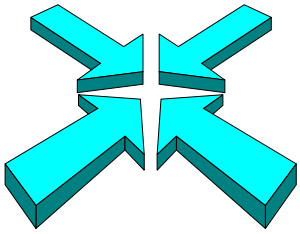


2011 CPMEC Advisory Council Meeting

Auckland, NZ

Chair's Report

INTRODUCTION

2011 was a year of consolidation for CPMEC. After a period of financial uncertainty a three-year agreement was finalised with the Department of Health and Ageing (DoHA) that has secured funding until June 2014. Despite this financial uncertainty, CPMEC continued to provide a national and occasionally trans-Tasman voice on key issues in prevocational medical education and training. In this report, I will highlight some of the main issues that were addressed during the year.

DEVELOPMENTS IN PREVOCATIONAL EDUCATION & TRAINING IN 2011

Internship and the National Registration and Accreditation Scheme

At the 2010 Advisory Council meeting it was noted that the Medical Board of Australia (MBA) requested advice from the Australian Medical Council (AMC) on:

- *national standards for intern training;*
- *what should be expected of interns at the completion of the internship period to enable the MBA to grant general registration; and*
- *how the AMC might apply a national framework for intern accreditation to the current State-based accreditation processes of post-graduate medical councils to ensure that appropriate and consistent standards are in place for all jurisdictions.*

Following a brief AMC consultation process in late 2010 that involved all Postgraduate Medical Councils (PMCs), an AMC/MBA/CPMEC working party was formed to oversee further work on these issues. The working party developed a draft registration standard for interns, which was forwarded to MBA and then released for consultation in July 2011. The registration standard requires 47 weeks of equivalent full time experience in an accredited intern position within a 2 year period, including a minimum of 10 weeks exposure to medicine, 10 weeks exposure to surgery and 8 weeks exposure to emergency medical care.

The draft standard is a move away from compulsory 'general medicine' and 'general surgery' rotations. There is a focus on the type of experience obtained, including explicit allowance for part time internship and for part of the internship to be completed outside Australia. A minimum of eight weeks experience in 'emergency medical care' is proposed, rather than a rotation that must be completed in an Emergency Medicine department.

CPMEC's submission on the draft standards, based on consultation with PMCs, included the following recommendations:

- *Development of more detailed guidelines to clearly articulate the experience required in each term*
- *Specific details of requirements for part time, interrupted and deferred internship*
- *A clear statement of the minimum continuous time required in a term*
- *That ambulatory care experience can be achieved within the 47 week year rather than during the medical term, as recommended in the consultation draft.*
- *Development of a national approach to intern assessment based on achievement of ACFJD capabilities*
- *That the standard clearly state who is responsible for accreditation of overseas terms and the requirements for New Zealand graduates to achieve full registration in Australia.*

It is anticipated that the standard will be introduced for the 2012 intern cohort.

The AMC has recently appointed Professor David Prideaux and the ACFJD National Project Coordinator, Ms Debbie Paltridge, to develop learning objectives for the intern year from the ACFJD. This will lead to development of uniform national processes for workplace based assessment during the intern year and for certification of satisfactory performance to allow progression from provisional registration to full registration at the end of the intern year.

AMC has recently established a new working party to develop a national framework for intern accreditation processes. The working party will be chaired by Professor Robin Mortimer (AMC Deputy President) with representatives from CPMEC, DoHA, AMA's Council of Doctors in Training and State health departments. Professor John Collins has also been invited to join the working party.

AMC also plans to complete two other related tasks in 2012; development of national standards for intern training and development of a process for accreditation of PMCs by AMC.

It is anticipated that there will be extensive consultation on the draft learning objectives and assessment processes, the proposed national framework for intern accreditation, the draft standards for intern training and the proposed accreditation process for PMCs.

Prevocational Training in New Zealand

CPMEC also provided a submission to the Medical Council of New Zealand on *'Prevocational training requirements for doctors in NZ: Discussion paper on options for an enhanced training framework'.* The discussion paper sets out four options for prevocational training, based on 4 month runs over 12 to 24 months.

CPMEC's submission highlighted the desirability of harmonisation of the two countries' internship and prevocational requirements. We were pleased to note that New Zealand is planning to use the ACFJD to guide the development of a national curriculum for prevocational training for all training runs. A proposal to increase exposure to ambulatory medicine in community care settings was commended.

16th Prevocational Forum

The 2011 Prevocational Forum is the first occasion that this meeting has been held outside of Australia. I would like to congratulate the Medical Council of New Zealand on the quality of the program and for their hard work to make this year's Forum a truly trans-Tasman event.

CPMEC has been involved in both the Scientific Committee (through Barry McGrath, Alison Jones & Jag Singh) and the Organising Committee (through Carol Jordon) of this year's Forum. We are grateful for the opportunities provided to identify keynote speakers to address topical issues in prevocational education and training in Australia and New Zealand.

In a departure from previous years, CPMEC has managed the sponsorship provided by DoHA for Australian JMOs to attend the 2011 Prevocational Forum. I am very

pleased that all sixteen places available to states and territories have been taken up and very grateful to DoHA for their continued support.

Prevocational Medical Accreditation Framework (PMAF)
CPMEC developed the PMAF to guide prevocational medical accreditation in Australia following extensive consultation with internal and external stakeholders. The final version of the PMAF was signed off by member PMCs in October 2009. All PMCs are now using the PMAF to review standards and policies. A CPMEC survey undertaken in March confirmed the value of PMAF as a unifying national framework.

CPMEC will promote the PMAF to the AMC working party established to develop a national framework for intern accreditation processes.

Accreditation Funding
There is continuing uncertainty about funding for prevocational accreditation activities under the National Registration and Accreditation Scheme. MBA has continued funding previously provided by state and territory Medical Boards for 2 years but long term funding arrangements are still not clear.

Accreditation of PGPPP Training Posts
CPMEC and PMCs have had a series of discussions with General Practice and Education Training Ltd (GPET), the two General Practice Colleges (RACGP and ACRRM) and Regional Training Providers to consider a more streamlined approach to the accreditation of general practices hosting both PGPPP and vocational training posts.

GPET convened a workshop in Melbourne on 19 May 2011. One of the outcomes of the workshop was a decision to undertake a limited number of pilot surveys. PMCs in Victoria, Northern Territory and Western Australia have agreed to participate in these pilots, commencing in November 2011. It is expected that the pilots will be completed by July 2012. A Steering Committee, comprising key stakeholders in prevocational general practice accreditation, has been established to oversee the pilots. .

National Intern Allocation Working Party (NIAWP)
A national audit of multiple intern job acceptances by final year medical students was conducted again this year under the auspices of the NIAWP chaired by Professor Geoff Thompson. All students who accepted more than one intern position were contacted by the audit project administrator to encourage a quick decision so that health services were given adequate notice of vacant positions.

The total number of duplicate acceptances identified was double that of last year with 80 applicants accepting 2 positions (vs 40 applicants in 2010). Two applicants had accepted 3 positions (1 applicant in 2010). Most of those holding multiple acceptances had decided which position they would accept by mid-September.

The NIAWP has also been working to achieve greater consistency in national intern allocation priority rankings, and for intern application opening and closing dates. A national application process has been discussed. Members of the NIAWP have also

been involved in discussions with Health Workforce Australia to develop a national response to provision of internships to international full fee paying students graduating from Australian medical schools. Professor Thompson and CPMEC General Manager, Dr Jag Singh, are members of the Short Term Management of Employment Demand – Medicine Expert Reference Group.

Professional Development Program for Registrars (PDPR)
The PDPR is now a nationally accepted program aimed at building clinical supervisory capacity for registrars who are increasingly responsible for the teaching and supervision of prevocational trainees. Dr Singh continues to deliver the PDPR and a Trainer Accreditation Program. In 2011, 10 PDPR programs and 2 Trainer Accreditation Programs were delivered. Evaluations for both programs continue to be extremely positive.

STAKEHOLDER MEETINGS

Australian Indigenous Doctors' Association (AIDA)
Following a presentation by AIDA to the 2010 CPMEC Advisory Council meeting, CPMEC and AIDA have been working on a collaborative agreement framework modelled on the highly successful agreement between AIDA and Medical Deans of Australia and New Zealand. It is envisaged that the framework will guide identification of priority projects in prevocational training for the two organizations, including mentoring and support programs for Indigenous prevocational doctors.

Medical Training Review Panel (MTRP)
CPMEC continues to provide updates on prevocational training to MTRP meetings. In 2010 CPMEC requested consideration of uniform changeover dates for registrars, residents and interns in each jurisdiction. This issue has been taken up by the Health Workforce Principals Committee (HWPC) with in-principle agreement to coordinate commencement dates for interns and registrars

Funding for priority projects in prevocational training that was previously available through the MTRP has been discontinued. In previous years this funding led to many highly successful programs, including the ACFJD, the PDPR and the PMAF. Lack of project funding for CMPEC and its member PMCs is a significant impediment to improvement and reform of prevocational training.

Health Workforce Australia (HWA)
CPMEC continues to engage with HWA at various levels. CPMEC representation includes:

- *National Training Plan (NTP) Governance Committee – CPMEC Chair*
- *NTP Geographical Distribution Expert Reference Group- CPMEC Chair*
- *Simulation Learning Environment Expert Reference Group – ANZJMOC Immediate Past Chair, Dr Caitlin O'Mahony*
- *Short Term Management of Employment Demand – Medicine Expert Reference Group – Prof Geoff Thompson & CPMEC General Manager*
- *National Advisory Committee for Higher Education & Training Sector – CPMEC General Manager, Dr Jag Singh*

CPMEC has provided updates to HWA on intern numbers in each jurisdiction to assist with planning for intern places.

CPMEC has also contributed to a joint CPMC/Medical Deans/CPMEC submission to HWA for funding to develop a coordinated approach to supervision and training of supervisors.

Medical Deans

CPMEC has developed a strong relationship with Medical Deans at executive and secretariat levels. CPMEC has participated in the following Medical Deans meetings:

- *Medical Deans Annual Conference*
- *Medical Competencies Project Steering and Writing Groups*
- *Medical Deans – AIDA Indigenous National Medical Education Review Steering Committee*
- *Indigenous Academic Leadership Forum*
- *Leaders in Indigenous Medical Education (LIME) Network meetings*

CPMEC has also provided considerable support to the Medical Students Outcome Database (MSOD) project to increase PGY1 and 2 survey response rates, through review of questionnaires and participation in Stakeholder Advisory meetings.

Committee of Presidents of Medical Colleges (CPMC) Meetings

The CPMEC Chair is invited to attend the open session of the College Presidents' quarterly meetings held alternatively in Sydney and Melbourne. The Presidents/Chairs and CEOs of Medical Deans, CPMEC and CPMC have also held meetings prior to each CPMC meeting to discuss issues of mutual concern.

International Medical Graduates (IMGs)

CPMEC made a submission to the Inquiry into Registration Processes and Support for Overseas Trained Doctors by House of Representatives Standing Committee on Health and Ageing. Issues highlighted in the submission included the importance of:

- maintaining support for IMGs who are not in a specialist training program;
- continuing or expanding current levels of support for existing programs that are working well;
- development of nationally consistent programs for orientation and up-skilling of IMGs.

Other Interactions

CPMEC was contacted by Siggins Miller Consultancy, who were engaged by the Health Workforce Principals Committee of the Australian Health Ministers' Advisory Council (AHMAC) to research *accreditation practices for specialist medical training posts*. AHMAC had asked SMC to highlight areas where duplication in College accreditation processes could be reduced.

CPMEC also provided advice to the *National Rural Health Alliance* (NHRA) on their proposal to support more internships and junior doctor positions in rural and remote sites.

CPMEC GOVERNANCE

Organisation Structure

Under the new constitution, business affairs and strategic directions of the organisation are managed by a Board that comprises Chairs of each PMC. Between Board meetings, operational management has been delegated to a Management Committee. Portfolios have been allocated to Liaison Heads for Accreditation, Education and Workforce.

Membership of the Board in 2011 was:

- *Prof Brendan Crotty (Chair, Liaison Head – Education; PMCV)*
- *Prof Simon Willcock (Deputy Chair; NSW CETI)*
- *Prof Geoff Thompson (Liaison Head – Workforce; SAIMET)*
- *Dr Luis Prado (Liaison Head – Accreditation; PMCQ)*
- *Prof Louis Landau (PMCWA)*
- *Assoc. Prof Terry Brown (PMCT)*
- *Assoc. Prof Elizabeth Chalmers (PMCNT)*
- *Dr Allen Fraser (MCNZ Education Committee)*
- *Dr Elizabeth O'Leary (ACT Health – replaced Dr Jo Burnand in May 2011).*
- *Dr Jag Singh (General Manager and Board Secretary)*

Membership of the Management Committee was:

- *Prof Brendan Crotty (Chair, Liaison Head – Education)*
- *Prof Simon Willcock (Deputy Chair)*
- *Prof Geoff Thompson (Liaison Head – Workforce)*
- *Dr Luis Prado (Liaison Head – Accreditation)*
- *Ms Carol Jordon (Principal Officer' Committee Representative)*
- *Dr Jag Singh (Secretary)*

CPMEC also has a number of committees and working parties working in specific areas of interest:

- *Principal Officers' Committee, comprising the chief executive officers of each PMC*
- *Australasian Junior Medical Officers Committee (AJMOC)*
- *Australasian Directors of Clinical Training Committee (ADCT)*
- *Australasian Medical Officers' Committee (AMEOC)*
- *Prevocational Medical Accreditation Network (PMAN)*
- *National Intern Allocation Working Party (NIAWP)*

The organisation continued to be very well supported by three staff members:

- *Dr Jag Singh, General Manager*
- *Ms Debbie Paltridge, ACF National Project Coordinator*
- *Mrs Barbara Butterworth, Executive Officer*

A committee structure created to support the development and implementation of the ACFJD has been disbanded because of lack of funding. The slow rate of progress in this area has been the most disappointing aspect of my tenure as Chair of CPMEC and has been particularly frustrating for the ACF National Project Coordinator. Recent MBA/AMC activities on intern registration and training are a very welcome, if long overdue, development and will hopefully reinvigorate CPMEC's work on the ACF.

At a personal level, I have had some concerns about the new governance structure over the last 2 years:

- does the does the reduced frequency of Board meetings provide adequate representation and communication channels for all PMCs?
- is the approach of allocating portfolios to Liaison Heads working well?

I hope that these issues will be considered by the incoming management team.

Report to DoHA

The Final Report on the previous 3 year funding agreement between CPMEC and DoHA (extended by one year to June 2011) was submitted in June 2011. Achievements of CPMEC in those years included:

- *Development, implementation and revision of the Australian Curriculum Framework for Junior Doctors (ACF); and the piloting of national assessment tools*
- *An influential discussion paper on National Registration & Internship prepared by a CPMEC Working Party on Internship and the National Registration and Accreditation Scheme*
- *The continued growth of the National Prevocational Forum to become the premier Australasian medical education conference*
- *Introduction of awards to recognise outstanding contributions of junior doctors and clinical educators to prevocational medical education and training.*
- *Development and implementation of the Prevocational Medical Accreditation Framework (PMAF)*
- *Development and national rollout of the Professional Development Program for Registrars (PDPR)*
- *The National Intern Allocation Working Party's audit of multiple job acceptances by interns*
- *A recommendation to the Health Workforce Principals Committee to adopt uniform starting dates for registrars, residents and interns in each jurisdiction*
- *A discussion paper on National Priorities for Prevocational Medical Education and Training for MTRP*
- *A report on Clinical Training in the Prevocational Years for the MTRP Clinical Training Sub-Committee*
- *Submissions prepared in consultation with PMCs on a range of issues to ensure that concerns of the prevocational medical sector have been articulated in national policy making*
- *Updates to DoHA and HWA on national intern numbers*
- *Dissemination of information on outcomes of MTRP-funded projects*
- *Development of a new constitution for CPMEC*

ACKNOWLEDGEMENTS
I would like to acknowledge the continuing support of the Australian Government through the Department of Health and Ageing.

The Confederation is heavily dependent on contributions of State and Territory PMCs, particularly for the significant amount of pro bono work provided by PMC Chairs, Principal Officers and other office bearers.

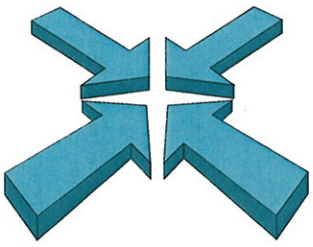
I would also like to acknowledge the strong support provided by CPMEC staff led by Jag Singh.

My two years as Chair of CPMEC have been immensely enjoyable and rewarding. I wish the new Chair, Simon Willcock, and his team every success in what will be a challenging 2 years for prevocational training in Australia and New Zealand.

Professor Brendan Crotty
Chair, CPMEC
November 6, 2011

Confederation of Postgraduate Medical Education Councils

ABN 144 489 038



ACT Health
Postgraduate Medical Council of Victoria
Postgraduate Medical Council of Tasmania
Postgraduate Medical Council of Queensland
Northern Territory Postgraduate Medical Council
Postgraduate Medical Council of Western Australia
Medical Council of New Zealand Education Committee
South Australian Institute of Medical Education and Training
New South Wales Institute of Medical Education and Training

12 September 2011

Dr Joanna Flynn
Chair
Medical Board of Australia
GPO Box 9958
MELBOURNE VIC 3001

Via email: medboardconsultation@ahpra.gov.au

Dear Dr Flynn

Re: Internship Registration Standard

The Confederation of Postgraduate Medical Education Councils (CPMEC) has appreciated the opportunity to provide feedback on your consultation paper *Proposed registration standard for granting general registration as a medical practitioner to Australian and New Zealand medical graduates on completion of intern training.*

Attached please find CPMEC's submission which comments on the registration standards and makes six recommendations. The submission is a coordinated response on behalf of all PMCs and represents the consensus view of all its members. It incorporates comments from the PMC Chairs, staff of PMC and CPMEC, other prevocational clinical educators, and junior medical officers.

You will note that CPMEC has made the following recommendations:

1. That more detailed guidelines are developed to clearly articulate the experience required in each term and an assessment process linked to achievement of ACF capabilities.

2. That specific details of requirements for part time, interrupted and deferred internship are included.

3. That there is a clear statement of the minimum continuous time required in a term.

4. That ambulatory care experience can be achieved within the 47 week year rather than during a medical term.

5. That a national approach to intern assessment based on achievement of ACF capabilities is developed.

CPMEC Administration Pty Ltd
C/O Postgraduate Medical Council of Victoria
P O Box 2900 St Vincent's Hospital
Fitzroy Vic 3065

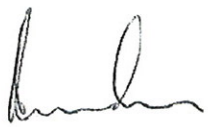
Telephone: 61 3 9419 1217
Facsimile: 61 3 9419 1261
Email: cpmec@cpmec.org.au

6. That the standard clearly states who is responsible for accreditation of overseas terms and the requirements for New Zealand graduates to achieve full registration in Australia.

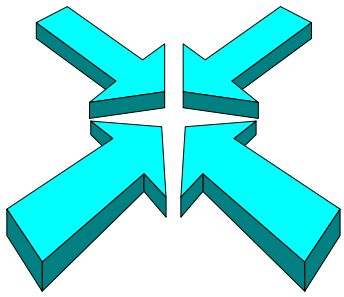
Given the interest and expertise of PMC and CPMEC in prevocational education and training matters, we would welcome the opportunity to work closely with the MBA and the AMC in addressing the issues that we have highlighted in our submission.

Please contact Dr Jag Singh at jsingh@cpmec.org.au or on Tele: 03 9419 1217 should you have any queries in relation to this submission.

Yours sincerely,



Prof Brendan Crotty
Chair



Confederation of Postgraduate Medical Education Councils (CPMEC)

Intern Registration Standard
Submission to Medical Board of Australia

12 September 2011

Introduction

On 12th July 2011 the Medical Board of Australia (MBA) released a draft standard for general registration for Australian and New Zealand medical graduates on completion of intern training. The Confederation of Postgraduate Medical Education Councils (CPMEC) welcomes the opportunity to comment on the draft standard.

CPMEC distributed the draft standard to member Postgraduate Medical Councils (PMCs[1]) and the Medical Council of New Zealand's Education Committee for comment. This submission represents a consolidation of their responses to the proposed registration standard. Specific recommendations are provided where appropriate.

General Comments

Overall there was support for the move from "general medicine" and "general surgery" experience to experience in medicine and surgery. This was considered more in line with the diversity of clinical experiences currently available to interns.

The proposal to allow part time internship was supported as it provides flexibility and is responsive to the needs of a component of the intern cohort. Opportunity to undertake part of the internship outside Australia was also generally supported.

The draft standard includes general statements about the experience to be gained during internship terms but there is limited detail about the nature of the experience during specific terms. CPMEC acknowledges that more detailed guidelines will be released for consultation and would welcome an opportunity to assist and/or comment.

PMCs commented that the standard should include a requirement to participate in mandatory intern education and training activities. CPMEC suggests that there should be specific reference to achievement of Australian Curriculum Framework for Junior Doctors (ACF) capabilities, which have already been incorporated into PMC accreditation standards. PMCs strongly believe that accreditation of all intern rotations is the best guarantee that interns receive appropriate clinical exposure and education.

PMCs also commented on the need to include more detailed guidelines on workplace based assessment of ACF capabilities. CPMEC has undertaken considerable work in this area that may be of benefit to the MBA working party.

Comments were also received on the need to provide guidelines for supervision or supervision standards for internship.

CPMEC and PMCs are very concerned about the slow rate of progress to date and are happy to provide assistance in the further development of the standard.

[1] PMCs include equivalent internship agencies such as the NSW Clinical Education and Training Institute and the SA Institute of Medical Education and Training

Recommendation 1:

That more detailed guidelines are developed to clearly articulate the experience required in each term and an assessment process linked to achievement of ACF capabilities.

Specific Comments

1. *Part time, deferred or interrupted internship:* PMCs commented on a perceived lack of clarity of the 2 year timeframe and highlighted the following:

    a. Is there a minimum FTE for part time internship (e.g. 0.5 FTE)?
    b. Does 'part time' include interruptions and variable FTE (e.g. full time for 6 months, then 6 months off and then full time for 6 months)?
    c. Some PMCs raised concerns about continuity of patient care, hospital service requirements and division of workload between part time and full time interns, and the importance of ensuring the interns working part time obtain the necessary experience to consolidate clinical knowledge and skills.
    d. Will PMCs be responsible for reviewing and accrediting part time terms on an individual basis?

There is support for the inclusion of an exceptional circumstances clause to deal with unexpected issues which prevent an intern from completing their internship in two years. It was suggested that the standard should also address deferral of internship. More detail should be provided, including any requirement for additional professional development or support upon return to internship.

Recommendation 2:

That specific details of requirements for part time, interrupted and deferred internship are included.

2. Intern Terms:

i) Medicine

PMCs expressed concerns about the proposed requirement for ambulatory experience. There are many excellent existing medical terms that are not able to provide ambulatory experience and this requirement would mean that they were not able to be used as a core term, perhaps threatening capacity to provide adequate core term in medicine for all interns. It was suggested that the standard be modified to include a requirement for some ambulatory care experience during ***any*** rotation in the intern year. Some PMCs expressed concern about the proposed requirement that the intern should admit and discharge patients as this may not be logistically possible in some existing core medical terms. It is not clear whether the standard allows for the core medical term to be taken outside the hospital setting.

ii) Emergency medicine

PMCs supported a compulsory emergency experience during internship. There was agreement that not all GP terms can provide the appropriate emergency experience. Junior Medical Officer (JMO) Forums in a number of states are strongly opposed to the use of GP terms for emergency medicine. They feel that it should remain within an Emergency Department environment because of acuity of patient presentations and the different skill sets required in these clinical settings. PMCs recommended more clarity on the suitability of posts for this core term. On the other hand, in states which have provided GP terms with core emergency competencies, feedback from interns indicates that the experience has been positive.

iii) Other

Some PMCs expressed concern about the different durations of the core terms, which may be challenging for rosters in some jurisdictions. They also requested details about whether these terms should be continuous experience or if they can be interrupted by annual or other leave.

Up to two weeks ward call experience within the core term could potentially reduce emergency experience to 6 weeks or medicine and surgery experience to 8 weeks. PMCs requested a clear statement on the minimum continuous duration for each term.

Some PMCs suggested inclusion of paediatrics and obstetrics & gynaecology as possible terms within the intern year.

iv) Accreditation of terms

The draft standard also refers to the need for all terms to be accredited according to the "Australian Standard". In this connection, PMCs wanted clarification if this referred to current PMC standards for accreditation. PMCs consider that they should continue to be responsible for the accreditation of intern positions. The Health Practitioner Regulation National Law indicates that an accrediting authority should be responsible for accreditation and the MBA for endorsing (or otherwise) that accreditation for registration purposes. The jurisdictional PMCs are best placed to ensure that each placement is able to satisfy fully all of the Board's requirements for competence to achieve general registration.

Recommendation 3:

That there is a clear statement of the minimum continuous time required in a term.

Recommendation 4:

That ambulatory care experience can be achieved within the 47 week year rather than during a medical term.

3. Assessment: There is general support for the use of an overall rating on completion of internship. A requirement for "satisfactory term supervisor reports" for all rotations is not consistent with current practice. Some interns have difficulties during one term, particularly the first term, but still achieve a satisfactory level of knowledge and skills by the end of internship. "Satisfactory" is not defined and there is no detail on

the assessment of the intern's performance. A national approach to assessment of interns' performance based on achievement of ACF capabilities is recommended.

Recommendation 5:

That a national approach to intern assessment based on achievement of ACF capabilities is developed.

Location of internship: Whilst there was support for some of the internship being undertaken outside Australia, there is a need to clearly articulate who would be responsible for accrediting overseas terms to ensure that they meet Australian accreditation standards.

Feedback from New Zealand identified concern about the requirements for New Zealand graduates to be granted general registration in Australia. If the composition of the intern year is different in New Zealand will NZ graduates still be eligible for general registration?

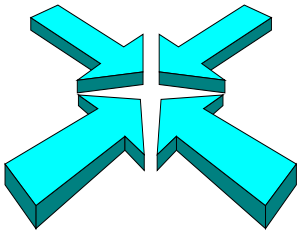
Recommendation 6:

That the standard clearly states who is responsible for accreditation of overseas terms and the requirements for New Zealand graduates to achieve full registration in Australia.

CPMEC thanks MBA for the opportunity to comment on this important standard and offers our expertise in prevocational medical education to assist MBA in developing the more detailed guidelines.

For any queries about this submission, please contact Dr Jagdishwar Singh at CPMEC (jsingh@cpmec.org.au).

Confederation of Postgraduate Medical Education Councils



CPMEC Response to the Medical Council of New Zealand Discussion Paper

Prevocational Training Requirements for Doctors in New Zealand

Introductory Comments

The Confederation of Postgraduate Medical Education Councils (CPMEC) is the peak body for State and Territory Postgraduate Medical Education Councils (PMCs) in Australia and New Zealand. Membership includes the Education Committee of the Medical Council of New Zealand. Postgraduate Medical Councils play a critical role in the clinical placement and quality of training, supervision and performance of junior doctors in the first two years of prevocational medical training.

The review of prevocational training requirements in New Zealand coincides with changes to internship arrangements in Australia through the establishment of national internship standards under the aegis of the Medical Board of Australia (MBA). CPMEC welcomes the opportunity to provide comments on what is a very timely review.

Over the past five years, CPMEC has made a major contribution to several significant developments in prevocational training in Australia. The development and implementation of the Australian Curriculum Framework for Junior Doctors (ACFJD) has provided a national template for prevocational educational and training programs for the first two years of prevocational training. Australian medical schools are increasingly mapping their graduate outcomes against the ACFJD. Prevocational medical training and accreditation standards in Australia are being benchmarked by PMCs against the Prevocational Medical Accreditation Framework (PMAF) developed by CPMEC.

CPMEC has also coordinated measures to improve coordination of intern allocation processes between jurisdictions in Australia. To enhance the quality of teaching and supervision of prevocational trainees, national programs such as Teaching on the Run and the Professional Development Program for Registrars have been implemented.

Given the movement of medical graduates between Australia and New Zealand, greater harmonisation of internship and prevocational requirements is desirable. Any reforms implemented in New Zealand would clearly need to take cognisance of New Zealand (and to some extent Australian) workforce and service delivery imperatives. In this regard we are pleased to note that New Zealand is planning to use the ACFJD to guide the development of a national curriculum for prevocational training that will 'overarch ALL runs' (p.6) CPMEC considers it highly desirable that prevocational doctors have an opportunity to experience general practice or community practice irrespective of their subsequent specialisation. A great deal of health care delivery occurs in the community setting and it is desirable that a majority of doctors have some training in these settings. This has been difficult to achieve in Australia and CPMEC applauds MCNZ for placing a high priority on this experience during prevocational training.

We note that the discussion paper has focused on a 'review of the prevocational framework' (p.10) and that issues relating to an assessment framework, training and support for supervisors, and accreditation will be dealt with subsequently (p.11). CPMEC encourages MCNZ to integrate these issues into planned reforms as they are essential components of a comprehensive prevocational training program.

The report notes that 'investment in training' is deemed to be 'out of scope' for this phase of the review. Our own experience in Australia in relation to funding to support the implementation of the ACFJD emphasises the importance of ensuring adequate resourcing to sustain reforms.

In response to the seven key questions on page 8:

1. ***Are there any important issues and drivers that we have either omitted or overstated?***

Most of the key issues and problems have been captured in the discussion paper.

Defining the PGY2 year has proven to be a particularly challenging task in Australia. Whilst some would like to retain PGY2 as an undifferentiated generalist year, others see it as unnecessarily prolonging postgraduate medical training for graduates who have made early career choices. A number of the options proposed in the discussion paper effectively mean a two-year prevocational training program and the reactions from other stakeholders will be of interest to CPMEC. To our knowledge there is limited evidence to support decisions about the duration of internship.

The '*Issues and Problems'* section might benefit from a brief discussion of some of the macro-environmental issues likely to impact on postgraduate training requirements. These include the impact of increased Australian medical graduate numbers, changing demographics and patterns of care and service delivery, and technological innovations (including the use of simulated learning environments).

Whilst 'safety and quality of patient care is listed as a paramount principle' (p.5), and is mentioned in the discussion of services provided by PGY2 locums, it may be appropriate to list as a key driver of change in training arrangements. There will almost certainly be additional patient safety concerns as prevocational trainees undertake rotations in new settings. Adequate supervision will be critical. This issue has arisen following the expansion of the Prevocational General Practice Placements Programs (PGPPP) in rural and remote settings in Australia, where a lack of suitable supervisors for junior doctors can be a significant challenge.

2. ***Do you agree with the objectives and principles? Would you delete or add any?***

The purpose statement outlined on page 4 accords with CPMEC's approach to prevocational training. The PMAF states:

> The aim of prevocational clinical training is to further the general professional development of recently graduated doctors and prepare them for vocational (specialty) training programs. During this period, the prevocational doctor acquires practical experience and develops increasing responsibility for delivery of safe patient care under supervision. Prevocational training posts should enable graduates to acquire general clinical knowledge and skills, and to develop the confidence and maturity of judgment necessary for safe, competent, independent medical practice. It is a phase of moving from 'knowing about' to 'doing'[1].

The recently released draft MBA internship registration standard states:

[1] CPMEC, Prevocational Medical Accreditation Framework, p3, 2009

> Internship is a period of mandatory supervised general clinical experience. It allows medical graduates to consolidate and apply clinical knowledge and skills while taking increasing responsibility for the provision of safe, high quality patient care.[2]

The competency domains in the purpose statement of clinical care, communication and professionalism mirror the ACFJD. The MBA standard is also similar although it amplifies the clinical management domain to include diagnostic skills and management skills, including therapeutic and procedural skills.

We presume that in the next stage, operational definitions of 'demonstrated proficiency' along with workplace based assessment methods will be addressed.

We note that under 'Objectives' the need for a national curriculum with specific learning objectives for 'each run' has been identified. This is highly commendable as it ensures an educational focus linking all runs to ensure acquisition of the full range of competencies required for general registration.

The last of the Objectives urges all senior doctors to participate in the supervision and training of junior doctors. Australian experience indicates varying levels of commitment which is compounded by resourcing and time constraints. CPMEC will follow developments in New Zealand with interest.

3. Should there be mandatory runs? If so, what should these be?

Mandatory runs should provide prevocational trainees with exposure to achieve the necessary breadth of experiences across the curriculum.

The MBA draft internship standard is based on 47 weeks of full time equivalent service in accredited positions within a 2 year period. There is a move away from compulsory 'general medicine' and 'general surgery' rotations towards terms of at least 10 weeks experience in 'medicine' and 'surgery.' The standard focuses on the type of experience obtained, including explicit allowance for part time internship and for part of the internship to be completed outside Australia. A minimum of eight weeks experience in 'emergency medical care' is proposed, rather than a rotation that must be undertaken in an Emergency Medicine Department. It is anticipated that the standard will be introduced for the 2012 intern year.

CPMEC is supportive of mandatory runs to ensure that prevocational doctors are able to develop key competencies across all domains rather than a narrow proportion of the curriculum.

4. What is the appropriate length of the internship that will ensure training in a variety of clinical settings and allow for assessment of competence?

Individual doctors achieve competence in different domains at different times depending on a range of individual and systemic factors. In the absence of robust assessment procedures it is difficult to provide flexible internship periods to reflect this variation in skill acquisition. Furthermore, there are some concerns about adopting a competency-based training approach. As noted in a recent Australian Medical Council Consultation Paper, the 'development of tacit knowledge requires time and quality experience, with exposure to a number of cases, variability of cases and contexts, and to multiple practitioners as role models.' [3]

Based on Australian experiences, a minimum one-year internship appears reasonable. It allows supervisors time to adequately assess competence and changing levels of

[2] Medical Board of Australia, Draft Proposed-registration-standard-for-interns, 2011
[3] AMC, Competence-based Medical Education – AMC Consultation Paper, 2010, p.2

performance over time. For doctors in difficulty it provides an adequate timeframe to address issues and develop performance remediation plans.

There is some contention about whether a one-year internship provides an adequate generalist educational grounding. This is a complex issue, particularly for junior doctors who have completed a graduate entry medical course.

5. What are the consequences of each option?

As a general comment, there seems to be acceptance of four-month rotations and more discussion on the evidence to support this change could be useful. The discussion paper correctly notes that there is a 'trade-off between breadth and depth of rotations.' Before moving to a new model, it may be useful to undertake some trials that assess the benefits and risks of moving to 4-month runs.

In relation to the options, CPMEC's specific comments are:

Option 1: Some prevocational doctors will not gain experience in managing either community-based patients or emergency medicine conditions. This is inevitable if New Zealand moves to four month intern runs and retains a 12 month internship and CPMEC assumes that MCNZ has carefully considered this trade-off as opportunities to experience a variety of runs in order to better inform career choices will be somewhat limited.

Option 2: Provides a greater range of experience and includes both community-based care and emergency medicine. There will be significant rostering issues if a 16 month internship is adopted, including the impact on availability to enter Australian training programs which accept applications at the end of first year of training, e.g. surgery.

Option 3: This option provides the more comprehensive clinical experience but will effectively extend internship to 2 years for most graduates (many of whom already complete 2 years of generalist training before commencing vocational training).
There may be some impact on access to postgraduate training programs. It would be important to ensure that NZ could offer these runs to all PGY1s and PGY2s.

Option 4: This option provides the most comprehensive clinical experience at the expense of a longer internship. It would be important to ensure that NZ could offer these runs to all PGY1s and PGY2s.

6. What is your preferred option and why?

Apart from the observation that option 4 would provide the most comprehensive experience at the expense of a longer internship, CPMEC does not believe it is appropriate for a predominately Australian organization to state a preferred option.

7. Is there an alternative option that is not outlined in this paper that would be consistent with the objectives and principles outlined in this paper?

No.

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