National Training and Assessment Guidelines for Junior Medical Doctors PGY 1 and 2

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GLOSSARY

AHMAC	Australian Health Ministers' Advisory Council
AMA	Australian Medical Association
AMC	Australian Medical Council
Accreditation	The process by which certification is granted to an organisation which meets the standards and criteria upon which it is reviewed
CEPTSA	Council for Early Postgraduate Training in South Australia
CPMEC	Confederation of Postgraduate Medical Education Councils
DCT	Director of Clinical Training; clinician responsible for overseeing education for prevocational doctors
Internship	The first postgraduate year of training after graduation from medical school; also called postgraduate year 1 or PGY1
JMO	Junior Medical Officer, usually PGY1-3
JMO Managers	Junior Medical Officer Managers; generally coordinators of junior medical staff in hospitals
MEO	Medical Education Officer
MTRP	Medical Training Review Panel
NTPMC	Northern Territory Postgraduate Medical Council
PMEFQ	Postgraduate Medical Education Foundation of Queensland
PGMIT	Postgraduate Medical Institute of Tasmania Incorporated
PGY	Postgraduate year
PGY1	The first postgraduate year of training after medical school graduation (called intern year)
PGY2	Postgraduate Year 2; second postgraduate year immediately following intern year
PGY3	Postgraduate Year 3; third postgraduate year immediately following second postgraduate year
PMCNSW	Postgraduate Medical Council of New South Wales
PMCV	Postgraduate Medical Council of Victoria Incorporated
PTAC	Prevocational Training & Accreditation Committee, Western Australia

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Overview

Junior doctors work in supervised training positions and have a key role in Australian hospital-based healthcare delivery. The first *National Guidelines for Intern Training and Assessment* were published by the Australian Medical Council in 1996. Since then there have been considerable changes in both the processes and expectations for prevocational medical education, hospital training and professional development of junior doctors. There have also been changes in rates of movement of medical undergraduates and junior doctors between States within Australia. In response to recommendations by the Medical Training and Review Panel (MTRP), there are now Postgraduate Medical Councils (PMCs) in each State and a national body, the Confederation of Postgraduate Medical Education Councils (CPMEC) that play a key role coordinating, planning, resourcing and accrediting the training of intern and PGY2 doctors.

In 2001 an advisory committee with broad representation was set up under the auspices of the Confederation of Postgraduate Medical Education Councils to review and update the national guidelines for the training and assessment of junior doctors in their intern year (PGY1) and to develop general principles in relation to the second postgraduate year (PGY2).

Each State and Territory medical board has established intern training and assessment procedures and are guided by their respective legislation. These national guidelines are not intended to replace state-based programs or standards. Rather they are intended to provide general principles which may be considered to achieve the broad aims and objectives of the prevocational years. Each state and territory should use the guidelines as a framework for informing their processes and for identifying gaps in specific goals and objectives. The guidelines are informed by examples of best practice and experiences in each state.

These guidelines, including a range of resource documents, are available at the following website: http://www.health.gov.au/workforce/

A list of resource documents available at this website is listed in Appendix 2.

Nomenclature relating to prevocational trainees differs across states and territories and in these guidelines we interchangeably use the terms Postgraduate Year 1 (PGY1), Postgraduate Year 2 (PGY2) and Junior Medical Officer (JMO) to refer to prevocational trainees. A table developed by the Medical Training Review Panel explaining the nomenclature used in each state can be found at: http://www.health.gov.au/workforce/meducatr/mtrp/mtrp.htm

The development of these national guidelines comes from a commitment from the Confederation of Postgraduate Medical Education Councils (CPMEC), postgraduate medical councils (PMCs), the Medical Training Review Panel (MTRP), and the Australian Medical Council (AMC) to promote national standards, to share information on education, training and workforce issues of relevance to prevocational trainees, their supervisors and hospital managers and to facilitate interstate movements of trainees.

There were many organisations and individuals consulted in the review of these guidelines. This involvement through written submissions and consultation assisted the Advisory Committee in revising these guidelines. Ms Carol Jordon, Executive Officer, Postgraduate Medical Council of Victoria, supported the Advisory Committee in the final production of the guidelines.

National Advisory Committee

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"Some patients, though conscious that their condition is perilous, recover their health simply through their contentment with the goodness of the physician."

Hippocrates 460-400 B.C.

1.0 Organisations involved in prevocational medical education and training

1.1 National and State bodies

There are a number of national and state-based bodies concerned with the setting of standards for accreditation, education and training, professional development and workforce planning in relation to prevocational medical graduates in Australia. The Australian Medical Council (AMC) is a national standards body for basic medical education and training. It accredits the Australian and New Zealand medical schools and courses and specialist medical training programs, assesses overseas trained medical practitioners seeking to practice in Australia, advises State and Territory medical boards on uniform approaches to the registration of medical practitioners, and advises the Australian Health Ministers' Advisory Council on registration issues and on the recognition of medical specialties. There is comprehensive information about the role of the Australian Medical Council on their website: http://www.amc.org.au

The Medical Training Review Panel (MTRP) was established by the Commonwealth Government in December 1996 and first met in March 1997. Its primary function is to compile information on training opportunities for hospital medical officers and to monitor the impact of the provider number legislation. The main focus of the work of MTRP is to monitor the supply and demand for vocational training places. It is also charged with identifying and addressing the training needs of young Australian doctors affected by the provider number restrictions, namely those in their first two postgraduate years (PGY1 and PGY2), as well as non-vocationally trained Hospital Medical Officers in postgraduate year three (PGY3) and beyond. There is further information about the role of the Medical Training Review Panel on their website: http://www.health.gov.au/workforce/meducatr/mtrp/mtrp.htm

The Postgraduate Medical Councils (PMCs) in each State and Territory are responsible for supporting and developing the training requirements of practitioners in their early postgraduate years and hospital medical officers who are not in vocational training programs. The PMCs have a range of responsibilities, which vary between states and may include accreditation of PGY1 and PGY2 positions, allocation of junior medical staff to hospital positions, workforce planning, development of curriculum frameworks, evaluation of terms/rotations, provision of educational resources and promotion of educational and training programs. Website details for postgraduate medical councils are given below:

Postgraduate Medical Council of Victoria: http://www.pmcv.com.au
Postgraduate Medical Institute of Tasmania: http://www.healthsci.utas.edu.au/pgmit/pgmit.htm
Northern Territory Postgraduate Medical Council: http://www.ntpmc.org.au
Postgraduate Medical Council of New South Wales: http://www.medeserv.com.au/pmc/
Postgraduate Medical Education Foundation of Queensland: http://www.pmefq.com.au
Council for Early Postgraduate Training in South Australia: http://www.ceptsa.org.au
Prevocational Training and Accreditation Committee, Western Australia: http://www.ptac.org.au

The Confederation of Postgraduate Medical Education Councils (CPMEC) established in 1998, is a national body representing the State and Territory Postgraduate Medical Councils. It develops, monitors and evaluates postgraduate medical education from a national perspective. The CPMEC through its membership interacts with the Medical Training Review Panel, the Australian Medical Council, AMA (Doctors in Training), Australian Medical Students Association (AMSA), Committee of Presidents of the Medical Colleges (CPMC) and the Deans of the Medical Schools.

All State and Territory medical boards require medical graduates to undertake a year of supervised clinical training before they are registered unconditionally for practice. Each Council has a responsibility to their respective Medical Board, reporting to the Board on the adequacy of the intern programs in training hospitals. Contact details for medical boards in Australia are available at the Australian Medical Council website: http://www.amc.org.au/board.asp

2.0 Accreditation of Training Programs [i]

Each State and Territory that provides intern training should have in place an accreditation process for monitoring programs and training standards across its health services or networks. The aims of an accreditation process should be to ensure that all hospitals employing junior medical officers (JMOs) offer sufficient experience, education, training and supervision to enable the JMOs to meet the objectives of their training program.

In each State or Territory that provides training for prevocational trainees, there should be a designated authority for monitoring the standards of intern and PGY2 training; this may be the medical board or another body delegated with the responsibility such as a Postgraduate Medical Council. The accreditation process should involve periodic on-site assessment by professional and trained peer review teams. There should be provision for monitoring standards between the formal site visits.

State guidelines for prevocational training should be published and updated regularly to reflect changes in other phases of medical education and in medical practice. They should be consistent with these national guidelines.

State accreditation guidelines should include standards and criteria for the following:

- organisation and administration of the training and education program;
- structure and content of the training and education program;
- supervision of junior medical officers;
- assessment of junior medical officers;
- feedback from junior medical officers about their programs and supervisors; and
- procedures for ongoing evaluation of the training program.

The accreditation criteria must be sufficiently explicit for there to be a possibility of non-accreditation or of limited accreditation. Failure to satisfy the accreditation standards and a result of non-accreditation could lead to junior staff being relocated and to workforce issues for the institution, there should be opportunities for a hospital to address its deficiencies and to be re-evaluated for accreditation.

2.1 The Intern Year [ii]

The medical internship is primarily one of clinical apprenticeship and is principally based on inservice training across a range of supervised hospital posts that provide a broad base of experience and training. While it is a necessary condition for registration, completion of the intern year is insufficient preparation for independent practice of medicine.

Given the pivotal role of internship in the transition from basic medical education to vocational training, it is desirable that the intern year provides:

- a learning environment in which the intern is supported and supervised in the development of their professional values and identity;
- opportunities for an intern to consolidate and develop further the knowledge, skills and professional attitudes acquired during their undergraduate years;
- experience of a range of medical practices and advice in career options;
- assistance to the intern to develop a sound basis for life-long education;
- allocation to units where registrars and consultants have a demonstrated commitment to junior medical officer training;
- supervision by an experienced medical practitioner responsible for monitoring the progress of the intern;
- appropriate rostering and after hours supervision;
- sufficient contact between supervisors and interns to permit an adequate assessment of performance and to ensure early warning of the need for remediation; and
- supervisors with an outline of their responsibilities and regular feedback about their performance as supervisors.

2.2 The Postgraduate Year 2 (PGY2)

The second postgraduate year (PGY2) should not be viewed in isolation from the postgraduate year 1 (PGY1). PGY1 and PGY2 should provide continuous learning opportunities with PGY2 allowing for greater independence, flexibility in terms, encouragement to accept greater responsibility and to be an active participant in the learning process. The Medical Training Review Panel has highlighted the need for medical practitioners to have balanced and generalist orientation to their first two postgraduate years which will allow them to access vocational training offered by medical colleges.[iii]

It is essential that the internship and other prevocational training in the succeeding year provide a sound general basis from which specific vocational training may proceed. It is expected that those trainees who have made a choice regarding their ultimate vocational training program will have the opportunity during their PGY2 year to acquire limited experience in their chosen field, without compromising their own opportunity to consolidate their general clinical training or to change their vocational career choice. (see also Section 4.1- The Aims and Objectives of the first two postgraduate years).

Junior Medical Staff working in a Special Care Nursery
(Courtesy of Box Hill, a member of Eastern Health)

3.0 Roles and responsibilities of parties involved in medical education

3.1 The Junior Doctor

The junior doctor is a fundamental team member involved in: initial assessment of the patient, communication with the patient (or their legal guardian or 'person responsible'), communication with senior medical staff and other members of the team providing care to the patient and coordination and facilitation of diagnosis, management and discharge planning for the patient. Research skills and training are also a fundamental aspect to any professional career and should be a component of the JMOs' professional development.

There is an expectation that junior medical officers must conscientiously make time for educational activities. This may involve attending educational activities, or may involve making a particular effort to attend all clinical teaching opportunities; these activities may be offered within working hours or outside of rostered working hours. A commitment to life-long education and self-assessment should be developed through involvement in audit and peer review, journal clubs, attendance at programmed educational activities and use of the library, computers and other resources.

The success of prevocational training and any subsequent vocational training will depend on the junior doctors capacity for self-assessment and self-learning. There are a number of areas of educational opportunity which junior doctors should utilise to their benefit. [iv]

Increasing knowledge, skills and proficiency in patient management through: taking case histories; making physical examinations and establishing the diagnoses; planning patient management; managing patients with specific conditions; seeking feedback from patients; developing discharge plans for patients; comparing their patient management with those of their peers; accepting increasing responsibility during each term; reviewing relevant published literature; and informatics and computer literacy.

Addressing deficiencies in knowledge by: seeking assistance from registrars, consultants, colleagues, nursing staff and other health professionals; using other resources such as the library and critically evaluating the information received.

Monitoring own progress by: maintaining a self-assessment checklist or portfolio; and self-appraisal of level of empathy and tolerance, and of professional attitudes and philosophy.

Participating in educational activities by: attending educational sessions; giving presentations; and teaching others.

Participating in the assessment process by: meeting weekly with the supervisor to discuss progress and to receive constructive feedback on performance; discussing with the supervisor at half-term and end-of-term meetings; assessment of own progress; discussing the assessment form at end-of-term meetings, and participating in the evaluation of each completed term.

Learning to be an effective member of the health care team by: becoming familiar with hospital and ward procedures; developing communication skills; availing themselves of mentors when necessary; and utilising effective time management.

3.2 The Clinical Teacher

Clinical teachers play an integral role in the training and educational development of junior doctors. Clinical teachers should be expected to, among other things: [v]

- discuss the learning objectives of the term with the junior doctor at the start of term;
- supervise junior doctors;
- participate in the Postgraduate Clinical Education Program by providing on the job teaching appropriate to their clinical caseload in the hospital/community facility;
- assist junior doctors to develop study and research skills relating to particular patient presentations; and
- provide regular feedback on the junior doctor's performance during the term. This may include a mid-term formative appraisal and should include formal written assessment at the completion of each term.

Clinical teachers can assist to develop the clinical and good doctoring skills of Junior Medical Officers through:

- modelling good clinical practice, including the building and maintenance of professional relationships with patients and staff;
- promotion of individual responsibility for self-evaluation and development among junior doctors;
- assisting in the development and refinement of clinical skills and practice in accordance with the PGY1 and PGY2 curriculum and provide guidance in the day-to-day management of patients;
- provision of career guidance to junior doctors based on a critical assessment of their abilities, potential and professional goals; and
- encouragement of the development of critical abilities in the provision of health care in order to facilitate the cost-effective use of medical resources.

In conjunction with other members of the hospital staff (eg Term Supervisors, Medical Education Officers), they may also facilitate the orientation of the junior doctor into the new working environment upon commencement of a new term by providing an orientation to the facility, and access to relevant information.

3.3 The Registrar

Registrars usually have a responsibility for facilitating the teaching and learning experience of junior staff in hospitals. The registrar has a central role in this process, being the key team member with whom the JMO interacts. Hospitals should support and ensure appropriate training of registrars in order to fulfil this role. It is expected that registrars: [vi]

- provide junior medical officers with a comprehensive orientation at the beginning of the term/rotation.
- be enthusiastic in their role as teachers and instructors;
- give informal teaching on ward rounds and during acute admitting days;
- provide appropriate verbal feedback throughout the term/rotation;
- understand their responsibilities for supervision of junior medical officers clinical work, procedural skills development, test ordering and interpretation, reports and discharge summaries;
- identify aspects of poor performance early to the appropriate supervisor;
- encourage and actively assist junior doctors to attend education sessions regardless of other commitments;
- encourage active participation of junior medical officers in ward rounds, continuing medical education activities, departmental meetings, X-ray sessions and the like;
- encourage junior medical officers to attend outpatient clinics, laboratories and theatres; and help make these good learning opportunities; and
- encourage junior medical officers to share duties so that they can leave the ward at designated times for educational experience.

3.4 The Employer Hospital [vii]

It is expected that each hospital employing prevocational doctors demonstrate a commitment to their development through the provision of appropriate administrative and organisational support and infrastructure. This should include providing an orientation program in paid time for junior doctors at the commencement of their employment.

The orientation program should be organised by the primary allocation or parent hospital. In the case of interns, this orientation program will be conducted at the beginning of each year or as part of the trainee internship. In the case of PGY2 doctors, an orientation program will be conducted at the commencement of their employment.

It is expected that secondment or rotation hospitals will provide a general hospital orientation in conjunction with the specific term orientation to junior doctors at the commencement of their secondment or rotation.

Hospitals should provide documentation that will include at least the following components: [viii]

- an outline of the Postgraduate Clinical Education Program relevant to their level, including the role of the key educational staff (see also Section 4.5 – Postgraduate Clinical Education Program);
- information on the hospital's organisational structure and lines of communication;
- a statement of the general clinical duties of junior doctors and the standard of clinical duties required;
- a statement of the learning responsibilities of junior doctors eg to attend educational programs on a regular basis and to participate actively in seeking learning opportunities;
- a statement of the assessment procedures to be used in the Postgraduate Clinical Education Program;
- personnel issues, including information about employment and award conditions, leave procedures, salaries, medical indemnity; professional associations;
- personal support procedures or mechanisms; and
- other policies and procedures of relevance to the junior doctors.

Effective communication is an essential component of all junior medical staff jobs. It is the responsibility of all junior medical staff to ensure effective handover of patients (day-night handover). Guidelines for effective patient handover can be viewed at the following website:
http://www.rcplondon.ac.uk/pubs/handbook/gpt/gpt_handbook_app4.htm

3.5 Postgraduate Clinical Training Committee
It is expected that a body such as a Postgraduate Clinical Training Committee will be established in each hospital with junior medical staff to organise, develop and monitor the postgraduate education and training program. Membership of this body should include representatives of junior medical staff, administration and clinical teachers.

3.6 Director of Clinical Training [ix]
Each institution should have a director or supervisor of clinical training who has both a clinical and educational role. A Director of Clinical Training (DCT), appointed and supported by adequate resourcing by a hospital, is responsible for developing, coordinating and promoting the clinical training of junior medical officers. The Director of Clinical Training works in association with those personnel involved in the management of junior medical staff, and the Postgraduate Clinical Training Committee. The Director of Clinical Training should have clear authority to fulfil the educational and administrative responsibilities for the prevocational training program. The DCT plays a major role in the planning, delivery and evaluation of JMO education, and should provide counselling on career options and professional development. They can also facilitate feedback to JMOs about their performance; and

liaison with Term Supervisors regarding JMO issues. They also have an important role as an advocate for JMOs by interacting with hospital management and administration and as such should not participate in the assessment of the JMOs. The DCT has a pastoral role and helps identify junior doctors with special needs and ensures that effective systems of support are implemented.

3.7 Term Supervisor [x]
Junior medical officers are expected to be under the supervision of the Term Supervisor who is responsible for ensuring the adequacy and effectiveness of supervision and support for the JMO to function safely within the term. Term or unit supervisors have a responsibility for ensuring that junior medical staff are provided with an orientation to each unit or term, discuss with the JMO the skills, knowledge and experience to be gained during the term, ensure that there is appropriate supervision and support, and to provide formal and informal assessment and feedback during the term.
(see also Section 6 - Supervision, Assessment and Feedback].

3.8 Medical Education Officer
In those States that employ Medical Education Officers (MEOs) their role is to facilitate the continuing education of prevocational doctors. They work with Senior Medical Staff responsible for the supervision and education of prevocational medical staff to maximise and promote teaching and learning for this group. The role of the MEO is unique to each setting and responsive to the needs of that setting. In Victoria, a MEO works in the office of the Postgraduate Medical Council providing educational support to the hospital-based Medical Education Officers and policy support to Council members, in particular, to the Education subcommittee.

3.9 Other doctors, health care professionals and the Government [xi]
All doctors on a team to which JMOs are attached, should provide a good example of the professional attitudes expected of a doctor. The interest and commitment of consultants and members of the medical team are critical to the creation of high quality JMO posts. Every consultant and registrar in the team shares educational responsibility for: teaching and guiding JMOs, providing feedback on clinical progress and the welfare of JMOs. Other doctors in the team may also share these responsibilities and should take an interest in the progress of junior medical officers. All members of the medical team should discuss areas of concern with JMOs and, if problems persist, should alert educational supervisors to any deficiencies in performance. The views of nurses and other health care professionals about the clinical progress being made by junior medical officers will be particularly valuable to trainees and their educational supervisors. Other health care professionals may also have particular skills to impart to junior medical staff, and such inter-professional educational and learning opportunities should be encouraged. Constructive feedback should be discussed with trainees and educational supervisors should be alerted whenever there are significant deficiencies or problem areas identified (see also Section 7.3 – Personal Health).

Health authorities are responsible for identifying the health needs of the local population and for developing a strategy to meet these needs. Health authorities should bear in mind the pivotal contribution which medical staff, particularly JMOs, make to the attainment of their health care goals. In relation to prevocational training, high standards of clinical service, educational facilities and organisational support are required to form the basis of high quality training. Trainees are recognised as a valued resource and should have access to good support systems and facilities.

4.0 Education and Professional Development

4.1 Aims and objectives of the first two postgraduate years

Many of the challenges for JMO training lie in the clarification of the key skills, knowledge and procedures required for the first two years of clinical training. It is imperative that all hospitals and medical educators demonstrate a commitment to the development of junior medical officers. This can be demonstrated by ensuring that: [xii]

- there are policies and programs in place that demonstrate a commitment to learning;
- the hospital has a suitably trained and supported Director of Clinical Training;
- Junior medical officers are actively encouraged to assume responsibility commensurate with their own personal skills and experience;
- Junior medical officers are actively encouraged to develop their own personal and professional education and develop a sound basis for life-long and continuing medical education;
- Junior medical officers have access to confidential counselling and career advice; and
- educational programs are coordinated between the allocation or parent hospital and secondment or rotation hospital.

The first two postgraduate years should be viewed at a national level as a period in which all medical graduates gain appropriate knowledge, attitudes and skills, which will equip them to proceed to general, or specialist vocational training. Emphasis should be placed on practical experience so that competence is attained through caring for patients who have a broad range of medical and surgical conditions. In particular, therapeutic and procedural skills need to be developed under appropriate supervision. Teaching needs to be linked to, but not totally dependent upon, the service requirements of internship and residency. Much of the junior medical officers' learning will occur at the bedside; hence they need to feel comfortable in seeking guidance from their senior colleagues.

By the end of the first two years of postgraduate training, the JMO should be able to demonstrate: [xiii]

- honesty, integrity and reliability in dealings with patients and colleagues alike;
- adequate knowledge of basic and clinical sciences, and application of this knowledge to the care of patients with a broad range of common and important medical and surgical conditions;
- appropriate clinical skills, including history taking and physical examination, to permit sufficient definition of the patient's problems in order to make a provisional diagnosis and formulate an appropriate plan of investigation and the ability to interpret commonly used investigations and tests;
- the ability to organise, synthesise and act on information gained from the patient and other sources so as to exhibit sound clinical judgement and decision-making;
- the ability to use information technology to access key information, clinical practice guidelines and evidence based medicine;
- the ability to act effectively in emergency situations;
- an understanding of preventive care and the importance of modification of risk factors and life style in plans of management for patients and their families;
- the ability to perform simple procedures competently, understanding the indications for, and risks of the procedures undertaken;
- the ability to work effectively within a team of health care personnel, including other doctors, nurses, allied health professionals and undergraduate students;
- effective time management;
- a commitment to self assessment and continuing medical education and an ability to locate and critically appraise biomedical literature relevant to everyday clinical practice; and
- a willingness to be involved in teaching of others, including undergraduate medical students, nurses and allied health professionals.

Suturing Workshop for interns
(Courtesy of Royal Melbourne Hospital, a member of Melbourne Health)

4.2 Consolidation of communication and counselling skills [xiv]
Communication and counselling are best practiced and consolidated after graduation when the JMO assumes responsibility for patient care. Issues such as bereavement, modification of life style, and care of the elderly require effective communication with patients, their families and other health care personnel. By the end of the first two years of postgraduate training, the JMO should be able to demonstrate:

- an ability to communicate effectively with patients and their families using techniques that have been shown to affect outcome in terms of reduction of patient anxiety and apprehension, risk factor modification and compliance with medication;
- an ability to counsel patients and their families, particularly with respect to prognoses of death, dying and disability; and
- ability to work effectively within a team of health care personnel, to contribute appropriate knowledge and expertise and to value the contributions of other team members.

4.3 Use of diagnostic and consultant services with increasing discrimination [xv]
Clinical practice is becoming increasingly complex. Technological development has led to a widening array of options for investigation and effective therapy of patients yet increasing pressure is being brought to bear on health care personnel to take responsibility for the provision of cost-effective services. Issues of resource allocation and utilisation are likely to have an even greater impact on clinical practice in the future. By the end of the first two years of postgraduate training the JMO should be able to demonstrate:

- a commitment to critical appraisal, quality assurance and peer review;
- an understanding of the use of common investigations, including knowledge of how diagnostic test characteristics influence the selection of investigations and interpretation of their results;
- the ability to seek expert consultation thoughtfully, having first, under appropriate supervision, appraised the clinical situation and initiated appropriate investigation and management; and
- responsibility for their actions in human and economic terms so as to achieve the desired clinical outcome for the patient to the lowest cost to the community.

4.4 Formal education [xvi]
Junior medical staff must be provided with appropriate formal education opportunities which are relevant to their needs, and to clinical needs of the hospital, and based on adult learning principles. Each hospital should:

- provide structured education programs specifically for PGY1/2;
- provide education programs that are accessible to junior medical staff and are ‘protected’ from excessive intrusions from clinical responsibilities;

- ensure a program that has a focus on clinical skills acquisition;
- ensure that junior medical officers have access to appropriate facilities and educational resources to support and maintain self-learning activities (such as internet access at work); and
- ensure that education programs are evaluated to meet the needs of junior medical staff.

It is also necessary within a best learning environment and educational framework that:

- education sessions are interactive and not unduly didactic;
- immediate written evaluation forms are completed at the completion of the teaching session (these should be consolidated by a third person and fed back to the presenter);
- specific sessions for PGY1s emphasise clinical problems of direct relevance to their daily work and seek to consolidate and expand their student learning; and
- education sessions for PGY2s provide exposure to different disciplines which reflect their long term career goals.

Wherever possible, educational sessions should take place within rostered hours, with formal teaching sessions of about 3 hours per week for PGY1s and, for PGY2s, at least 1-2 hours per week. These sessions should be specifically designed to meet the needs of PGY1s and, to a lesser extent, of PGY2s. It is important that there is a clear expectation that the PGY1/2 will attend and arrangements are made to minimise interruptions eg formal ward rounds are not scheduled and wards know that trainees should be paged only for urgent problems. During the specific teaching sessions it is desirable that arrangements be made for someone else to hold the trainee's beeper and the trainee is disturbed only for emergencies and not for routine calls initiated by relatively junior staff.

Valuable learning opportunities exist outside the structured training sessions. These teaching sessions for PGY1 and 2 may include: [xvii]

- discussion of particular clinical problems demonstrated by patients on the ward with active participation by the PGY1 or PGY2 either before or after a ward round;
- Department or unit meetings where the PGY1/2 presents patients and Grand Rounds or other division or hospital-wide educational activity;
- Radiology and/or pathology demonstrations;
- Mortality and morbidity audits; and
- Clinical skills sessions.

4.5 Postgraduate Clinical Education Program

It is expected that a hospital will provide and maintain a satisfactory Postgraduate Clinical Education Program. The principles of a Clinical Education Program include: [xviii]

- an integrated approach to training in the first two years, encompassing clinical experience, on-the-job training and formal education;
- a focus on specific term objectives for the relevant level of training;
- provision of junior doctors with terms of appropriate length, quality and content, as well as adequate levels of supervision and education sessions;
- core terms of surgery, medicine and emergency medicine during PGY1;
- offer further experience in the PGY2 year, for example in adult or paediatric medicine, emergency/critical care medicine, surgery and rural/community medicine;
- development of a collaborative approach between the primary allocation/parent and secondment/rotation hospitals to ensure that the learning opportunities available for junior doctors are accessible and effectively integrated; and
- preparation for junior doctors for practice in a wide variety of settings, for example, both urban and rural settings.

5.0 Skills Acquisition, Proficiency and Rotations

The skills and knowledge that JMOs could be expected to learn during their first two postgraduate years vary according to hospital, supervisors and training terms. Curriculum frameworks and a Clinical Training Portfolio have been developed which can assist Directors of Postgraduate Medical Education, Unit Heads and Directors of Clinical Training to identify clinical and procedural skills to discuss with junior medical officers in developing their learning objectives to be achieved during a term or rotation. The learning objectives within the curriculum framework covers areas including: procedural skills, emergency care, first line management of common primary presentations, patient assessment skills, professional skills, preventive care skills, communication skills and professional development. The curriculum framework can be viewed at: http://www.pmefq.com.au.

It is important that educators regularly evaluate clinical skills to take into account emerging themes in medicine. This may include:

- genetics (such as genetics as a screening tool vs genetics in selected families or ethical implications and insurance implications);
- patient safety (computer assisted prescribing, correct management of drug reactions);ethics and privacy (attention to the ethics and privacy of computer records/ databases);
- antibiotic resistant bacteria (hand washing skills); and
- infectious diseases.

5.1 Term Rotations

Each term should have clearly articulated educational objectives with the opportunity for any additional objectives to be negotiated between the JMO and the supervisor. A mix of terms, both core and non-core, should reflect the educational objectives of the PGY1 or PGY2 program, should provide for meeting the appropriate medical registration requirements and meet the interests of the prevocational doctor.

The internship and early years of residency should provide the junior medical officer with sufficient opportunities in clinical practice to enable meaningful decisions to be made regarding career choice and vocational training. Exposure to paediatrics, obstetrics, liaison psychiatry, general practice and other community based experience, and anaesthesia and intensive care is highly desirable to supplement the core experience in general medicine, surgery and emergency medicine. Hospitals and other training organisations should endeavour to improve JMO education and training by encouraging active participation of attending medical officers in educational programs, including bedside teaching. Career counselling regarding career choice and other matters should be available through term supervisors and the Director of Clinical Training.

Although registration is conferred at the end of the intern year, many medical graduates in their second postgraduate year remain within the network of hospitals to which they have been allocated as interns. This potentially allows a hospital sufficient time to develop comprehensive term rotations and broad educational programs.

5.2 Community and Rural rotations

The Medical Training Review Panel has recommended that junior medical officers be exposed to at least one rural and/or community based term. [xix] Such terms enable junior doctors to broaden their experience and gain a greater understanding of how the health system operates outside large metropolitan teaching hospitals. Some of the identified aims of rural and community terms include:[xx]

- an appreciation of the resources available in rural, district and referral health services, to maximise their efficient use of resources;
- opportunity to care for patients primarily in outpatient, ambulatory care or community settings, many of whom live with chronic illness;
- attainment of skills in the assessment of patients' health status and care needs and their implementation in a community context;
- development of an understanding of the responsibility of providing continuing care through practical experience;
- assessment and treatment of the acutely ill patient in the home;
- management of illness within a network of community-based health care professionals and services.

The wider clinical and health service experience offered by rural and community terms provides the necessary patient focus to contribute to the well-rounded, generalist orientation that characterises the first two years of postgraduate training.

A copy of a report, *Rural and Community Terms for Junior Doctors in Australia- A National Review* can be viewed at: http://www.health.gov.au/workforce/pdf.report.pdf

6.0 Supervision, Assessment and Feedback

6.1 Supervision

Supervision in the prevocational years should allow for graded opportunities for independent decision-making. The proximity of supervision required in each work situation is predetermined by: the hospital setting, type of term, and experience and skill level of the junior medical officer. It is important that the hospitals provide junior medical officers with adequate and appropriate supervision and encourages JMOs to ensure that they are adequately supervised according to the limitations of their knowledge and experience. Providing opportunities and supporting the training of supervisors is also very important to the educational and professional development process.

Junior medical officers are expected to be under the supervision of a Term Supervisor who is responsible for ensuring the adequacy and effectiveness of supervision within normal operations. All doctors providing supervision to JMOs should be made known to them. The process for contacting these supervisors must be clear to all involved. Greater supervision is required in PGY1. There should be relatively less direct supervision and more clinical responsibility in PGY2, preferably with greater exposure to sub-specialty terms.

Supervision should be provided as follows: [xxi]

- During the first week of the junior doctor's attachment, the clinical teacher/mentor will discuss with the junior doctor their role and responsibilities in the Unit(s) or facility, and highlight the responsibility of the junior doctor to be pro-active in their learning;
- Hospitals should provide direct supervision of PGY1 doctors by a registrar or other suitably experienced medical practitioner at all times. In hospitals where a registrar or equivalent is not employed, attending medical officers must be available at short notice for the supervision of junior medical officers;
- Direct supervision may not be required for PGY2 doctors but their supervisors must be readily available;
- The position description for all staff responsible for supervising JMOs clarifies their role and responsibilities for supervision;
- Each clinical teacher/mentor should ensure that their contact with each junior doctor is sufficient to permit a valid assessment of the junior doctor's performance by *direct* observation;
- Supervision of junior doctors should allow for increasing opportunities for independent decision-making; and
- The adequacy and effectiveness of JMO supervision is evaluated.

6.2 Assessment

Hospitals are required to facilitate regular assessments of junior doctors. A range of individuals should contribute to the assessment and feedback process including consultants, registrars, nursing staff and other health professionals. Assessment in each term/rotation should be: [xxii]

- the responsibility of the assigned clinical supervisor in conjunction with other unit staff (medical, nursing and allied health);
- a valid, reliable process explained to junior doctors at the commencement of each term as required;
- based on observations of the junior doctor's performance; inclusive of a mid-term formative assessment process for all terms greater than 5 weeks;
- continuous, both on a formal and informal basis, leading to a written report from the clinical teacher to the Medical Superintendent via the Supervisor of Intern Training or Director of Clinical Training at the end of each term;
- a transparent process which includes opportunity for both self-assessment and access to the supervisor's report by junior doctors; and
- accompanied by ongoing feedback and guidance from the supervisor.

Each hospital should have a mechanism in place that clearly explains the criteria, process and timing of assessment and feedback to junior medical staff, which must be known to the junior doctor.

6.3 Feedback

Provision of continuous feedback to junior medical staff is fundamental. Hospitals should clearly explain the criteria, process and timing of assessment and feedback to JMOs at the commencement of each term. There should be opportunity for both formal and informal assessment and both mid-term and end-of-term feedback.

JMOs are encouraged to take responsibility for their own performance, and to seek feedback from their supervisors in relation to improving their performance. It is very important that the progress of the junior medical officer is monitored, and that Supervisors and Directors of Clinical Training and junior medical officers themselves consult with Term Supervisors regarding individual performance where appropriate.

6.4 Unsatisfactory performance [xxiii]

The routine monitoring and evaluation of the progress of junior medical staff by each hospital and across the network is critical. Where problems are identified, or there is unsatisfactory performance, including remediation and reassessment, the procedure for supervision and counseling must be explicit and must be known to the JMO. The hospital needs to maintain the confidentiality of the JMO receiving personal support. The hospital also needs to balance the privacy of the junior medical officer with the need to engage additional support to ensure patient safety.

7.0 Welfare of junior medical staff

7.1 Safe working hours [xxiv]

Safe working hours influence the way doctors practice. Traditionally, non-specialist doctors, including residents and interns, registrars and career medical officers, employed in a hospital environment have worked long hours usually in shifts. The resulting fatigue restricts performance, and its effects are well documented. Concentration, data processing and short-term memory are impaired, variability of performance increases and decision-making is erratic. Inevitably, tired doctors make errors, fail to spend adequate time with patients, fail to communicate effectively with them and neglect to complete appropriate case notes.

Of note, fatigue is not available in law as a defence for negligence by a doctor in a legal action by a patient (Nocera and Strange Khursandi, 1998). There are therefore safety and quality, humanitarian and legal reasons to limit excessive hours, which in recent times have been recognised in other nations and other industries in Australia. View details of the Australian Medical Association Safe Hours Project, which seeks to raise awareness of the problems and risks associated with hours of work of junior hospital doctors at the following website:
http://domino.ama.com.au/AMAWeb/IRRemun.nsf/Work+Life+Flexibility [xxv]

Mid-term feedback meeting between a Registrar and Intern, Registrar "Train the Trainer Program"
(Courtesy of Austin Health)

7.2 Junior Medical Officer Management [xxvi]

Hospitals need to provide effective organisational structures for the management of junior medical staff. Policies and procedures for the management of grievances need to be documented and freely available to junior medical staff. Hospitals and the relevant staff need to comply with occupational health and safety obligations. In supporting junior medical officers, hospitals should encourage their junior medical staff to take responsibility for their self-care and provide access to personal support mechanisms to ensure their well being. For junior medical officers with special needs, it is essential that hospitals identify and support JMOs with special needs. A hospital should provide an accessible, safe and comfortable recreational area with a range of amenities (such as residents lounge for on call shifts, study area and computer resource room) to support the well being of all junior medical officers.

7.3 Personal health

Medicine can be a stressful experience and counselling and support services should be readily available. Peer support and opportunities for junior doctors to share their experiences are of fundamental importance. Junior doctors should have their own general practitioner to help them stay healthy. Junior medical officers with a health problem should consult their general practitioner first. Junior medical officers with professional and personal problems should consult their Supervisor or Director of Clinical Training for advice.

Medical boards have established processes for the assessment, reporting and rehabilitation of doctors whose health has impaired, or may impair, their ability to practice medicine.

The Confederation of Postgraduate Medical Education Councils conducted a Symposium in July 2001, "The Student and Junior Doctor in Distress". The proceedings of this Symposium have been published as a supplement to the *Medical Journal of Australia*, Vol.177, 1 July, 2002 and can be viewed at the following website: http://www.mja.com.au/public/information/supplements.html

8.0 Selection and retention of junior medical staff

8.1 Principles of selection and appointment [xxvii]
The process for selecting and appointing junior medical officers to training programs and posts should be open and systematic. It must be free from discrimination and comply with equal opportunity legislation. This can be facilitated by providing selectors with advice on anti-discrimination and equal opportunity legislation.

Wherever possible:

- Training opportunities should be advertised and appointments made on the basis of open competition;
- Job descriptions, including person specifications and selection criteria, should be available when training programs or posts are advertised;
- The service commitments and educational opportunities of training programs and posts should be made explicit in job descriptions;
- Standardised open references should be used;
- Those involved in selection and appointment should receive training in interviewing techniques;
- Selection should include a process of short-listing that involves all who expect to interview candidates;
- Interviews should follow a consistent, structured pattern using standardised questions that give all candidates the opportunity to demonstrate their suitability for the program or post;
- A record should be kept of each interview;
- Candidates should be told at interview how and when they will be informed of the selection panel's decision; and
- Unsuccessful candidates should be given the opportunity to receive professional feedback following interviews.

8.2 Flexible training options
Flexibility at work is becoming increasingly a factor to be considered in the medical workforce due to technology, gloabalisation, social changes and expectations. There is increasing recognition of the importance of balancing life and work, of balancing the needs of both the employers and employees. Hospitals are encouraged to think about ways of developing more flexible family-friendly work arrangements, which could be achieved through rostering, job-share, part-time work or flexible work hours. (see also Section 8.3 – Retention of Junior Medical Staff)

The Australian Medical Association's publications and research on work life flexibility can be viewed at: http://www.domino.ama.com.au/AMAWeb/IRRemun.nsf/Work+Life+Flexibility

Until recently internship has generally been regarded as a full-time experience but Medical Boards and State postgraduate medical councils recognise the desire of some graduates to complete their intern year on a part-time basis. Such placements can only be achieved after careful negotiation between individual interns and the relevant hospital. The Confederation of Postgraduate Medical Education Councils has developed broad principles to guide the States and Territories in consideration of individual requests for the completion of internship on a part-time basis. These principles are:

- Each instance must be documented and approved by the relevant hospital and reported to the appropriate State/Territory Medical Board;
- Requirements for internship must be completed within two years from the date of commencement with the equivalent of 48 weeks intern experience;
- The intern must be able to participate in training activities for at least 50% of a full-time trainee (ie a minimum of 20 hours per week)
- The intern must participate in pro-rata educational activities;
- The intern must participate in pro-rata out of hours work;
- In general, part-time internship should be conducted in partnership with another intern and share rosters.

There are some specific requirements established by Medical Boards in some states and prospective interns seeking part-time internship should check these requirements.

In all cases, part-time training must be of the same quality and equivalent duration as full-time training and normally requires negotiation with the employing hospital.

8.3 Retention of junior medical staff [xxviii]
JMO training places great demands upon junior doctors and can be a very challenging period. The Federal and State Health departments, the Postgraduate Medical Councils, colleges, universities and hospitals need to explore ways of retaining the commitment of trainees to medicine. Wherever possible, training programs should be tailored to meet the needs of individual trainees. Trainees should be provided with career guidance, which will assist their personal and professional development. Such guidance is particularly important for trainees who have fulfilled the aims of JMO training and are waiting in anticipation to begin higher specialist training. Practical steps, which could be taken to make training less rigid, include:

- Introducing working patterns, which are compatible with outside commitments, for example flexible training and opportunities for career breaks (e.g. Parental leave for men and women) or when training on a full-time basis is not practical (eg family or personal responsibilities);
- Encouraging junior doctors to gain a breadth of experience beneficial to their professional and personal development, for example by working in a cognate specialty that complements their intended career;
- Establishing systems that allow junior medical officers to gain experience overseas as part of their training; and

- Developing training schemes that help junior medical staff to keep their knowledge and skills up to date during career breaks, or help them to return to work following a career break (including part time training, appropriate child care, breastfeeding facilities, career/ College training support).

9.0 Ethical and legal issues relating to medical practice

Junior medical officers are accountable for their actions and have legal responsibilities in areas such as medical record keeping and the issuing of medical certificates. Informed consent and confidentiality, issues discussed in medical school, must now be dealt with in daily practice. Administrative competence must also be gained and time must be managed effectively and efficiently. Critical review of medical records by senior staff is essential and should be sought by the JMO. By the end of the first two years of postgraduate training the junior medical officer should be able to demonstrate: [xxix]

- an awareness of the important ethical principles (such as patient confidentiality) that govern clinical practice and an ability to work within that framework;
- competence in medical record keeping by maintaining clear, complete, concise and accurate records on each patient under his or her care;
- knowledge of pertinent areas of law relating to the practice of medicine eg the relevant State and Territory Medical Board Act(s) as amended;
- the ability to manage time effectively and efficiently; and
- the ability to follow correctly the administrative policies and procedures of the institution in which he or she works.

10.0 Overseas trained doctors

This section deals principally with doctors who trained and qualified outside Australia. Overseas trained doctors seeking to practice medicine in Australia should contact the Australian Medical Council or their relevant state medical board. The Australian Medical Council website including contact details for medical boards in Australia can be viewed at: http://www.amc.org.au/.

10.1 The Australian Medical Council process

The Australian Medical Council administers the national examinations of overseas trained medical practitioners seeking to practise medicine in Australia. The AMC examinations are designed to assess, for registration purposes, the medical knowledge and clinical skills of overseas trained doctors whose basic medical qualifications are not recognised by State and Territory Medical Boards; that is, doctors trained in medical schools that have not been formally reviewed and accredited by the Australian Medical Council.

The standard of the AMC examinations is defined as the level of attainment of medical knowledge, clinical skills and attitudes required of newly qualified graduates of Australian medical schools who are about to commence intern training.

10.2 Guidance for overseas trained doctors who wish to train in Australia [xxx]

Overseas trained doctors make a valuable contribution to the health workforce in Australia. Those seeking to undertake part of their training in Australia should be:

- provided with clear, up to date and comprehensive information about working and training opportunities in Australia;
- provided with comprehensive information about the types of registration available to them in Australia;
- encouraged to develop their educational objectives before applying to train in Australia; and
- access to contact details to those individuals and organisations, both locally and nationally, who are able to help and advise them.

Overseas trained doctors will also require additional careers and training advice tailored to their particular needs, together with support while working in an environment, which may be quite different to what they have previously encountered. Hospitals, in collaboration with the Australian Medical Council should ensure that the induction programs of overseas trained doctors new to Australia provide:

- an orientation to the system they are to work in;
- opportunities to develop their communication skills, including English language skills needed to work with peers and supervisors and to communicate with patients and other staff; and
- an introduction to the principles of professional practice set out by the Australian Medical Association, Australian Medical Council and the Confederation of Postgraduate Medical Education Councils and medical boards.

11.0 Monitoring and evaluation [xxxi]

The monitoring and evaluation of training and assessment processes for junior medical officers can be best achieved in an integrated way through cooperative endeavours between junior medical staff, their hospitals, and the various state and national organisations involved in prevocational education and training. Each state and territory postgraduate medical council has a key role in accreditation of training positions, surveillance and promotion of educational programs, workforce planning and research. Each PMC needs to ensure equity of access to quality training programs, continual development of programs, evaluation and research into their efficacy.

Personnel involved in development and delivery of education and training programs, including junior medical staff, are encouraged to be active participants in committees, planning groups and to attend workshops and conferences at the state and national level.

State and Federal Departments of Health are expected to provide adequate funding to support the education and training needs of junior doctors.

11.1 Monitoring [xxxii]

These guidelines contain an outline of the general principles which may be considered to achieve the broad aims and objectives of the prevocational years. Each state or territory postgraduate medical council and/or individual hospital can use this framework as a basis for identifying more specific goals and standards to suit their local circumstances.

There may be variation in the importance which each state and territory PMC and hospital attaches to the different elements of training, and many of the gaols and standards selected may be context-specific. For example, future opportunities for junior doctors to gain experience in a community or rural setting will lead to changes in their clinical experience. Reform of work practices may lead junior medical doctors to gain more or less experience in carrying out certain procedures. The monitoring focus may concentrate on some of these changes in order to ensure that they are practical, useful and acceptable. Where there is evidence that such changes are valued, careful monitoring can help to maintain them.

Once of the specific goals and standards have been decided upon, a variety of approaches can be taken to the collection of information concerning the success of training programs:

- Evidence from accreditation surveys that training hospitals are providing high quality programs;
- Evidence that junior doctors are achieving agreed levels of competence as measured by supervisor's structured feedback;
- Feedback from junior doctors about the quality of their experience. (The collection of such feedback provides an excellent opportunity for monitoring across the states);
- Feedback from directors/supervisors of clinical training;
- Feedback from medical administrators concerning the training-service balance and workforce issues; and

- Evidence that junior doctors experiencing difficulties are being recognised and assisted in a timely and effective way.

Each State and Territory is encouraged to prepare an annual report on their training program as a means of reviewing the program and ensuring continuous improvement.

States are strongly encouraged to develop and use instruments which have established validity and reliability to assist in evaluating the success of the training programs. Examples are junior doctor assessment forms and surveys on the quality of the education programs, and on the term/rotation experience. There has been developmental work in many of these areas in several States.

At the national level the Confederation of Postgraduate Medical Education Councils has a role to ensure monitoring of the quality of the prevocational training programs, to identify key national issues and foster information sharing and education research.

11.2 Evaluation [xxxiii]

Annual reporting by each State and Territory postgraduate medical council as recommended above would allow each state PMC to document their success and learn from the experiences of others.

A reasonable match between graduating numbers and appropriate training opportunities in clinical service positions at a national level is a worthwhile goal. While individual States or Territories may be faced with a mismatch between graduate numbers and available positions, a national goal must be to provide the best available training in the right number of positions. Another matter of special interest is the retention rates for junior doctors during the first two years after graduation and each State and Territory should ensure appropriate systems exist to monitor and report to relevant State and Commonwealth agencies on the reasons why junior medical staff are remaining within, moving between or leaving the healthcare system.

Flexible training and opportunity for part-time completion of prevocational training or job sharing is an emerging issue to which States and Territories are encouraged to respond. Monitoring changes to work practices is also important in this regard.

Each State and Territory, through the Confederation of Postgraduate Medical Education Councils, and the Australian Medical Council could collaborate to develop instruments, to collect, at regular intervals, feedback from junior doctors, directors/supervisors of clinical training, clinical supervisors, training colleges and medical administrators.

This form of evaluation could provide useful information to be used by each State and Territory in setting its own goals and standards. It has been suggested that patient outcomes could be included in such a list (for example patient satisfaction with junior doctors working in new training settings).

An approach to identifying and assisting junior colleagues in difficulty, without threatening their professional development and career choice is an important outcome measure. This is a complex area, where interstate communication on successful initiatives would be invaluable.

The Advisory Committee for the National Guidelines for Junior Medical Officer Training and Assessment.

9 January 2003

References

i The following section has been adapted from the “National Guidelines for Intern Training and Assessment,” Australian Medical Council, November 1996, pp 14-15

ii The following section has been adapted from the “National Guidelines for Intern Training and Assessment,” Australian Medical Council, November 1996, pp 8-12.

iii Medical Training Review Panel, Second Report, November 1998, p.38

iv The following section has been adapted from the “National Guidelines for Intern Training and Assessment,” Australian Medical Council, November 1996, pp 12-13.

v The following section has been adapted from the “Accreditation Standards for Junior Doctor Education PGY 1 and 2”, Postgraduate Medical Education Committee, Queensland, 2001, pp 14-15.

vi The following section has been adapted from “Education, Training and Supervision for New Doctors", Medical Council of New Zealand, November 2001, p.47.

vii The following section has been adapted from the “Accreditation Standards for Junior Doctor Education PGY 1 and 2”, Postgraduate Medical Education Committee, Queensland, 2001, pp 16-17.

viii The following section has been adapted from the WA Accreditation Guide, Prevocational Training and Accreditation Committee, Draft, 6, June 2001 and the “Accreditation Standards for Junior Doctor Education PGY 1 and 2”, Postgraduate Medical Education Committee, Queensland, 2001.

ix The following section has been adapted from the “Standards for Junior Medical Officer Education and Supervision”, Postgraduate Medical Council of New South Wales, Fourth Edition, 2002.

x The following section has been adapted from the “Standards for Junior Medical Officer Education and Supervision”, Postgraduate Medical Council of New South Wales, Fourth Edition, 2002.

xi The following section has been adapted from a publication by the General Medical Education Council, UK, “The New Doctor”, April 1997, pp 35-36.

xii The following section has been adapted from “A Guide for Interns”, a joint publication of the Postgraduate Medical Council of Victoria and the Medical Practitioners Board of Victoria, December 2001, p.5.

xiii The following section has been adapted from the WA Accreditation Guide, Appendix B, Prevocational Training and Accreditation Committee, Draft 6, June 2001.

xiv The following section has been adapted from the WA Accreditation Guide, Appendix B, Prevocational Training and Accreditation Committee, Draft 6, June 2001.

xv The following section has been adapted from the WA Accreditation Guide, Appendix B, Prevocational Training and Accreditation Committee, Draft 6, June 2001.

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xvii The following section has been adapted from the publication by the General Medical Council, UK, “The New Doctor”, April 1997, p.40.

xviii The following section has been adapted from the “Accreditation Standards for Junior Doctor Education PGY 1 and 2”, Postgraduate Medical Education Committee, Queensland, 2001.

xix Medical Training Review Panel, Third Report, August 1999, p.36

xx “Community and Rural Terms for Junior Doctors in Australia”, produced by the Postgraduate Medical Council of NSW, Funded by the Commonwealth Department of Health and Ageing, March 2002.

xxi The following section has been adapted from the “Accreditation Standards for Junior Doctor Education PGY 1 and 2”, Postgraduate Medical Education Committee, Queensland, 2001.

xxii The following section has been adapted from the “Accreditation Standards for Junior Doctor Education PGY 1 and 2”, Postgraduate Medical Education Committee, Queensland, 2001.

xxiii The following section has been adapted from the “Standards for Junior Medical Officer Education and Supervision”, Postgraduate Medical Council of New South Wales, Fourth Edition, 2002.

xxiv The following section has been taken from The Australian Medical Workforce, Department of Health and Aged Care, Occasional Papers, Series No. 12, August 2001, pp 93-95. This paper was prepared by Monica Pflaum with input and assistance from Catherine Wall, Beth Slatyer, Clare Boutchard, Rhonda Jolly and Katherine Harris, Commonwealth Department of Health and Aged Care.

xxv Nocera A and Khursandi DS, 1998, Doctor’s working hours: can the profession afford to let the courts decide what is reasonable?, *Medical Journal of Australia*, 1998, Vol.168, pp 616-618.

xxvi The following has been adapted from the “Standards for Junior Medical Officer Education and Supervision”, Postgraduate Medical Council of New South Wales, Fourth Edition, 2002.

xxvii The following section has been adapted from the publication by the General Medical Council, UK “The Early Years Recommendations on SHO Training”.

xxviii The following section has been adapted from the publication by the General Medical Council, UK “The Early Years Recommendations on SHO Training”.

xxix The following section has been adapted from the WA Accreditation Guide, Appendix B, Prevocational Training and Accreditation Committee, Draft 6, June 2001.

xxx The following section has been adapted from the publication by the General Medical Council, UK “The Early Years Recommendations on SHO Training”.

[xxxi] The following section has been adapted from the "National Guidelines for Intern Training and Assessment," Australian Medical Council, November 1996, pp15-17.

[xxxii] The following section has been adapted from the "National Guidelines for Intern Training and Assessment," Australian Medical Council, November 1996, p.17.

[xxxiii] The following section has been adapted from the "National Guidelines for Intern Training and Assessment," Australian Medical Council, November 1996, p.17.

APPENDIX 1 – USEFUL WEBSITES

Section 1 – Organisations involved in prevocational medical education and training in Australia

Australian Medical Council: http://www.amc.org.au

Confederation of Postgraduate Medical Education Councils:
http://www.health.gov.au/workforce/education/postgrad.htm

Medical Boards
Contact details on the AMC website: http://www.amc.org.au/board.asp
New South Wales: http://www.nswmb.org.au/
Northern Territory: http://www.nt.gov.au/health/org_supp/prof_boards/prof_licensing_auth.shtml
Queensland: http://www.medicalboard.qld.gov.au/
South Australia: http://www.medicalboardsa.asn.au/
Tasmania: http://www.medicalcounciltas.com.au/
Victoria: http://medicalboardvic.org.au/
Western Australia: http://www.wa.medicalboard.com.au/

Medical Training Review Panel
http://www.health.gov.au/workforce/eduction/mtrpcpmec.htm

Postgraduate Medical Councils
Postgraduate Medical Council of Victoria: http://www.pmcv.com.au
Postgraduate Medical Institute of Tasmania: http://www.healthsci.utas.edu.au/pgmit/pgmit.htm
Northern Territory Postgraduate Medical Council: http://www.ntpmc.org.au
Postgraduate Medical Council of New South Wales: http://www.medeserv.com.au/pmc/
Postgraduate Medical Education Foundation of Queensland: http://www.pmefq.com.au
Council for Early Postgraduate Training in South Australia: http://www.ceptsa.org.au
Prevocational Training and Accreditation Committee, Western Australia: http://www.ptac.org.au

APPENDIX 2 – USEFUL RESOURCE DOCUMENTS

The National Guidelines for Training and Assessment for Junior Medical Officers (PGY1 & PGY2):
http://www.health.gov.au/workforce/

Section 1: Organisations involved in prevocational medical education and training
Nomenclature used by each state for prevocational and vocational training posts:
http://www.health.gov.au/workforce/pdf/res1.2.pdf

Section 2: Accreditation of training programs
The Medical Training Review Panel Annual reports, including recommendations in relation to prevocational training: http://www.health.gov.au/workforce/education/intrpcpmec.htm

Section 3: Roles and responsibilities of parties involved in medical education

Director of Clinical Training: http://www.health.gov.au/workforce/pdf/res9.pdf

Guidelines for a Postgraduate Clinical Training Committee:
http://www.health.gov.au/workforce/pdf/res8.pdf

Junior Medical Officer Survival Tips: http://www.health.gov.au/workforce/pdf/res4.pdf

Recommended Topics for inclusion in a JMO Handbook:
http://www.health.gov.au/workforce/pdf/res7.pdf

Sample position descriptions for junior medical staff:
http://www.health.gov.au/workforce/pdf/res5.pdf
http://www.health.gov.au/workforce/pdf/res6.pdf

Sample role and position descriptions for Medical Education Officers:
Hospital-based MEO role: http://www.health.gov.au/workforce/pdf/res12.pdf

Hospital-based position description: http://www.health.gov.au/workforce/pdf/res11.pdf

Central MEO role: http://www.health.gov.au/workforce/pdf/res13.pdf

Sample position description for a Term Supervisor: http://www.health.gov.au/workforce/pdf/res10.pdf

Section 4: Education and Professional Development

Skills and knowledge which could be acquired during the JMO years:
http://www.health.gov.au/workforce/pdf/res14.pdf

Sample term description template: http://www.health.gov.au/workforce/pdf/res15.pdf

Section 6: Supervision, Assessment and Feedback

JMO Attachment, Feedback and Appraisal Form
(developed by the Postgraduate Medical Council of New South Wales)
http://www.health.gov.au/workforce/pdf/jmoattach1.pdf
http://www.health.gov.au/workforce/pdf/jmoattach2.pdf
http://www.health.gov.au/workforce/pdf/jmoattach3.pdf
http://www.health.gov.au/workforce/pdf/jmoattach4.pdf

JMO Progress Review Form
(developed by the Postgraduate Medical Council of New South Wales)
http://www.health.gov.au/workforce/pdf/jmoprogress1.pdf
http://www.health.gov.au/workforce/pdf/jmoprogress2.pdf

Section 10: *Overseas Trained Doctors*

Australian Medical Council process: Assessment of Overseas Trained Doctors
http://www.amc.org.au

Medical Registration
Refer to Medical Board contact details in Appendix 1

Information on immigrating to Australia and visas requirements:
Department of Immigration, Multicultural and Indigenous Affairs:
http://webster.immi.gov.au/department/dept.htm

Online visa services: http://webster.immi.gov.au/level2/10_online.htm