National Framework for Prevocational (PGY1 & PGY2) Medical Training

Frequently asked questions

Framework overall and implementation

1. Why is the AMC changing the framework for internship and PGY2?

The current framework was introduced in 2014 and covers only the intern year (PGY1). Since then it has become apparent that prevocational training should be enhanced to better reflect the healthcare needs of the Australian population, including increased emphasis on Aboriginal and Torres Strait Islander health, more focus on trainee wellbeing and better supervision. Some of the proposed changes were recommendations of the 2015 Council of Australian Governments' (COAG) Review of Medical Intern Training and were agreed by COAG Health Ministers in 2018: development of a two-year capability and performance framework, introduction of Entrustable Professional Activities (EPAs) and development of an e-portfolio to support the framework.

The AMC also conducted its own evaluation of the framework with stakeholders to define the scope of the review. Some of the proposed changes are based on feedback about problems which have become apparent with the existing framework: the mandatory clinical exposure in the framework does not provide training that reflects the healthcare needs of the Australian population; there should be more focus on clinical work and less on administrative tasks; there are significant variations in the quality of supervision; there should be increased emphasis on Indigenous health; and there is insufficient attention to prevocational trainee wellbeing.

2. When will the revised framework begin?

PGY1 doctors (interns) will commence the new framework in 2024. The AMC has completed a targeted consultation on whether PGY2 doctors should commence in 2024 or 2025. The outcome of this consultation is a decision to adopt a flexible approach: health services and jurisdictions will be able to implement the framework for PGY2 in 2024 or 2025.

3. **Is the program on track to be implemented in 2024? Will this implementation be gradual, or will it apply to all medical graduates entering PGY1 in 2024?**

   Yes, the program is on track to be implemented in 2024. The current framework will continue until the end of 2023 and all PGY1 doctors will be covered by the new framework in 2024. There will be a phased approach to implementation of PGY2 from 2024 or 2025.

4. **Will PGY2 doctors work under the new framework in 2024?**

   The AMC has undertaken a targeted consultation on whether PGY2 doctors should commence in 2024 or 2025. The AMC will adopt a flexible approach: health services and jurisdictions will be able to implement the framework for PGY2 in 2024 or 2025.

5. **Will the new framework be Australia wide?**

   Yes.

Requirements for programs and terms (PGY1)

6. **Will the revised framework change term requirements for PGY1 doctors?**

   Yes, program and term requirements will change; however, it is anticipated that the majority of current PGY1 terms will be able to be accredited under the revised framework. The current framework mandates 10-week accredited terms in general medicine and general surgery and an 8-week accredited term in emergency medical care. Under the revised framework PGY1 must include a minimum of four terms (of at least 10 weeks each term) in different specialties. During 47 weeks PGY1 doctors can only practise a maximum of 25% in any one subspecialty and a maximum total of 50% in any one specialty (including its subspecialties). For example, they may not work more than 50% in surgical terms or paediatric terms.

   During the year they will be required to gain exposure to four different types of clinical experience:

   - care of patients with undifferentiated presentations,
   - peri-procedural care,
   - care of patients with chronic illnesses, and
   - care of patients with acute and critical illnesses.

   Each term will be accredited for one or two of these types of clinical experience by the jurisdictional (state or territory) Postgraduate Medical Council (PMC).

   Prevocational training should reflect the health needs of the Australian community and therefore should occur in a range of settings, including hospitals in metropolitan, regional and rural communities, general practices and other community-based health services. During the two prevocational years you are encouraged to work in a range of settings to better understand Australia's healthcare system.

   The AMC supports innovation in clinical training in diverse health settings, while maintaining the quality of the clinical experience. You can complete work-based clinical experience in a number of settings, even within a specific term; hospital wards, critical care (ICU, Emergency Department, anaesthetics), mental health services, general practice and community health centres. Terms that do not involve direct clinical care, such as teaching, research, pathology, and administration, are not allowed during PGY1.

   Note the current PGY1 term requirements are defined in the *Medical Board of Australia's registration standard for granting general registration for Australian and New Zealand medical graduates on completion of internship* and the AMC has proposed changes to this standard as above; this will be reviewed by the Board in 2022 and 2023.

7. **Can individual terms be mapped to multiple areas of patient care?**

   Yes, each term can be mapped to a maximum of two types of clinical experience (care of patients with undifferentiated presentations, care of patients with chronic illnesses, care or patients with acute and critical illnesses and peri-procedural care). While a term may provide some exposure to all four types of clinical experience, only the one or two most significant areas of care will be mapped to that term. This is to ensure adequate exposure to all areas of care occur during the year. Term mapping will be reviewed as part of the accreditation process by Prevocational Medical Councils.

Requirements for programs and terms (PGY2)

8. **Will the revised framework impact the positions I can apply for in PGY2?**

   Yes. Under the new framework, you will be required to complete a minimum of three terms (of 10 to 24 weeks) in different subspecialties, with a maximum of 25% in single subspecialty. During the year you will be required to gain exposure to three of the four different types of clinical experience: care of patients with undifferentiated presentations, care of patients with chronic illnesses, and care of patients with acute and critical illnesses. Each term will be accredited for experience in one or two of these clinical areas by the jurisdictional (state or territory) Postgraduate Medical Council (PMC). It is anticipated that a majority of current PGY2 terms will be able to be accredited under the new framework.

   Prevocational training should reflect the health needs of the Australian community and therefore should occur in a range of settings, including hospitals in metropolitan, regional and rural communities, general practices and other community-based health services. During the two prevocational years you are encouraged to work in a range of settings to better understand Australia's healthcare system.

   The AMC supports innovation in clinical training in diverse health settings, while maintaining the quality of the clinical experience. You may undertake work-based clinical experience in a number of settings, even within a specific term; hospital wards, critical care (ICU, Emergency Department, anaesthetics), mental health services, general practice and community health centres. In PGY2 you can complete accredited terms that do not involve direct clinical care, such as teaching, research, pathology, and administration. The maximum time working in these positions is 25% of the year.

9. **Can a PGY2 spend a full year in one term/unit. Would this meet the AMC framework requirements?**

   No, the prevocational years are a period of generalist training. While PGY1 doctors must meet the requirements documented in the MBA General Registration Standard, the program and term requirements for PGY2 allow for more flexible and innovative approaches. PGY2 doctors will be required to complete a minimum of 3 terms (of 10 to 24 weeks) in different subspecialties, with a maximum of 25% in a single subspecialty. However, longer 'blended' terms may offer exposure to a range of clinical specialties, settings and supervisors during the term. Possible examples include:
   - a 24-week term in a rural setting combining general practice, ward-based and Emergency Department experience where different days of the week are spent in different settings with different supervisors, or some weeks are spent in one setting before switching to another,
   - a 24-week women's health term with 12 weeks in the labour ward and 12 weeks attached to a gynaecology ward. These terms would need to be accredited by the jurisdictional (state or territory) Postgraduate Medical Council (PMC).
   - a year of paediatric training that includes a variety of subspecialties, e.g. 24 weeks in a paediatric Emergency Department, 12 weeks attached to a general paediatric ward and 12 weeks attached to a paediatric surgery ward.

Community terms

10. **What is the definition of a community term, and will this be mandated during the two years?**

    A community term is a term providing non-hospital clinical experience. The AMC recognises the importance of community or non-hospital clinical experience; however, the revised framework does not mandate a community term during prevocational training. It is anticipated that it will become mandatory after the next revision of the framework.

Assessment

11. Will the amount of assessment in PGY1 and PGY2 increase?

Yes. Formative mid-term assessments will be mandatory under the new framework. End-of-term assessments will continue to be conducted at the end of each term. Prevocational doctors will also be assessed on four entrustable professional activities (EPAs) at least 10 times during each year. These assessments will take place during routine clinical work and are intended to provide opportunities for feedback based on observed routine clinical activities. In each year there will be at least four assessments of EPA 1 - Clinical Assessment (usually one in each term) and at least two assessments of the other three EPAs (Recognition and Care of Acutely Unwell Patients, Prescribing and Team Communication). It is intended that the EPAs will anchor the prevocational years in clinical activities and improve the feedback provided to junior doctors, both of which are issues that have been raised in consultations on the revised framework.

End-of-term and EPA assessments will be considered by the health service's Assessment Review Panel at the end of each year, as well as other learning activities in the record of learning. The panel will make a recommendation on whether the PGY1 or PGY2 doctor has met all the *Prevocational Outcome Statements* at the required standard. There is no requirement to pass a minimum number of end-of-term or EPA assessments.

It is intended the workload associated with an increase in assessment will be mitigated by the introduction of an e-portfolio to assist in conducting, recording and reviewing assessments.

More information about the assessments can be found in Section 3A of *Training and assessment requirements for prevocational (PGY1 and PGY2) training programs*.

12. Do I have to pass all term assessments?

No. At the end of each year the health service's Assessment Review Panel will make a global judgement on whether you have reached the required standard and achieved all the *Prevocational Outcome Statements* by the end of the year. The panel will review each term assessment but there is no requirement to pass a minimum number of assessments.

13. Do I have to 'pass' all EPA assessments?

No. At the end of each year the health service's Assessment Review Panel will make a global judgement on whether you have reached the required standard and achieved all the *Prevocational Outcome Statements* by the end of the year. The panel will review the EPA assessments and the levels of entrustability documented by your supervisors. EPAs and their assessment are discussed in more detail in the FAQs that follow. No matter how well you are performing, it is unlikely that your assessor will say that you need minimal supervision early in PGY1 to safely care for a very complex patient. There is no requirement to reach a high level of entrustability in a minimum number of EPA assessments.

Entrustable Professional Activities (EPAs)

14. What is an EPA? Is an EPA an assessment?

An entrustable professional activity (EPA) is a description of work that you undertake regularly in your clinical practice. Your performance of an EPA can be assessed, but an EPA is not in itself an assessment. In the assessment your supervisor makes a judgement about how safely you can perform this piece of work – your level of entrustability.

The four EPAs included in the revised framework have been adapted from the Royal Australasian College of Physicians (RACP) Basic Training EPAs and are based on the routine clinical work of prevocational doctors:

- Clinical assessment,
- Recognition and care of the acutely unwell patient,
- Prescribing and
- Team communication – documentation, handover and referrals.

Apart from EPA 2 (Recognition and care of acutely unwell patients) these activities occur on a daily basis.

Detailed descriptions of the four EPAs can be found in Section 2B of *Training and assessment requirements for prevocational (PGY1 and PGY2) training programs*. These descriptions outline the focus and content of the EPA, the activities (work) that could be assessed and the contexts that they can be assessed in. There are also detailed explanations of the behaviours that suggest a prevocational doctor requires minimal supervision (a high level of entrustability) or more detailed supervision.

As a prevocational doctor you are continually developing and improving your skills. EPA assessments provide an indication of whether you are on the right track. The level of complexity of your clinical work will vary and it is to be expected that for some EPAs you will require a higher level of supervision. Using the feedback from an EPA assessment you can improve your knowledge and skills and perhaps undertake another assessment in that area when you feel more confident.

15. Is an EPA the same as an OSCE?

EPAs are different to an Objective Standardised Clinical Examination (OSCE) or clinical skills assessment. They are not standardised. By observing your work, your supervisor makes a judgment about how much they can trust you to safely perform this part of the job in the workplace – your level of entrustability. Your supervisor will provide feedback on how you are performing in the workplace.

16. Why have EPAs and EPA assessments been included in the framework?

EPAs are descriptions of the core clinical work in PG1 and PGY2 and they have been included in the framework to increase the emphasis on clinical work in prevocational training. In a busy clinical environment, it can be difficult to pin down your supervisor for a chat about how you're going. The EPAs and their assessment have been designed to ensure that you get specific, structured feedback from your supervisor on the work you are doing as part of the clinical team. Each EPA has been mapped to the *Prevocational Outcome Statements* to help you and your supervisor document your progress to achieving these outcomes by the end of the year.

At the end of each year your health service's Assessment Review Panel will make a global judgement on whether you have reached the required standard and achieved all the prevocational outcome statements. The panel will review the EPA assessments but there is no requirement to 'pass' a minimum number of assessments.

17. Do PGY1 and PGY2 doctors have the same EPAs?

Yes, the EPAs are the same for PGY1 and PGY2 doctors. There is a question on the EPA assessment form that asks the assessor whether the entrustability rating appropriate for the level of training, given the complexity of the case.

18. How are EPAs assessed?

EPAS will be assessed through an activity-based discussion which can be a combination of direct observation and case-based discussion. The following are essential components of the assessment:

- the assessment is based on a patient you are caring for
- the patient is known to the assessing supervisor
- the supervisor has observed a significant part of your clinical interaction with the patient. If this is not possible (e.g., EPA2) feedback is sought from someone who was present.

In practice you and your supervisor will agree to assess a particular EPA as part of your day-to-day work looking after one of your patients. You will perform a work task and the assessor will observe all or part of this task. Then there will be a discussion between you and the assessor about what took place.

The discussion might include some expansion of the parameters of the observed EPA, e.g., "what would you do if the patient was older?" or "…was from a non-English speaking background?" or "…lived

alone with no immediate carer support available?" or "How would ensure cultural safe care for a First Nations patient in this clinical setting?". If it's appropriate the discussion can include other members of the team (e.g., EPA 2).

EPA 3 (Prescribing) and EPA 4 (Team Communication) may involve your supervisor reviewing your discharge summaries, drug charts or referral letters. EPA 4 could also be assessed by your supervisor observing a verbal handover.

The assessor will provide verbal feedback. You and the assessor will each complete sections of the online form (which includes a section for written feedback). The assessor will sign and submit the form.

19. How can EPA 2 be demonstrated and assessed? What is meant by an acutely unwell patient?

Acutely unwell patients are found in almost all clinical settings: Emergency Departments, acute and subacute hospital wards, palliative care, mental health services and general practices. The patient will have presented acutely unwell or deteriorated from a previously stable state. The term applies to patients who are acutely unwell in either physical health or mental health.

The critical aspects that differentiate EPA 2 (Recognition and Care of the Acutely Unwell Patient) from EPA 1 (Clinical Assessment) are that you should:

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.

The EPA assessor will often not be present while the acutely unwell patient is being assessed (e.g., a Medical Emergency Team (MET) call after hours) and it is anticipated that assessment by direct observation will be less common than for the other three EPAs. The assessment should include input from someone who was present. (In the example of the MET call this could be your registrar or a member of the MET team.)

20. EPA 4 is Team Communication - what about communication with the patient?

Communication with the patient, family and carers is a key component of EPA 1 (Clinical Assessment) and can be an important component of EPA 2 (Recognition and Care of the Acutely Unwell Patient) and EPA 3 (Prescribing). EPA 4 is about the essential work of communicating about patient care with other members of the healthcare team, including documentation (medical notes, discharge summaries and letters), oral or written handover, and referrals.

21. Will more EPAs be added to the framework?

The four EPAs have been designed to cover the most important tasks undertaken by prevocational doctors in the different environments in which they work. At the present time there are no plans to develop more EPAs. Any need for additional EPAs will be considered in future evaluations of the framework.

22. I'm ready for an EPA assessment. How do I engage my supervisor?

You do this by asking your supervisor to assess a particular EPA during your day-to-day work. It's important to be explicit about the work you would like to be assessed and for the supervisor to agree to take a few extra minutes to complete the online assessment form and give you some feedback. Here are some examples of how this might be done:

Example 1 (EPA 1): While working in the Emergency Department or in a general practice you are asked to see a new patient. You ask your supervisor to watch you take the history and/or examine the patient and then present your findings and management plan. The supervisor gives you feedback about your approach and may suggest some areas for improvement. The supervisor fills out an EPA assessment form either at the time, or later that day.

Example 2 (EPA 2): During a ward round with your registrar and supervisor you arrive at the bedside of a patient you were called to see the previous evening because of fever and low blood pressure.

You ask if you could present the problem on this round, take them through a brief description of how you managed the acute situation and then have your work assessed. You describe your history, physical examination findings, any relevant investigation results, your diagnostic thinking and what you did to manage that patient's problem before your registrar arrived to assist you. There will probably be a team discussion about the ongoing management of the patient. After the discussion or at the end of the ward round your supervisor or registrar will give you some feedback and complete the EPA form.

Example 3 (EPA 3): You ask your supervisor to review the medications you prescribe during an Emergency Department shift and give you some feedback. Your supervisor watches while you talk to patients about new drugs, and/or the indications, side-effects, interactions and contraindications of their medications, and reviews the drug charts you have completed. Alternatively, you could ask your registrar to review the medications you have prescribed during one or more ward calls while you have been working an evening shift. Your registrar reviews the entries you have made in the drug charts of the patients you were asked to see and you discuss the appropriateness of the medications you have ordered. In each case your assessor gives you feedback on your prescribing and then completes the EPA form.

Example 4 (EPA 4): You are asked to discharge an elderly patient with complex medical and social issues. You ask your supervisor or registrar to review the discharge summary before the patient is discharged or on a discharge ward round or during a discharge summary review meeting. You discuss the summary with your supervisor or registrar, including the key follow up items to discuss with the patient, carer, or general practitioner. The registrar or supervisor gives you feedback on your discharge summary and then completes the online EPA form.

23. Who is responsible for arranging the EPA assessment and providing the EPA assessment form?

Prevocational doctors will drive the EPA assessment process. They will suggest the patient for the assessment and make arrangements for the assessment if the supervisor agrees that the suggested assessment is appropriate. The supervisor may suggest another patient or assessment if the clinical scenario is too similar to a previous assessment, if there are concerns about a particular area of clinical practise, if one or more of the *Prevocational Outcome Statements* has not been covered, or if they think that a more complex issue should be assessed (e.g., towards the end of each year). Prevocational doctors will enter the patient and clinical details onto the EPA assessment form. If assessments are overdue, it is intended the e-portfolio will send reminders to prevocational doctors and their supervisors, with copies to the Medical Education Unit.

24. How many EPA assessments will I complete in one year?

To cover the range of professional skills described in the four domains of the Prevocational Outcome Statements, a prevocational doctor is expected to undertake:

- A minimum of ten EPAs assessments during the year.
- A minimum of two EPAs assessments in any one term (depending on whether there are 4 or 5 terms).
- At least one assessment of EPA 1 in each term
- A minimum of two assessments of EPAs 2, 3 and 4 during the year.

EPAs are part of your day-to-day work and their assessment will take place while you work. The assessments will provide valuable real time feedback on how you are developing your skills as a doctor. Using the feedback from an EPA assessment you can improve your knowledge and skills and perhaps undertake another assessment in that area when you feel more confident. You are strongly encouraged to ask your supervisors to complete more than the minimum number of assessments, particularly in areas where you feel you need further development, and to complete the assessments in a variety of settings (hospital ward, Emergency Department, general practice, outpatient clinic etc).

25. Who can observe an EPA and conduct the assessment?

At least one EPA each term must be assessed by your Primary Clinical Supervisor (the supervisor with consultant level responsibility for managing patients that you are caring for during a term). This supervisor will be a specialist or equivalent.

The other EPAs can be assessed by other practitioners as appropriate if they have completed EPA assessor training, including other consultants, registrars, pharmacists, and nurse/nurse practitioners. For example, a pharmacist could assess EPA 3 and provide feedback.

26. How many descriptors need to be ticked on page 1 of the EPA assessment form?

Each EPA assessment form includes a description of the EPA which lists the tasks that may be observed during performance of the work of the EPA. Depending on the actual work observed, it may not be possible to observe all tasks listed on the form. You will be asked to tick the task descriptors that are relevant to your assessment, but this may be changed by your assessor.

27. How to ensure that a variety of tasks are assessed, that any significant gaps are addressed and that the doctor is assessed at the appropriate level of complexity?

Prevocational doctors are required to achieve all the *Prevocational Outcome Statements* by the end of PGY1 and PGY2. EPAs and end of term assessments are mapped to the outcome statements in the e-portfolio, leading to a record of learning which identifies any gaps.

The term supervisor will have access to the prevocational doctor's assessments during the term and the Director of Clinical Training and the Medical Education Unit will have access to all assessments during the year. Supervisors and prevocational doctors should ensure that breadth of experience and a range of task complexities are covered by the EPA and end of term assessments over the course of the year.

28. How does the assessment of EPAs interact with the other assessment processes and the global judgement at the end of the year?

The two main forms of assessment for prevocational doctors will be assessment of the EPAs (assessment of an observed activity) and the mid/end of term assessments (global ratings based on performance across the term). The end of term assessment forms will include information on the EPAs assessed within that term. The EPAs and the clinical experience in each term will both be mapped to the *Prevocational Outcome Statements*. It is intended that this mapping and the EPA assessment outcomes will be automatically collected in the e-portfolio and made available to the term supervisor completing the end of term assessment form.

At the end of the year a global judgement will be made by the health service's Assessment Review Panel, based on consideration of the end-of-term assessments, the EPA assessments and any other learning activities documented in the e-portfolio's record of learning. The panel will make a recommendation on whether a PGY1 or PGY2 doctor has met all the *Prevocational Outcome Statements* at the required standard. There is no requirement to 'pass' a minimum number of EPA or end-of-term assessments.

29. Can I practice my EPA on the actual patient before I am assessed on my interaction with that patient?

EPAs are descriptions of the core clinical work in PG1 and PGY2. You will be performing this work on a daily basis. There should be no need to undertake additional practice before an assessment.

Improving performance

30. What if a prevocational doctor is underperforming?

Multiple factors can impact performance, including individual skills, wellbeing, and the work environment. All these factors need to be assessed and addressed to optimise performance. The revised 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.

There is a three-phase process to assist these doctors, which involves the prevocational doctor, the Director of Clinical Training and term supervisor(s): an informal discussion, a formal discussion and action plan, and a period of managed supervised practice. The health service's Assessment Review Panel will also be involved if there are more significant issues (phases 2 and 3). More details can be found in Section 3B *Training and assessment requirements for prevocational (PGY1 and PGY2) training programs*.

31. Will the revised Framework increase workload for health services, supervisors and prevocational doctors?

There will be some increase in workload, particularly in the changeover period: reviewing terms, term descriptions and orientation programs to ensure they are consistent with the new term and clinical exposure requirements, mapping terms to the Prevocational Outcome Statements and to one or two of the four types of clinical experience, establishing Assessment Review Panels and ensuring supervisors receive training. However, it is anticipated that most of the current PGY1 and PGY2 terms will still be eligible for accreditation.

After the Framework has been introduced the main change will be increased assessment requirements. The EPAs have been designed to be incorporated into daily work to minimise disruption. Primary Clinical Supervisors are only required to complete one EPA assessment each term; the rest can be assessed by other supervisors, including registrars.

It is intended that the e-portfolio will reduce workload for some tasks – e.g., automatic reminders to supervisors and prevocational doctors when assessments are due or overdue, mapping of assessments to Prevocational Outcome Statements, automatic collation of all assessment outcomes, and production of tailored reports for accreditation visits or accreditation progress reports.

Supervisor training

32. Will all supervisors need training?

The revised *National Standards for Prevocational Training Programs* require health services to ensure that supervisors have training in supervision, assessment and feedback, and cultural safety. Training for term supervisors will be mandatory within three years of implementation of the revised framework. Relevant supervision training programs provided by medical schools or specialty colleges will be recognised.

33. What materials will be provided by the AMC for Term Supervisor Training?

The AMC is developing a number of resources to train supervisors, including:

- a guide for supervisors to support the revised Framework
- a series of short videos to support implementation of the Framework

The AMC will continue to consult with stakeholders about the development of training resources.

Certifying completion

34. How will General Registration be granted?

General Registration will continue to be granted by the Medical Board of Australia after satisfactory completion of an accredited PGY1 (intern) year. The Board is currently reviewing its *registration standard for granting general registration for Australian and New Zealand medical graduates on completion of internship* to reflect the revised framework and a new registration standard will be introduced in 2024. It is anticipated that the decision to grant general registration will be informed by recommendations of health services' Assessment Review Panels.

Specialty training

35. Will these changes delay entry into specialty training by one year?

No. Trainees will still be able to enter College training programs in PGY2 where this is allowed by the Colleges delivering the training program.

Leave, remuneration and contracts

36. Can a prevocational doctor take a year off between PGY1 and PGY2?

Yes.

37. Can a prevocational doctor change health services or hospitals between PGY1 and PGY2?

Yes.

38. Does the pay rate between PGY1 and PGY2 stay the same?

The revised framework will have no impact on industrial awards.

39. Will these changes result in two-year contracts rather than one-year contracts for internship?

Health services will be able to offer one-, two- or three-year contracts. This is currently, and will remain, a decision for individual health services and/or jurisdictions.

40. How will the new framework impact on part time internships?

Prevocational doctors who are employed part time in PGY1 or PGY2 will be covered by the revised framework. They will be required to complete the equivalent of 47 weeks of PGY1 training within three years and 47 weeks of PGY2 training within 4 years.

Support

41. Where do I go if I need help?

If you have concerns about your progress, you should discuss them with your registrar, primary clinical supervisor, term supervisor or Director of Clinical Training. Scheduled discussions with your supervisors will take place at the beginning of term meeting, at mid- and end of term assessments, and after each EPA assessment but you shouldn't wait for these if you are unsatisfied with your performance.

You should discuss any concerns about the supervision you are receiving with your term supervisor or Director of Clinical Training.

Prevocational training can be physically, intellectually and emotionally challenging. It is important that you monitor and maintain your wellbeing and your mental and physical health during PGY1 and PGY2, and as you progress further in your medical career. Having your own general practitioner is critical to maintaining good health and wellbeing throughout your career.

If you have concerns about your personal wellbeing or have witnessed or experienced bullying, harassment or discrimination, it is very important that you seek help. There will be a number of individuals in your health service who have the experience and authority to provide this help, including your supervisor, your Director of Clinical Training (DCT), your Supervisor of Intern Training, your Medical Education Unit, your Medical Education Officer (MEO) or your Director of Medical Services (DMS). The health service's Human Relations or People and Culture Department will have confidential mechanisms for reporting bullying, harassment or discrimination.

In addition to consulting your general practitioner about any physical or mental health concerns, you can contact Doctors Health Programs in all states and territories and you can access telephone support at any time of the day from the Doctors Health Service confidential telehealth line (see here for contact details. You can also access support from services such as Lifeline or Beyond Blue.

You can read more about your health service's obligations to support your wellbeing in the *National Standards for Prevocational Training Programs.*

Accreditation process

42. Current intern and PGY2 training programs are accredited by individual PMCs. How will the new AMC Framework affect the accreditation process?

PGY1 and PGY2 training programs will continue to be accredited by PMCs but accreditation will be based on the standards in the revised framework. The current accreditation cycle will not be affected but the AMC expects that PMCs will receive annual reports from accredited health services on progress towards implementation of the new framework. It is intended that the e-portfolio will provide reports that will assist the accreditation process.