NATIONAL FRAMEWORK FOR PREVOCATIONAL (PGY1 AND PGY2) MEDICAL TRAINING

Assessment Review Panels

A GUIDE FOR PREVOCATIONAL TRAINING PROVIDERS

Australian Medical Council Limited

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.

Introduction

The revised National Framework for Prevocational (PGY1 and PGY2) Medical Training will require prevocational training providers to appoint an appropriate assessment review panel. Each panel will be responsible for monitoring and making decisions about the longitudinal progress of prevocational doctors in that health service or training network.

This guide aims to assist prevocational training providers to establish a panel (or making modifications to an existing panel) with the aim of meeting the requirements for both:

- **Training and assessment** (described in *Training and assessment requirements for prevocational (PGY1 and PGY2) training programs)* and
- **The training environment** (described in *National standards and requirements for prevocational (PGY1 and PGY2) training programs and terms).*

This guide contains important information about the panel's purpose and functions, membership, meetings, processes, decision making outcomes, appeals and documentation. The appendices include a template for terms of reference, as well as references and links to further information.

All information should be read in conjunction with the *National standards and requirements for programs and terms* (Standards 2.3.4, 2.5.2 and 3.2.5) and the processes described in Training and assessment requirements, particularly the sections on improving performance (3b) and certifying completion of PGY1 and PGY2 training (3c). Further information on the revised National Framework can be found at https://www.amc.org.au/framework/

We encourage you to use this guide as you consider how to establish an assessment review panel in your health service or prevocational training network.

This guide should be read in conjunction with *Training and assessment requirements*, particularly, sections on improving performance (3b) and certifying completion of PGY1 and PGY2 training (3c).

Purpose and rationale

What is the purpose of the panel?

The panel's primary purpose is to assess whether a prevocational doctor has met the learning outcomes appropriate to their year level and can progress to the next stage of training. Through this function, panels ensure prevocational doctors are meeting requirements during their longitudinal progress.

Throughout the year, the panel will monitor progress and ensure that supports and processes are in place to help PGY1 and PGY2 doctors successfully progress through each stage of training.

At the end of each year, the panel will make a global judgement on whether to recommend that each prevocational doctor progress to the next stage of training. Further information about how the panel might undertake these responsibilities is provided in later sections of this guide.

What is the rationale for a panel?

Traditionally, the global judgement of an intern's readiness for general registration has been made by an individual, usually the director of clinical training (DCT) or equivalent.

However, international experience tells us that group decision-making (rather than individual) is preferred when evaluating the global clinical progress of medical trainees. When a progress review is performed by an assessment review panel – whose members have relevant medical training and assessment and remediation expertise – the process is optimal and promotes objective, evidence-based and impartial decision making.

Where evaluations identify prevocational doctors who require additional support, the panel can also be an important source of expert advice on remediation strategies. This maximises the likelihood that the prevocational doctor meets the learning outcomes and successfully progresses to the next stage of training.

The primary purpose of the assessment review panel is to monitor and support the longitudinal progress of prevocational doctors, ensure that they are meeting learning outcomes, and to make a global judgement on whether to recommend each doctor progress to the next stage of training

Roles and functions

What are the roles of the panel?

1

Making recommendations on progression

Making recommendations on progression for all PGY1 and PGY2 doctors in the health service or training network. The panel will assess that the vast majority of PGY1 or PGY2 doctors meet learning requirements and can be recommended to progress to the next stage of training. Where the panel recommends a delay to progression, the panel will also provide recommendations about how to support the doctor to achieve completion (for example, term allocation, additional time or specific assessment requirements, such as additional EPAs).

2

Providing advice and expertise on assessment and remediation

Providing advice and expertise on more complex performance improvement strategies for individual prevocational doctors who are at risk of failing to progress.

Can the panel have any additional functions?

In addition to these core roles, the panel may also play a part in the following:

- appeals of term assessments
- providing advice to the director of medical services (DMS), or equivalent, on performance, conduct or significant patient safety issues
- identifying and advising on trends emerging in aggregated performance data, at the level of both the individual prevocational doctor and the clinical unit or program. This information may assist the prevocational training provider in determining priorities for improving the overall performance of the program.

The panel should have a primary focus on matters relevant to the two key roles described above and be clearly distinguished from the roles and responsibilities of other relevant education and training governance committees in the health service. Any additional functions of the panel will be outlined in the terms of reference.

Does the role of the panel differ between certifying completion of PGY1 and PGY2?

The requirements for certifying completion of PGY1 and PGY2 are different.

For PGY1, the panel is responsible for synthesising information at the end of the year and assisting the delegate for each prevocational training provider (usually the DCT or DMS) in providing a recommendation to the Medical Board of Australia (the Board) about satisfactory completion of PGY1. The Board then decides whether to grant general registration.

For PGY2 doctors, the panel provides a recommendation to the delegate within their health service about the satisfactory completion of PGY2.

Key principles

What are the key principles that underpin the roles and functions of the panel?

As panel decisions are made without prevocational doctors being present, the operating principles of the panel must be clear.

Panel processes must be informed by the following:

- confidentiality
- a supportive (versus punitive) approach
- procedural fairness
- independence
- avoiding bias
- managing conflict of interest
- transparency
- decision-making that is proportional and based on triangulation of evidence.

Further information about how a panel may structure meetings and approach its activities to uphold these principles are provided in the following sections.

Membership and composition

Who should be members of the panel?

Prevocational training providers have some flexibility in determining the members of the panel based on what is practical for their specific context, geographical location and numbers of prevocational doctors.

The panel must have a least three members, who should all have a sound understanding of prevocational training requirements and the operating principles identified in the previous section.

Members may include the following roles:

- Aboriginal and/or Torres Strait Islander representation
- DCT
- DMS or chief medical officer
- medical education officer
- experienced term supervisor or senior clinician
- an individual with HR expertise*

Prevocational doctors should not be included as panel members.

* The role of an individual with HR expertise is to provide advice in wellbeing and remediation discussions and on relevant matters such as support and leave options, documentation and record keeping. Note importantly that, given the panel's role in medical training assessment decisions, the HR role does not include, *and should be clearly distinguished from*, performance management or employment related matters.

The panel should include members with expertise in:

- medical education and assessment
- clinical practice
  (consider clinicians across a range of disciplines)
- the medical training continuum
  (undergraduate through to vocational training)
- HR processes

Although not specifically required, the panel may also include a member who is not a medical practitioner, such as a senior nurse or allied health professional, an Aboriginal and/or Torres Strait Islander health worker or a consumer representative.

The terms of reference should be sufficiently flexible to allow the panel to seek expert or technical advice as required, such as co-opting an additional member for specific purposes.

It is important to note that with so many different Aboriginal and/or Torres Strait Islander cultures, that one member would insufficient to address all these diverse needs.

Who should chair the panel?

Selecting the panel chair is pivotal to the success of the panel and programs should carefully consider the role. The chair should generally be a senior doctor, but not the DCT.

The roles and responsibilities of panel members will be articulated in the terms of reference*.

Skills and attributes may include:

- reflective thinking
- listening to others
- ability to form a consensus view
- critical analysis
- confidentiality
- impartiality

* Refer to the Appendices for a terms of reference template.

Appointing the DCT as the panel chair is not recommended as the DCT will be responsible for requesting assistance with more complex performance improvement issues.

Structure and processes

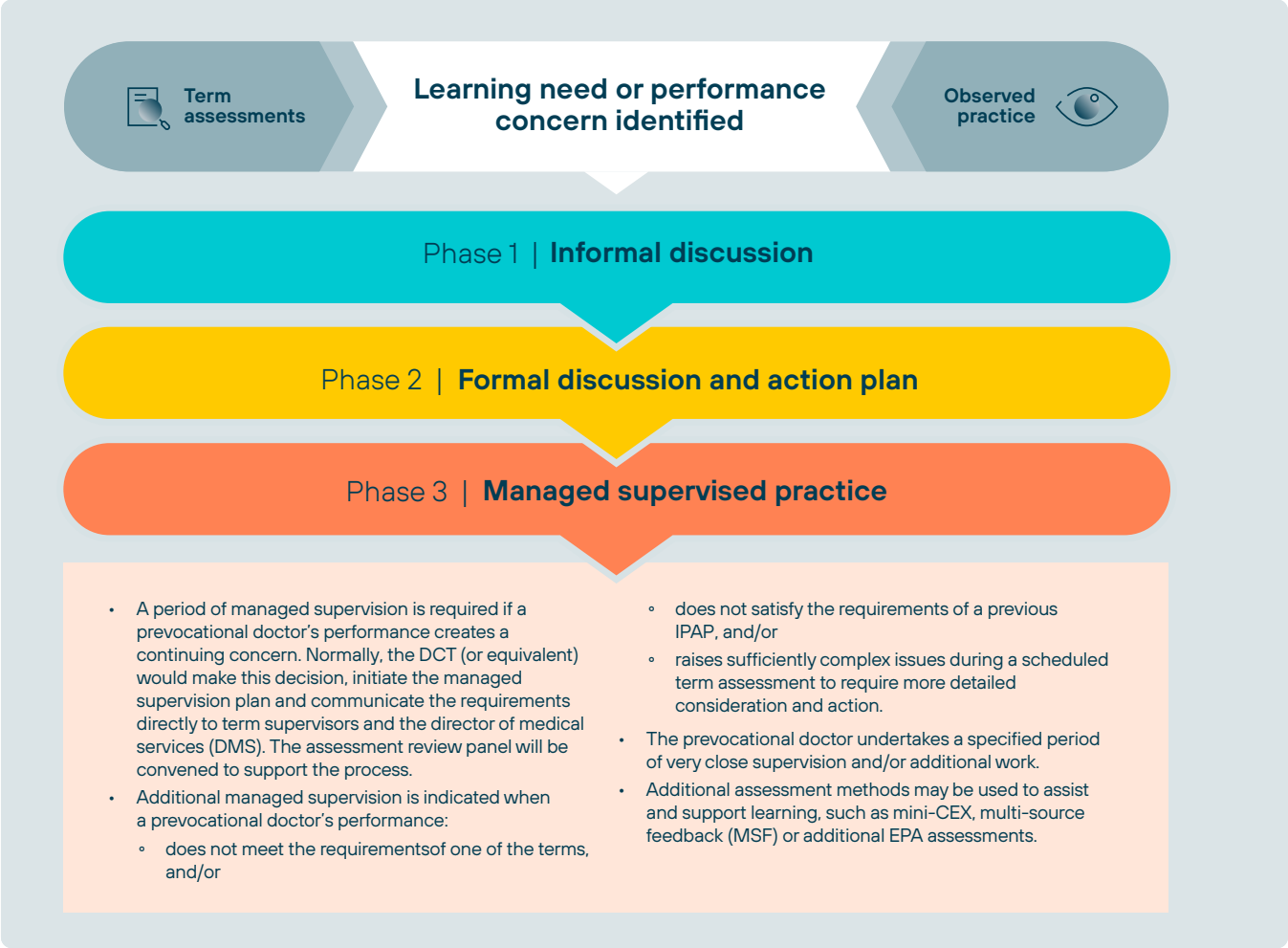
What are some important considerations for the timing and agenda of meetings?

The panel will meet at least once a year to discuss progression recommendations. However, the panel may also be convened more often to support the *improving performance process*, particularly for prevocational doctors in **Phase 3** of the process (see Figure 1).

Meetings should be scheduled with sufficient time to implement improving performance processes and subsequent assessment of their success before the end of the clinical year. Consider who is best involved in this process. For example:

- If issues for consideration relate to cultural safety or Aboriginal and/or Torres Strait Islander health outcomes, then processes should occur with Aboriginal and/or Torres Strait Islander people.
- If the prevocational doctor being considered is an Aboriginal and/or Torres Strait Islander person. Confirmation with the prevocational doctor of their cultural needs should occur. For example, including or deferring to Aboriginal and/or Torres Strait Islander people.

Figure 1: Phase 3 of the improving performance process.



Extract from *Training and assessment requirements*, page 53.

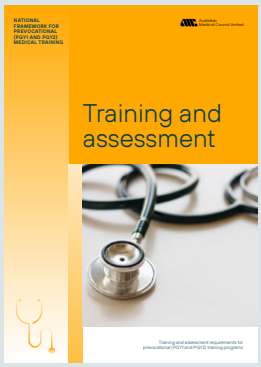
How does the panel ensure appropriate oversight of assessment decisions in programs that have large numbers of prevocational doctors?

To streamline the process, the panel might consider the evidence in varying levels of detail, depending on the outcomes of assessments. Table 1 provides a suggested approach to allow sufficient in-depth discussion for more complex decisions.

Table 1: 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. (all components satisfactory)	For noting only.
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.

Extract from *Training and assessment requirements*, page 59.



Decision-making and potential outcomes

What information might the panel consider in reaching decisions?

The panel should consider a range of information on prevocational doctor progression, most commonly:

- outcomes of EPA assessments
- end-of-term assessment forms
- other learning activities in the record of learning that address the prevocational outcome statements not covered by the assessments (for example, cultural safety training modules, professional development course).

The panel will consider both quantitative and qualitative information, which may include other relevant information provided by the prevocational doctor, the medical education unit (however named) or other relevant person (such as a term or clinical supervisor). Accessing additional information will be especially relevant in complex decisions.

Additional sources of information may include:

- mid-term assessment forms
- multisource feedback or 360° feedback
- compliments
- issues raised outside of the term assessment process
- other direct observation data
- medical record review
- efficiency data (for example, the number of patients reviewed per shift in an ED compared with peers).

The panel may consider both quantitative and qualitative information in their synthesis of a prevocational doctor's progression

The panel should have clear processes that outline how a prevocational doctor or other relevant individuals (such as a term supervisor who is not a member of the panel) may provide supplementary information to assist the panel in making a decision.

For most prevocational doctors (the 'routine' group in Table 1), the panel will make a statement that:

- all end-of-term assessments were satisfactory
- X number of EPAs were completed and there were no concerns noted
- all prevocational outcome statements were achieved.

As shown in Table 1, more detail would be provided for the 'routine with some areas for discussion/noting' and the 'complex' groups.

Panels will also have a role in reviewing information and assessments for prevocational doctors who may not have met other requirements (such as 47 weeks FTE) to determine whether they are able to recommend progression to the next stage of training.

What are the potential decisions that a panel may make?

In making decisions, the panel has several outcomes to choose from:

- requesting more information
- making a recommendation to progress without feedback to the prevocational doctor
- making a recommendation to progress with specific feedback to the prevocational doctor
- making a recommendation to delay progression with specific feedback to the prevocational doctor*
- making a recommendation to refer the issue to the DMS or equivalent.**

* When the panel recommends a delay to progression, the panel should also make additional recommendations that provide clear advice to the prevocational doctor (and other relevant parties on a need-to-know basis) about what the prevocational doctor is required to do so that they optimise the likelihood of meeting the prevocational outcome statements and receiving a favourable decision to progress in the future.

Such recommendations may include additional time requirements in particular terms, additional EPAs, or receiving favourable reports from the clinical supervisor, nurse unit manager (or equivalent) or other relevant team members.

The panel may consider providing other points of feedback or suggestions to the prevocational doctor. The DCT may deliver these in person, but the prevocational doctor should also receive a written summary.

** In very rare cases, issues may emerge for individual prevocational doctors that fall outside the scope of the panel, such as reports of misconduct, criminal behaviour or significant patient safety concerns. These matters would generally be referred to the DMS (or equivalent) in line with the organisation's policy.

How should the panel arrive at a decision?

After considering the information provided, the panel will generally arrive at a decision by consensus. Should a vote be required, the terms of reference should stipulate which members have voting rights.

What does the panel do if a prevocational doctor has a conditional pass or an unsatisfactory assessment in an individual term?

The panel should take a longitudinal approach to assessment. Satisfactory performance should therefore be judged on whether the prevocational doctor has attained the required standard by the end of the year, rather than as a requirement to pass a specified number of EPAs or end-of-term assessments.

At completion of PGY1, the Board requires only 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 described in *Registration standard – Granting general registration as a medical practitioner to Australian and New Zealand medical graduates on completion of intern training, have been clarified as:*

"Term supervisors are expected to indicate whether interns have satisfactorily 'passed' each term, but the 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."

Cognitive bias

During assessment processes and decision-making, bias is normal and common (Dickey et al, 2017). Given the high-stakes nature of panel outcomes, efforts must be made to minimise the effects of bias on decision-making.

Acknowledging the potential for bias is an important first step and panels should discuss what strategies may effectively reduce or minimise bias in their deliberations. Table 2 provides a number of examples of bias in panel deliberations.

Table 2 – Cognitive bias types with examples.

BIAS	DEFINITION	EXAMPLE
Anchoring	Holding on to an initial observation or opinion and not acknowledging changes.	A poor patient history and physical examination by a PGY1 early in the clinical year, may "anchor" in a panel member's mind and result in overlooking information that provides evidence of improvements in clinical skills over the course of the year.
Availability	Giving preference to data that are more recent or more memorable.	In a panel meeting, a panel member may give more weight to his or her own observations of a prevocational doctor than to observations of supervisors in other rotations.
Bandwagon	Believing things because others do.	A panel member mentions an insignificant mishap by a prevocational doctor and other members join in and mention other minor issues that would not have been described otherwise.
Confirmation	Focusing on data that confirms an opinion and overlooking evidence that refutes it.	A panel member with a negative opinion of a prevocational doctor recalls a single instance of a prescribing error and neglects the 99% of medication charts written correctly.
Groupthink	Judgement influenced by overreliance on consensus.	Panel members choose not to challenge a decision in order to preserve group camaraderie. More senior panel members exert undue influence over other panel members.

Table 2 – Continued.

BIAS	DEFINITION	EXAMPLE
Overconfidence	Having greater faith in one's ability to make a judgement than is justified.	Panel members may have too little data to make a decision, yet feel comfortable reaching a decision.
Reliance on gist	Judgements based more on context than on specific observations or measurements.	The panel members may think, "this is a good prevocational doctor" and make a decision rather than reviewing the specific information and data to support that decision.
Selection	Relying on partial information that is not truly random or representative.	A term supervisor may meet a panel member by chance in the corridor and describe a prevocational doctor's minor breach of professionalism. Had the panel member not run into the term supervisor, the story might not have been relayed. Now the panel member may place too much emphasis on the event during panel deliberations.
Visceral	Judgement influenced by emotions rather than objective data.	A "difficult" prevocational doctor may receive a different recommendation to another prevocational doctor for a similar performance.
Adapted with permission from Dickey, CC, et al., 2017		

Key resource

Dickey CC, Thomas C, Feroze U, et al. Cognitive Demands and Bias: Challenges Facing Clinical Competency Committees. J Grad Med Educ. 2017 Apr 1;9(2):162–4.

Appeals

When establishing an assessment review panel, prevocational training providers will need to consider an appeals process, which should be consistent with the policies and processes that the health services already have to manage appeals arising from other decisions.

In creating an appeals process, the training provider should consider:

- grounds for appeal
- governance structure and reporting
- escalation pathway
- alignment with health service policies and processes.

Term supervisors should be encouraged to provide candid and robust assessments of prevocational doctors that reflect actual performance. Likewise, panel members should be encouraged to make decisions and recommendations based on the information presented to them.

The appeals process should explicitly state the grounds for making an appeal, which will generally be confined to errors of law or due process, relevant information not being considered, irrelevant information being considered, or established procedures or processes not being followed.

Despite there being an appeals process, the training provider should make clear to prevocational doctors (and others) that decisions and recommendations made by an appropriately constituted assessment review panel, acting in good faith, and following due process according to the established policies and procedures, are not able to be negotiated.

An appeals process is an essential part of panel governance that provides a mechanism to scrutinise decision-making in specific cases, which both protects prevocational doctors and ensures robust panel processes.

Feedback

An important role of the assessment review panel is to provide feedback to prevocational doctors on the outcomes of the panel's deliberations. Feedback should always be provided in instances where the panel recommends a delay in progression to the next stage of training.

In other circumstances, the panel may decide that the doctor has met the learning outcomes and can progress to the next stage of training but would benefit from some specific feedback to support their continued professional development.

The person providing the feedback to the prevocational doctor may be the DCT or one of the panel members.

Features of high-quality feedback include the following:

- **Timeliness** – feedback should be provided to the prevocational doctor as soon as practical following the panel's decision.
- **Specificity** – the feedback should include enough specificity and examples of the issues raised and what actions the prevocational doctor needs to take to meet the required learning outcomes.
- **Clear documentation** – the verbal feedback to the prevocational doctor should be supported by a clearly documented improving performance action plan (IPAP).

Features of high-quality feedback include timeliness and specificity, supported by clear documentation.

Documentation

Assessment review panels will need to decide how they will record their deliberations, decisions and recommendations, balancing the needs for both appropriate documentation and confidentiality. Documentation processes must also meet local record keeping requirements.

Written agendas should be released to allow sufficient review by the panel. Meeting minutes should be formally ratified by the membership within a specified time. Given the meeting frequency, this is likely to require out-of-session endorsement.

Where the panel makes a specific recommendation about a prevocational doctor, the panel must agree on both how the recommendation will be communicated and how that communication will be documented. Most commonly, the DCT (or equivalent) or Medical Education Unit (MEU) staff will discuss the outcome with the prevocational doctor, and also provide the prevocational doctor with a written summary of the decision. This discussion between the DCT and prevocational doctor would be recorded in the usual way for documenting discussions between prevocational doctors and the MEU.

Establishing an assessment review panel

What activities might assist in establishing a panel?

Before considering progression decisions or other issues, the panel should meet to formalise and endorse its terms of reference. Suggested headings for inclusion in the Terms of Reference are provided at Appendix A of this guide.

The panel should also discuss and document operating principles, protocols and agreed ways of working. This should include how to uphold the key principles (see page 8 of this guide) in all the activities and conduct of the panel.

The panel may also choose to discuss some hypothetical cases or conduct simulation activities to calibrate and test the agreed ways of working and approach to discussions.

International experience has found that these preparation and induction activities are valuable in establishing a panel and orientating members. Appendix B therefore provides some suggested questions for the panel to consider in refining its terms of reference and agreed ways of working.

How might a panel evaluate its effectiveness?

Prevocational training providers are encouraged to evaluate the effectiveness of the panel, as would occur for all medical education and training activities. The approach to evaluation should be practical and flexible and will depend on the local context. For example, the health service may have an existing process for reviewing committee effectiveness that could be used. Alternatively, some suggested approaches to evaluation are provided in Appendix C.

Key resource

Duitsman ME, Fluit CRMG, van Alfen-van der Velden JAEM, et al. Design and evaluation of a clinical competency committee. Perspect Med Educ. 2019 Jan 17;8(1):1–8.

Appendix A

Suggested headings for terms of reference

In establishing a terms of reference document for the assessment review panel, the following headings might be included:

- functions
- meeting frequency
- responsibility and authority
- chair
- quorum
- terms of office
- process for identifying and managing conflicts of interest
- decision making – by consensus, voting processes
- reporting
- meeting documentation
- process for providing feedback to prevocational doctors.

Appendix B

Some suggested questions for the panel to consider when establishing an assessment review panel and agreed ways of working

RECOMMENDATIONS FOR PROGRESSION AT THE END OF PGY1 AND PGY2	• Will all prevocational doctors be discussed by the panel? If not, what are the criteria for a doctor's portfolio to be noted and recommended for progression or a PGY2 certificate? • Will members be allocated to review PGY1 or PGY2 doctors' data, or will it be the responsibility of the DCT to present each person?
CASE DISCUSSIONS	• Will all prevocational doctors who have an IPAP be discussed by the panel, or will only complex performance concerns be considered? • Aside from prevocational doctors on performance improvement plans (and appeals if that is a role of the panel in the program), are there other criteria that can be used to initiate a case discussion? (e.g. prevocational doctors with attendance, professionalism or wellbeing concerns that may not yet be documented in an assessment outcome) • Who may initiate a meeting or case discussion?
SIMULATIONS AND TRAINING	• Before considering the first portfolio, does the panel wish to conduct any training, simulated case discussions or validation of their agreed approach?

Appendix C

Suggested questions to ask in evaluating the effectiveness of the assessment review panel

MEMBERSHIP

- Are there additional skills or perspectives that may be helpful to have within the panel membership?
- What role does the director of clinical training play in the panel? (chair, member, non-voting member, not present)

MEETING PROCESSES

- Is the meeting frequency and duration appropriate? Does the panel use extraordinary meetings when appropriate?
- Is the panel provided with sufficient information to be confident in their decisions?
- Who is responsible for preparing the agenda? Are there any improvements to the preparation for meetings that may assist the panel?
- How are the meetings minuted and decisions recorded?
- Does the panel receive an update on improvements, changes and outcomes for all cases discussed at previous meetings? Should any changes be made to this process?
- How are decisions of the panel communicated to prevocational doctors?
- Are all prevocational doctors' progression discussed at the panel? Or are criteria used to determine cases for discussion compared to noting by the panel? Or are cases divided up for allocated members to review? Do the criteria require adjustment?
- How is confidentiality respected?

DECISION-MAKING

- How does the panel mange conflicts of interest and prior knowledge? How are external perspectives sought?
- How might the panel improve on attempts to mitigate cognitive bias? How are external perspectives sought?
- What information was the most useful for making decisions or recommendations?
- What role did the qualitative information play? (e.g. comments on EPA forms or comments on mid and end of term assessments)
- Is a consensus or voting used to make decisions? How does the group manage differing opinions?

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