGY1 and PGY2) training programs and terms.*

Figure 5 – An example of assessment activities over a prevocational year



10. The Medical Board of Australia (MBA), 'Granting general registration as a medical practitioner to Australian and New Zealand medical graduates on completion of intern training', *Registration standards*, MBA website, 2002, accessed 21 April 2022.

3A

PREVOCATIONAL ASSESSMENT

Assessment approach

SUMMARY

Assessment approach

The National standards and requirements for programs and terms document is the basis for the assessment approach. Assessment must be based on prevocational doctors achieving the prevocational outcome statements (Standard 2.3.1) and it must be understood by supervisors and prevocational doctors (Standard 2.3.3).

Therefore, assessing prevocational doctors has three distinct imperatives:

1. The process must be clear and transparent for all involved.
2. The process must be based on outcomes consistent with the 'National standards' (Section 2 of *National standards and requirements for programs and terms*). To achieve this, prevocational doctors must be assessed against the prevocational outcome statements specified in 'Prevocational outcome statements' (Section 2A of *Training and assessment requirements for prevocational (PGY1 and PGY2) training programs*).
3. Assessment for PGY1 doctors must capture the essential information that prevocational training providers must give to the Medical Board of Australia for determining whether the PGY1 doctor has met the *Registration standard – Granting general registration on completion of intern training*. For PGY2, assessment must capture information to allow issuing a certificate of completion. See Section 3C – 'Certifying completion of PGY1 and PGY2 training' for more information.

Feedback and supporting continuous learning

The *National standards and requirements for programs and terms* document includes standards on feedback and supporting continuous learning (Standard 2.4). Prevocational training providers must:

- encourage and support prevocational doctors to take responsibility for their own performance and to seek feedback
- provide regular feedback to prevocational doctors on their performance and ensure feedback from supervisors is received every term
- have clear procedures to immediately address any concerns about patient safety arising from a prevocational doctor's performance
- document prevocational doctors' performance in assessments
- identify prevocational doctors who are not performing to the expected level and develop and deliver a performance improvement plan.

To meet these standards, supervisors should assess and provide feedback to prevocational doctors at the end of each term, and at the time of EPA assessments. For terms longer than five weeks, supervisors should also assess and provide feedback to prevocational doctors at the term's midpoint. Prevocational doctors are strongly encouraged to use the 'Prevocational training term assessment form' (Section 3D of this document) to complete self-assessments of their performance and discuss these self-assessments with their supervisor at midterm and end-of-term assessment meetings.

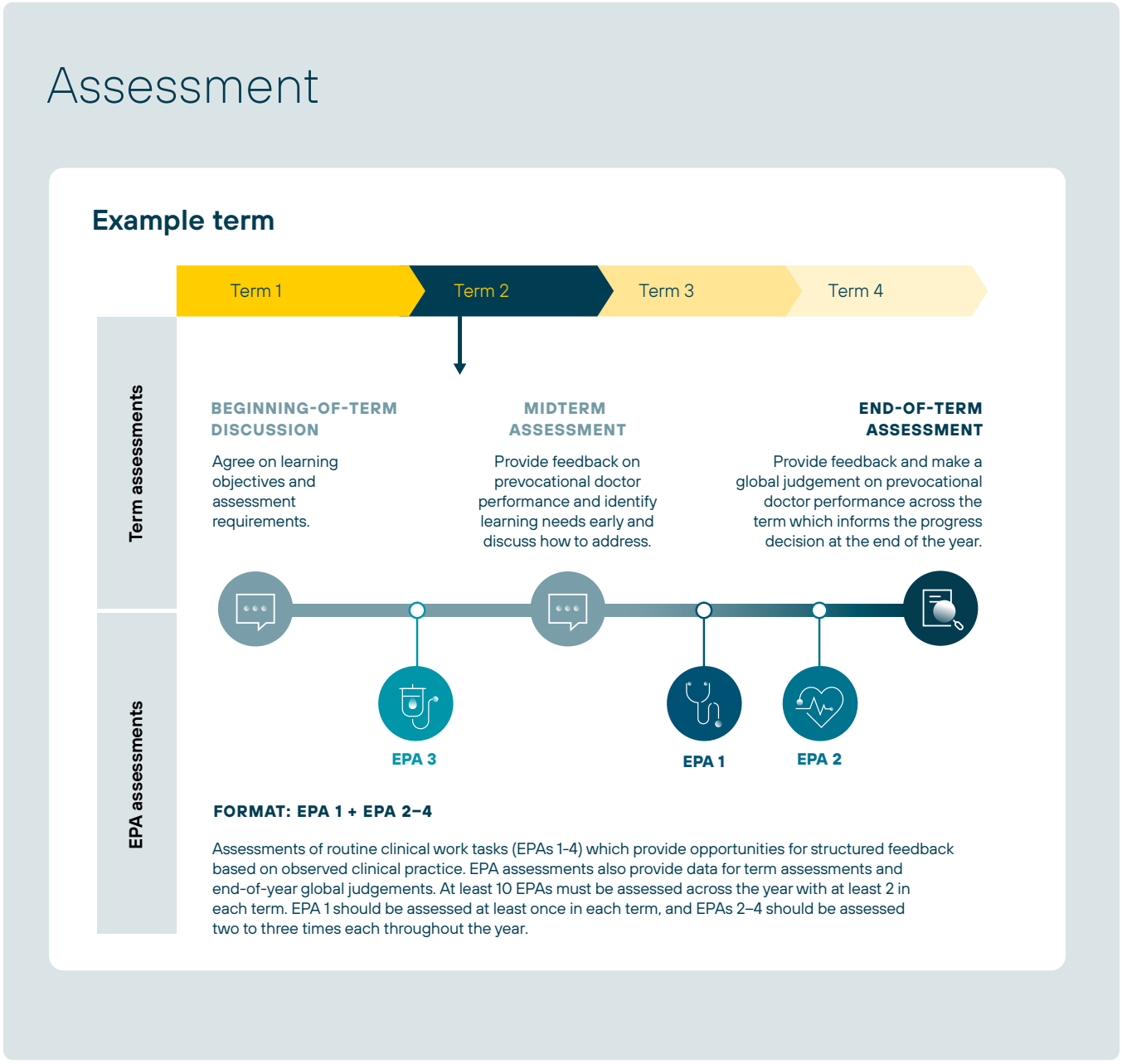
Assessment methods and process

Assessment in prevocational training is done through two main methods:

- term assessments
- assessments of EPAs.

Each term prevocational doctors will participate in a beginning-of-term discussion, a midterm assessment, at least two EPA assessments, and an end-of-term assessment. The assessment review panel will consider the outcomes of the EPA assessments and the end-of-term assessment at the end of the year. Note that there is no minimum number of successful EPAs or end-of-term assessments. The assessment review panel bases its decision on a judgement of whether the prevocational doctor has achieved the prevocational outcomes at the end of the year. The timing and format of these assessments is described below, including the relationship between the term assessments and the EPAs.

Figure 6 – An example of assessment activities within one term during a prevocational year



Beginning-of-term discussion

At the beginning of each term there is a mandatory discussion between the prevocational doctor and term supervisor. This is to review the term description and agree on learning objectives and assessments, including any specific learning outcomes or assessments the prevocational doctor wants to focus on during the term. This includes any additional EPAs or other activities that the prevocational doctor wants to undertake to ensure they achieve the prevocational outcomes. A template for the discussion will be provided.

Midterm assessment

PURPOSE:	The midterm assessment is designed to provide timely feedback on the prevocational doctor's performance, to identify any specific learning needs that have emerged during the term, and discuss how they can be addressed.
NUMBER:	One each term.
FORMAT:	A 'Prevocational training term assessment form' (Section 3D of this document) should be completed to document the discussion in the e-portfolio. Prevocational doctors are encouraged to complete a self-assessment using the form before the discussion.
ASSESSOR/S:	The midterm assessment should be completed by the primary clinical supervisor. Registrars may also complete the assessment with formal sign-off by the primary clinical supervisor.

End-of-term assessment

PURPOSE:	To provide feedback on performance and evidence to support a global progress decision at the end of the year.
NUMBER:	One each term.
FORMAT:	The term supervisor completes the 'Prevocational training term assessment form' (Section 3D of this document) as part of a discussion with the prevocational doctor. Prevocational doctors are encouraged to complete a self-assessment using the form before the meeting to assist with the discussion. In the discussion, the supervisor should consider the prevocational doctor's self-assessment, the data from EPA assessments, the observations of others in the health care team, and evidence of achievement of prevocational outcome statements in the e-portfolio record of learning. The supervisor gives a global rating of progress towards completion of PGY1 or PGY2.
ASSESSOR/S:	The term supervisor is responsible for the end-of-term assessment. To support flexibility in different settings, the term supervisor may delegate assessment to another clinical supervisor (such as a registrar or another consultant), who may fill in the information on the term assessment form and have an initial discussion with the prevocational doctor. The term supervisor must then counter sign the form.

ASSESSMENT OF OUTCOMES NOT DIRECTLY OBSERVED :	The e-portfolio provides a way to track achievement of all outcomes throughout the year. Where an outcome is not able to be directly observed, the prevocational doctor is expected to upload additional evidence (such as attending an approved course) to demonstrate achievement of the outcomes. For example, in some clinical settings, covering all of the outcomes relating to Aboriginal and Torres Strait Islander health may be difficult in EPA and end-of-term assessments. Alternative means of achieving those outcomes (such as attending a course or completing a training module) should be identified and documented in the e-portfolio record of learning. The term supervisor can then review these during the end-of-term assessment, and the assessment review panel review them at the end of the year. A guide to different ways of assessing achievement of the Aboriginal and Torres Strait Islander outcomes will be developed and will include: 1. an outline of the requirement for cultural safety training for supervisors in the *National standards and requirements for programs and terms* document 2. a rubric to assist term supervisors assessing through direct observation 3. an outline of the types of evidence that could demonstrate achievement of these outcomes.

EPA assessments

PURPOSE:	EPA assessments provide feedback based on observed clinical practice and data for end-of-year global judgements. Assessing an EPA is based on what is observed in that setting, at that time, with that particular patient. The goal of prevocational training is to reach the required level of entrustability by the end of the year, therefore entrustability is not necessarily reached for every EPA during the year.
NUMBER:	• At least 10 EPAs must be assessed across the year with at least 2 in each term. • EPA 1 (Clinical assessment) should be assessed at least once in each term, and EPAs 2–4 should be assessed two to three times each throughout the year. • Supervisors and prevocational doctors are encouraged to increase the number of EPAs for individuals with identified development needs.
FORMAT:	An activity-based discussion, which combines direct observation and case-based discussion with the following requirements: • that the assessment is based on interaction with a real patient for whom the prevocational doctor played an active role in delivering care • that the patient is known to the assessing supervisor • that the supervisor has observed some significant part of the clinical interaction (or if not possible (such as EPA 2), that feedback is sought from someone who did). The discussion might include some expansion on the parameters of the EPA observed, such as, 'What would you do if the patient were older?' or '... was from a non-English speaking background?' or '... lived at home alone with no immediate carer support available?'
ASSESSOR/S:	Supervisors and/or registrars are able to assess some EPAs after completing training. Other members of the health care team, such as a nurse or ward pharmacist, might also conduct or contribute to an EPA assessment in a term, where the supervisor deems this suitable. At least one EPA per term should be assessed by the primary clinical supervisor or an equivalent specialist.
PGY1/PGY2:	The same EPAs are 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.

Relationship between prevocational outcome statements, end-of-term assessments and assessment of EPAs

End-of-term assessments are based on whether the PGY1 or PGY2 doctor has achieved the prevocational outcome statements, which are included in the 'National assessment forms' (Section 3D of this document). Achievement of the prevocational outcomes is also included in the assessment of EPAs. The table in Attachment 1 indicates which prevocational outcome statements would be covered if the particular EPA was fully completed. This table shows that if all four of the EPAs are completed in full and fully assessed, all or nearly all of the outcomes will have assessor comments, and, assuming the commentary raises no concerns, all or nearly all of the outcomes can be determined as achieved.

When a single EPA is assessed, it may be that some outcomes are either not observed, or, because only a part of the EPA was assessed, not attempted. Satisfactory achievement of all outcomes is necessary for progression, and so prevocational doctors should:

- plan future EPA assessments to cover outcomes that have not been assessed (and are unlikely to be assessed in end-of-term assessments), and/or
- identify alternative means of achieving those outcomes in discussion with their supervisors.

In particular, in some clinical settings covering all of the outcomes relating to Aboriginal and Torres Strait Islander health may be difficult in EPA and end-of-term assessments. Alternative means of achieving those outcomes (such as attending a course or completing a training module) should be identified. These activities should be documented in the record of learning so that they can be reviewed by the assessment review panel at the end of the year.

Assessment forms

Assessment of prevocational training is work-based and term supervisor reports therefore have a key function. In the national registration system, national assessment forms support a consistent approach to assessment. These forms are the 'Prevocational training term assessment form' and the 'Prevocational training entrustable professional activity (EPA) assessment forms', both provided in Section 3D of this document.

Assessor training

Under the *National standards and requirements for programs and terms* (Standards 2.3.3 and 3.2), prevocational training providers must have processes for ensuring those assessing prevocational doctors have the relevant capabilities and an understanding of the processes involved.

Prevocational training providers should therefore incorporate specific training in using term and EPA assessment forms in their supervisor support and development programs, in addition to general training in assessment and feedback skills. Training may also include supervisor 'frames of reference' and calibration of ratings to improve reliability and validity of the assessment processes.

3B

PREVOCATIONAL ASSESSMENT

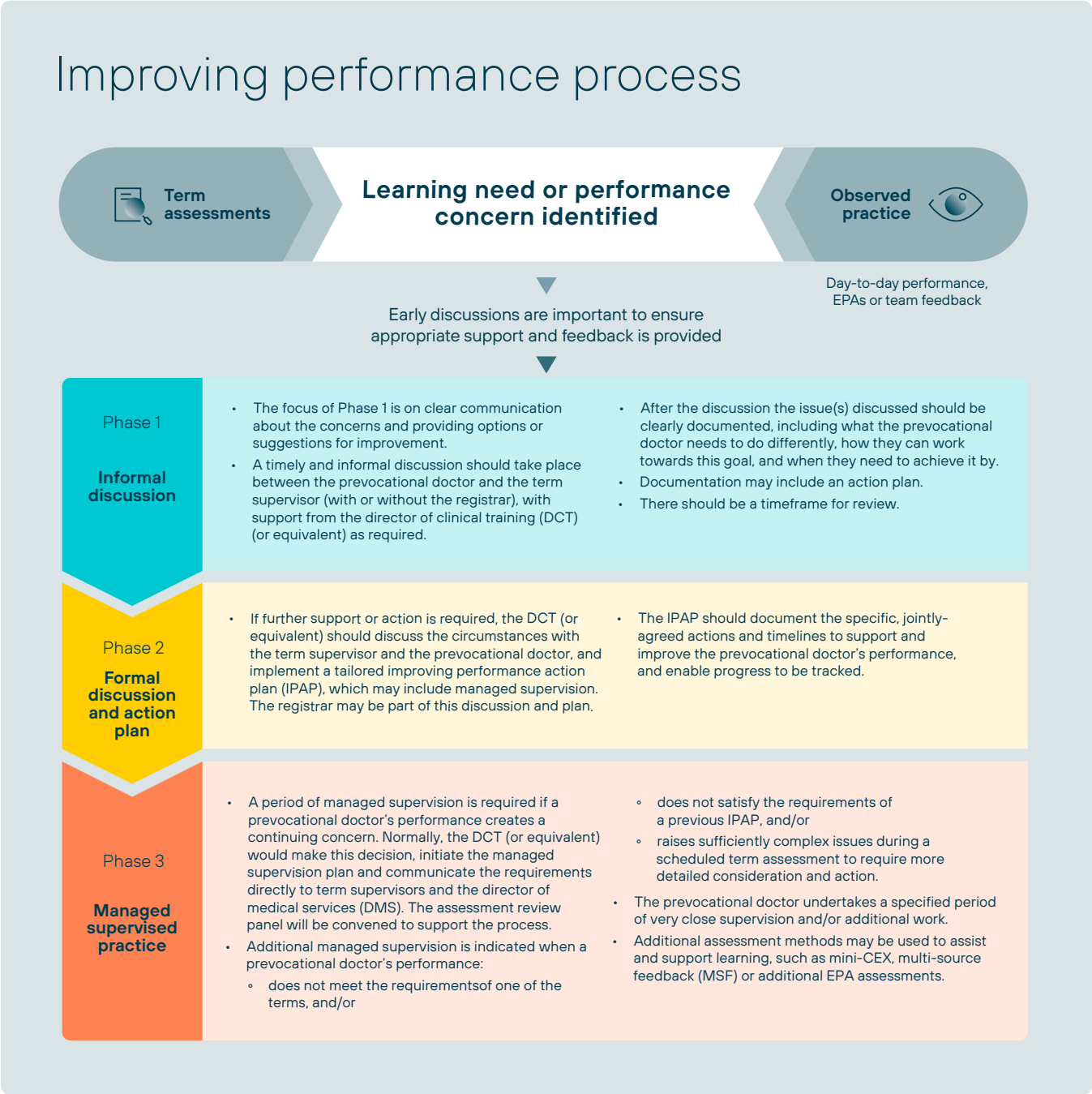
Improving performance

SUMMARY

Improving performance

The National Framework includes a strong emphasis on assisting prevocational doctors who are experiencing difficulties to improve performance, with a focus on early identification, feedback and support. The *National standards and requirements for programs and terms* describe what must happen in the improving performance process (Standard 2.5).

Figure 7 – Improving performance process



Multiple factors can impact performance, including individual skills, wellbeing and the work environment. All of these factors must be assessed and addressed to optimise performance. Longitudinal program and performance issues will be managed by the prevocational doctor, DCT and term supervisor(s) in a three-phase process outlined in Figure 7. All phases should be overseen by senior experienced practitioners (specialist or equivalent). There may be circumstances where the prevocational training provider considers it not appropriate to offer the prevocational doctor additional remediation within that employment period, or that remediation is unlikely to be successful. For PGY1 the training provider should report this to the Medical Board of Australia, using the same process as for certifying completion of internship described in Section 3C of this document.

All decisions regarding additional remediation or non-completion of a term must be clearly documented and communicated directly to the DMS. This will ensure that the employer is informed about these aspects of prevocational doctor performance.

Notifiable conduct

The *National standards and requirements for programs and terms* (Standard 1.3.7) require prevocational training providers to immediately address any concerns about patient safety, including possibly withdrawing a prevocational doctor from the clinical context. Sections 141 and 142 of the *Health Practitioner Regulation National Law* require employers and registered health practitioners to make notifications about registered medical practitioners who have engaged in 'notifiable conduct' as defined in Section 140 of the *National Law*. Notifiable conduct by prevocational doctors must be reported to the Medical Board of Australia immediately.

Assessment review and quality

An appropriately convened assessment review panel makes progression decisions in both PGY1 and PGY2. The panel will consider data gathered on each prevocational doctor, including term assessments, EPA assessments and other sources where appropriate. Based on that data, the panel will arrive at a majority consensus view regarding progression. In practice, the substantial majority of considerations are anticipated to be straightforward with no specific discussion because the documentation makes clear the requirements have been met.

Section 3C of this document describes the certifying completion process and procedure in detail.

3C

PREVOCATIONAL ASSESSMENT

Certifying completion of PGY1 and PGY2 training

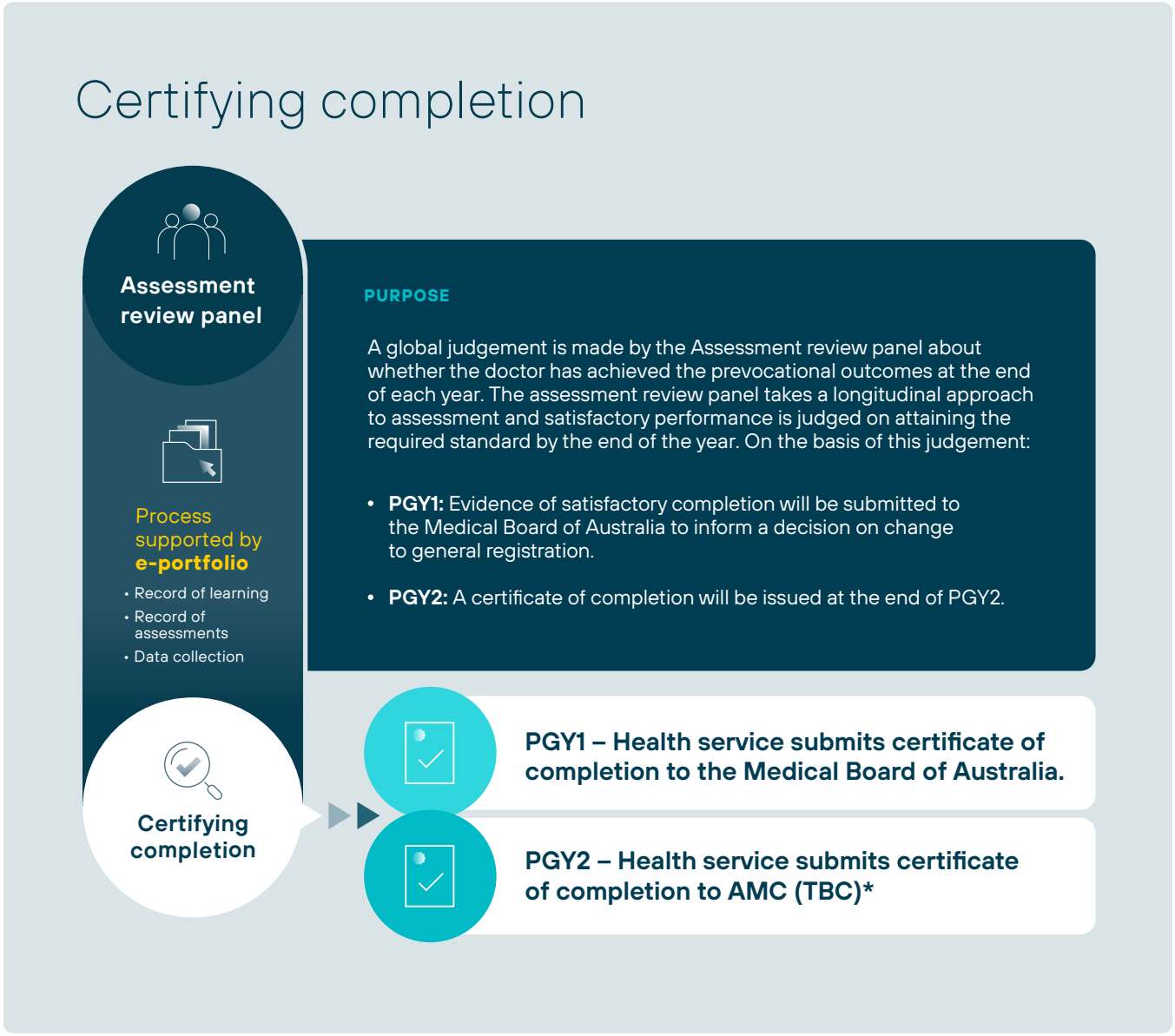
NATIONAL FRAMEWORK FOR PREVOCATIONAL (PGY1 AND PGY2) MEDICAL TRAINING

SUMMARY

Certifying completion of PGY1 and PGY2 training

At the end of each year an assessment review panel makes a global judgement on whether to recommend progression to the next stage of training. Note that the requirements for certifying completion of PGY1 and PGY2 are different, and that satisfactory completion of PGY1 remains the point at which the Medical Board of Australia makes a decision to grant general registration.

Figure 8 – Overview of process for certifying completion of PGY1 and PGY2 training



Purpose

The overall purpose is to make a global judgement about whether the doctor has achieved the prevocational outcomes at the end of each year, taking account of both EPA assessments and end-of-term assessment forms. The assessment review panel takes a longitudinal approach to assessment and satisfactory performance is judged on attaining the required standard by the end of the year, rather than a requirement to pass a specified number of EPAs or end-of-term assessments.

PGY1 Satisfactory completion of PGY1 will continue to be a requirement for general registration.

PGY2 A certificate of completion will be issued at the end of PGY2. The flexibility to enter vocational training in PGY2 remains.

Assessment review panel composition

Prevocational training providers have some flexibility in determining the members of the assessment review panel based on what is practical in their circumstances. The panel must have at least three members, who should have a sound understanding of procedural fairness and prevocational training requirements. Members might include the following roles: DCT, DMS or chief medical officer (CMO) or delegate, medical education officer (MEO), an individual with HR expertise, experienced supervisor/s and/or a consumer. The role of an individual with HR expertise is to assist the process and provide expertise in relevant matters, such as leave options in wellbeing and remediation discussions. Their role on the panel does not include performance management. Prevocational doctors should not be panellists.

Process and number of meetings

The panel will meet at least once a year to discuss progression recommendations. However, it will also be convened to support the improving performance process, particularly for prevocational doctors in Phase 3 of the process. Meetings should be scheduled to ensure sufficient time to implement improving performance processes and assessment of their success before the end of the year.

Evidence for recommendations

Table 2 summarises the evidence that must be provided to the panel at the end of the year to support recommendations on completion of PGY1 or PGY2. Much of this data will be collected in and reported through the e-portfolio record of learning.

To streamline the process, the panel might consider the evidence in varying levels of detail, depending on the outcomes of assessments. Table 3 illustrates an example approach that could be taken.

Table 2 – Assessment requirements

REQUIREMENT	DETAILS
Program length	Evidence that the prevocational doctor has completed the minimum time requirement for the year.
Term requirements	Evidence that the prevocational doctor has met the requirements for clinical exposure outlined in *National standards and requirements for programs and terms*. Note: Finalising a mandatory term requirement for PGY1 depends on the review of the Medical Board of Australia's *Registration standard – Granting general registration on completion of intern training*. The wording will be confirmed once this is complete.
Mid- and end-of-term assessments	The level of detail provided will depend on the prevocational doctor's overall performance – see Table 3.
Assessment of EPAs	**Number** Evidence that a minimum of 10 EPA assessments have been completed, including one assessment of EPA 1 in each term and at least 2 assessments of EPAs 2–4. **Outcomes** The level of detail provided will depend on the prevocational doctor's overall performance (see Table 3). For the majority of prevocational doctors there will be a summary of the levels of entrustability for each EPA. For more complex decisions, the panel may review all EPA forms. Note: The goal of prevocational training is to reach the required level of entrustability by the end of the year, therefore it is not necessary that entrustability is reached for every EPA during the year.
Achievement of the prevocational outcome statements	The e-portfolio record of learning includes a mechanism for demonstrating that each outcome statement is achieved at the end of both PGY1 and PGY2. Evidence of achieving outcomes includes: • mid- and end-of-term assessments • assessment of EPAs (outcome statements have been mapped to the EPAs) • documentation uploaded by prevocational doctors of other activities to achieve outcome statements (for example, attending a course or workshop or completing an online training module).

Table 3 – Levels of detail to inform panel decisions – example approach

PREVOCATIONAL DOCTOR GROUP	LEVEL OF DETAIL OF EVIDENCE REQUIRED	ASSESSMENT REVIEW PANEL ACTION
1. **Routine**	High-level summary of outcome of assessment components.	For noting only (all components satisfactory).
2. **Routine with some areas for discussion/noting**	Summary of assessment component outcomes with further detail as required – for example, for outcomes not met initially but successfully achieved later in the year.	For discussion/noting.
3. **Complex**	Detailed presentation of all assessment components for discussion.	For discussion.

Certifying completion – PGY1 for general registration

Prevocational training providers must certify satisfactory completion of internship. On the basis of the information provided, the Medical Board of Australia makes a decision on granting general registration to the intern.

The Board requires only the completion of the *Certificate of completion of an accredited internship form*, which is available on the Board's website. The training provider should store term and EPA assessment reports and supporting documentation, including outcomes of any remediation, in case the Board seeks additional information.

The Board's requirements for certification, as per the *Registration standard – Granting general registration on completion of intern training*, have been clarified as:

> Term supervisors are expected to indicate whether interns have satisfactorily 'passed' each term, but the Medical Board will consider the totality of advice in deciding whether to grant general registration. An intern who has performed marginally or unsatisfactorily in a specified term but who has demonstrated 'significant' progress with evidence of remediation may be deemed to have met the standard expected for general registration by the end of the year.

3D

PREVOCATIONAL ASSESSMENT

National assessment forms

NATIONAL FRAMEWORK FOR PREVOCATIONAL (PGY1 AND PGY2) MEDICAL TRAINING

SUMMARY

National assessment forms

Assessment of prevocational training is work-based and term supervisor reports therefore have a key function. In this national registration system, national assessment forms support a consistent approach to assessment.

These forms are:

- Prevocational training term assessment form
- Prevocational training EPA assessment forms.

Note: Both forms are intended to be created as online versions in the e-portfolio system before implementation. Most of the details in the form will be prepopulated in the e-portfolio, or entered by the prevocational doctor. Resources for supervisors will also be developed to support implementation of the revised assessment processes and forms.

1

Prevocational training term assessment form

Use this form for mid- and end-of-term assessments. Information about the process for term assessments is provided in 'Assessment approach' (Section 3A of this document).

Significant revisions were made to the form in the Framework Review finalised in 2022, including:

- addition of data from assessments of EPAs
- assessment against the domains rather than against the individual outcome statements, and the removal of behavioural anchors
- revision of the terminology for global ratings.

Acknowledgements

The original form's development was informed by the work of the Confederation of Postgraduate Medical Education Councils during 2008 and 2009, literature on assessment, and stakeholder feedback on draft forms and draft guidance during 2012 and 2013.

2

Prevocational training entrustable professional activity (EPA) assessment forms

Four assessment forms have been developed to assess each of the new EPAs, which are explained in 'Entrustable professional activities' (Section 2B of *Training and assessment requirements*). Use these forms for EPA assessments throughout the term. Information about the process for term assessments is provided in 'Assessment approach' (Section 3A of this document).

Acknowledgements

Multiple existing forms and processes were considered in developing this draft, including The Royal Australian and New Zealand College of Psychiatrists (RANZCP) entrustable professional activity forms[11], the Western Sydney University Medical School EPA trial and the Royal Australasian College of Physicians EPA form[12].

11. The Royal Australian and New Zealand College of Psychiatrists (RANZCP), *Entrustable professional activity (EPA) forms*, RANZCP website, n.d., accessed 22 April 2022.
12. The Royal Australian College of Physicians (RACP), *Entrustable professional activities for basic trainees in adult internal medicine and paediatrics & child health*, RACP website, 2017, accessed 22 April 2022.

Attachment 1

Entrustable professional activities (EPA) behaviours mapped to the prevocational (PGY1 and PGY2) outcome statements

- A shaded box indicates that the particular outcome is addressed specifically within an EPA.
- +/- (and a lighter shaded box) indicates that it is possible the outcome will be assessed when the EPA is assessed depending on the individual patient characteristics. For example, Aboriginal and Torres Strait Islander specific outcomes being assessed are entirely dependent on whether the case is carried out with an Aboriginal and Torres Strait Islander person or not, although as we have commented in the text, it is possible to explore how a doctor might have done things differently if the patient had been an Aboriginal and Torres Strait Islander person.

Domains	Outcome statement	EPA 1 Clinical assessment	EPA 2 Recognition and care of the acutely unwell patient	EPA 3 Prescribing	EPA 4 Team communication – documentation, handover and referrals
Domain 1: The prevocational doctor as a practitioner	1.1 Patient safety	+/-	+/-	+/-	
	1.2 Communication				
	1.3 Communication – Aboriginal and Torres Strait Islander patients*	+/-	+/-	+/-	+/-
	1.4 Patient assessment		+/-		+/-
	1.5 Investigations				
	1.6 Procedures	+/-	+/-		
	1.7 Patient management				
	1.8 Prescribing		+/-		+/-
	1.9 Emergency care			+/-	+/-
	1.10 Utilising and adapting to dynamic systems	+/-	+/-		
Domain 2: The prevocational doctor as a professional and leader	2.1 Professionalism				
	2.2 Self-management				
	2.3 Self-education				
	2.4 Clinical responsibility		+/-		+/-
	2.5 Teamwork	+/-			
	2.6 Safe workplace culture	+/-		+/-	+/-
	2.7 Culturally safe practice for Aboriginal and Torres Strait Islander patients*	+/-	+/-	+/-	+/-
	2.8 Time management				

Domains	Outcome statement	EPA 1 Clinical assessment	EPA 2 Recognition and care of the acutely unwell patient	EPA 3 Prescribing	EPA 4 Team communication – documentation, handover and referrals
Domain 3: The prevocational doctor as a health advocate	3.1 Population health			+/-	+/-
	3.2 Whole-of-person care		+/-		
	3.3 Cultural safety for all communities	+/-	+/-	+/-	+/-
	3.4 Understanding biases	+/-	+/-	+/-	+/-
	3.5 Understanding impacts of colonisation and racism	+/-	+/-	+/-	+/-
	3.6 Integrated healthcare	+/-		+/-	
Domain 4: The prevocational doctor as scientist and scholar	4.1 Knowledge				+/-
	4.2 Evidence-informed practice				
	4.3 Quality assurance	+/-	+/-	+/-	+/-
	4.4 Advancing Aboriginal and Torres Strait Islander health	+/-	+/-	+/-	+/-

Glossary

ASSESSMENT

The systematic process for measuring and providing feedback on a prevocational doctor's progress and/or level of achievement of the prevocational outcome statements. This occurs in each term through clinical supervisors' assessment of entrustable professional activities (EPAs) and through formal mid- and end-of-term assessments. At the end of each year (PGY1 and PGY2), an *assessment review panel* looks at the outcomes of term assessments and the record of learning, and makes a recommendation on progress to the next stage of training.

ASSESSMENT REVIEW PANEL

A panel that recommends whether a prevocational doctor can progress to the next stage of training, based on a global judgement of the doctor's achievement of the prevocational outcome statements.

The panel members have a sound understanding of procedural fairness and prevocational training requirements. The panel must have at least three members, who may include the director of clinical training (DCT), the director of medical services (DMS) / chief medical officer (CMO) or delegate, the medical education officer (MEO), an individual with HR expertise, experienced supervisor/s, or a consumer.

CERTIFICATION

The final sign-off at the end of each year. Certification says that the prevocational doctor has:

- completed the statutory requirements for general registration PGY1 (forwarded to the Medical Board of Australia); or
- achieved the required standard at the end of PGY2 (leading to the issue of an AMC Certificate of Satisfactory Completion of PGY2).

CLINICAL SUPERVISOR

A medical practitioner who supervises the prevocational doctor while they are assessing and managing patients.

- Primary clinical supervisor(s) – is the supervisor with consultant level responsibility for managing patients in the relevant discipline that the *prevocational doctor* is caring for. The consultant in this role might change and could also be the *term supervisor*.
- Clinical supervisor(s) (day-to-day) is an additional supervisor who has direct responsibility for patient care, provides informal feedback, and contributes information to assessments. This occurs in many settings, and the person in this role should remain relatively constant during the *term*. They should be at least PGY3 level, such as a registrar.

CONSUMER

A health consumer is someone who uses or has used healthcare services, including patients (clients), their family or carers. Many organisations, including the Australian Medical Council, use the experience and expertise of consumers as members of committees.

CULTURAL SAFETY	The AMC uses the Australian Health Practitioner Regulation Agency's (Ahpra) definition of cultural safety. Cultural safety is determined by Aboriginal and Torres Strait Islander individuals, families and communities. Culturally safe practice is the ongoing critical reflection of health practitioner knowledge, skills, attitudes, practising behaviours and power differentials in delivering safe, accessible and responsive healthcare free of racism. See full definition at: https://www.ahpra.gov.au/about-ahpra/aboriginal-and-torres-strait-islander-health-strategy.aspx
DIRECTOR OF CLINICAL TRAINING (DCT) (OR EQUIVALENT)	A senior clinician with delegated responsibility for developing, coordinating, promoting and evaluating the *prevocational training program* at all sites. This clinician also has an important role in longitudinal oversight, advocacy and support of prevocational doctors within the program. In fulfilling the responsibility of this role, the DCT will regularly liaise with term supervisors, MEOs and junior medical officer (JMO) manager(s), the DMS and others involved in the *prevocational training program*. The role has a range of titles in different jurisdictions and training sites, including director of prevocational education and training (DPET), and may interact with a supervisor of intern training, who has primary responsibility for PGY1 doctors (interns). Other titles may be used in community health settings, including general practice.
DIRECTOR OF MEDICAL SERVICES	A senior medical administrator with responsibility for the medical workforce at a health service, also known as the executive director of medical services (EDMS) or CMO. Other terms may be used for equivalent roles in community health settings or general practice.
FORMAL EDUCATION PROGRAM	An education program that the training facility provides and delivers as part of its *prevocational training program*. For *interns* (PGY1), there are usually weekly sessions, which involve a mixture of interactive and skills-based face-to-face or online training. Education programs for PGY2 doctors are more varied and may be adapted to address the career plans of these doctors.
INTERN	A doctor in their first postgraduate year (PGY1) and who holds provisional registration with the Medical Board of Australia.
MINI-CEX	The mini-clinical evaluation exercise is an assessment based on direct observation of a trainee in an encounter with a patient. The trainee performs a focused task such as taking a history, examining or advising the patient. The assessor records a judgement of the trainee's performance using a standardised rating form and provides feedback to the trainee on their performance.
PREVOCATIONAL DOCTOR	A doctor completing generalist, work-based clinical training during the first two years after graduation. The term is sometimes used to refer to any recent medical graduate who has not commenced a vocational training program, including PGY3 and beyond, but in this framework, it always refers to PGY1 or PGY2 doctors.

PREVOCATIONAL TRAINING PROGRAM	A period of two years of generalist, work-based, clinical training after graduation. Each year (PGY1 or internship, and PGY2) comprises 47 weeks of supervised clinical training that meets the requirements set out in the *National standards and requirements for prevocational (PGY1 and PGY2) training programs and terms*. Each year of the program includes orientation, formal and informal education sessions, and assessment with feedback, and may be provided by one or more training providers.
PREVOCATIONAL TRAINING PROVIDER	The organisation that provides supervised clinical practice, education and training, and that is responsible for the standard of the prevocational training program. The program may be delivered in hospital, community health or general practice settings in both prevocational years. Additional settings are possible in PGY2 year rotations, such as pathology, medical administration, research or medical education. Providers may be a hospital, community health facility, general practice, or a combination of these.
PGY	Postgraduate year, usually used with a number to indicate the number of years after graduation from medical school. PGY1 is the first postgraduate year, also known as internship, and PGY2 is the second postgraduate year.
SPECIALTY	A major branch of medical practice, usually represented by a specialty college. Examples include general practice, internal medicine, surgery, emergency medicine, anaesthetics, obstetrics and gynaecology, paediatrics and psychiatry.
SUBSPECIALTY	A branch of a *specialty*, most commonly in internal medicine or surgery. Examples include: cardiology, endocrinology, neurology, nephrology and oncology in internal medicine; paediatrics; cardio-thoracic surgery, orthopaedics, plastic surgery and vascular surgery in surgery; and drug and alcohol services in psychiatry.
SERVICE TERM	A *term* where the prevocational doctor is either (a) rostered to provide ward cover on night shifts (service nights term) or (b) rotated through a number of accredited terms for short periods of time to backfill for doctors on leave (relief service term). Two characteristics of service terms are: 1. discontinuous learning experiences, such as limited access to the formal education program or regular unit learning activities 2. less or discontinuous supervision, such as nights with limited staff.
TERM	A component of the *prevocational training program*, usually a nominated number of weeks in a particular area of practice, also called a clinical rotation, post, or placement.
TERM SUPERVISOR	The person responsible for orientation and assessment during a particular *term*. They may also provide primary clinical supervision of the *prevocational doctor* for some or all of the term.