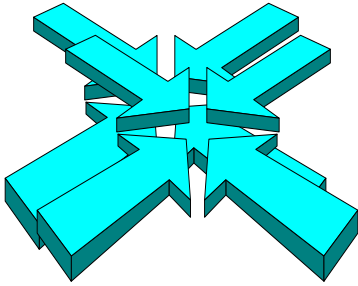


Confederation of Postgraduate Medical Education Councils



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

National Registration and the Internship

CPMEC Discussion Paper

November 2009

1. Introduction – Formation of the CPMEC Working Party

The new Medical Board of Australia will oversee the introduction of national registration and accreditation from July 1 2010. The Minister for Health and Ageing has recently announced that the Board will be chaired by Dr Joanna Flynn. Membership includes a medical practitioner from each jurisdiction and four community members.

Legislation to provide a legal framework for the National Registration and Accreditation Scheme (NRAS) will be introduced in all jurisdictions. The Health Practitioner National Law, 2009, has been passed in Queensland and it is anticipated that similar bills will be passed in other jurisdictions. The Confederation of Post Graduate Medical Educational Councils (CPMEC) provided comments on the exposure draft of the Queensland bill (Appendix 1).

The Australian Health Workforce Ministerial Council has indicated that the Australian Medical Council (AMC) will continue to accredit medical schools and specialty colleges after the introduction of NRAS. CPMEC has adopted a policy that prevocational training should also be accredited by the AMC. This policy was supported by the recommendations of the 2007 MedEd Conference. The AMC has agreed to establish a working party to investigate the feasibility of accreditation of post graduate medical councils (PMCs).

Accreditation of prevocational training positions in each state and territory is currently performed by PMCs. In some jurisdictions all prevocational positions are accredited, in others only intern positions are accredited. CPMEC is working towards the development and incremental implementation of a set of national accreditation standards for all prevocational positions, which include standards incorporating the educational goals of the Australian Curriculum Framework for Junior Doctors (ACFJD). CPMEC has finalised a national Prevocational Medical Accreditation Framework(PMAF).

Governance and regulation of the internship will be determined by the Medical Board of Australia. It seems highly likely that there will continue to be a specific category of provisional registration for interns, which will be converted to full registration on notification of satisfactory completion of internship. CPMEC has identified an opportunity to review the composition of the intern year and the process of notification of satisfactory completion. The aim of this review is to encourage a shift in focus from completion of mandatory periods of clinical experience towards an increased emphasis on educational achievement during internship.

At its November, 2008 meeting CPMEC agreed to form a working party with representatives from PMC's, the AMC, the Joint Medical Boards Advisory Committee and doctors in training, to make recommendations to the CPMEC Executive Committee.

The purpose of this working party is to provide advice to the CPMEC on the structure and content of the internship, and on a nationally consistent "sign off"

process. It is intended that content should be guided by the Australian Curriculum Framework for Junior Doctors (ACFJD) and that achievement of competencies listed in the ACFJD should be considered in the “sign off” process.

The membership and terms of reference of the working party are included as Appendix 2. The working group met in Melbourne on May 29 and July 17. A subgroup held a teleconference on August 20 to discuss emergency medicine experience during internship. Dr Flynn resigned from the working party on her appointment as Chair of the Medical Board of Australia in August. Prof Geffen withdrew in September because of difficulty attending meetings.

2. Internship in Australia

Internship is a period of mandatory general experience after graduation, predominantly in hospital settings, and usually lasting one year. Each state and territory recruits graduates from local and interstate medical schools, including temporary residents graduating from Australian medical schools. A small number of international medical graduates are also recruited. In general recruitment to hospitals or health service groupings is based on graduate and/or health service preferences, usually through a computerized match system.

It is not anticipated that national registration and accreditation will have any immediate impact on recruitment and allocation.

New graduates currently receive conditional registration from the medical board in the jurisdiction in which they will work during internship. Conditional registration restricts scope of practice to supervised practice in rotations which have been accredited by PMCs. Under current arrangements each medical board mandates a minimum period of clinical experience (a minimum of 47 weeks full time) and of clinical exposure to medicine, surgery and emergency medicine (8 to 10 weeks full time) during the internship. There are minor variations between jurisdictions.

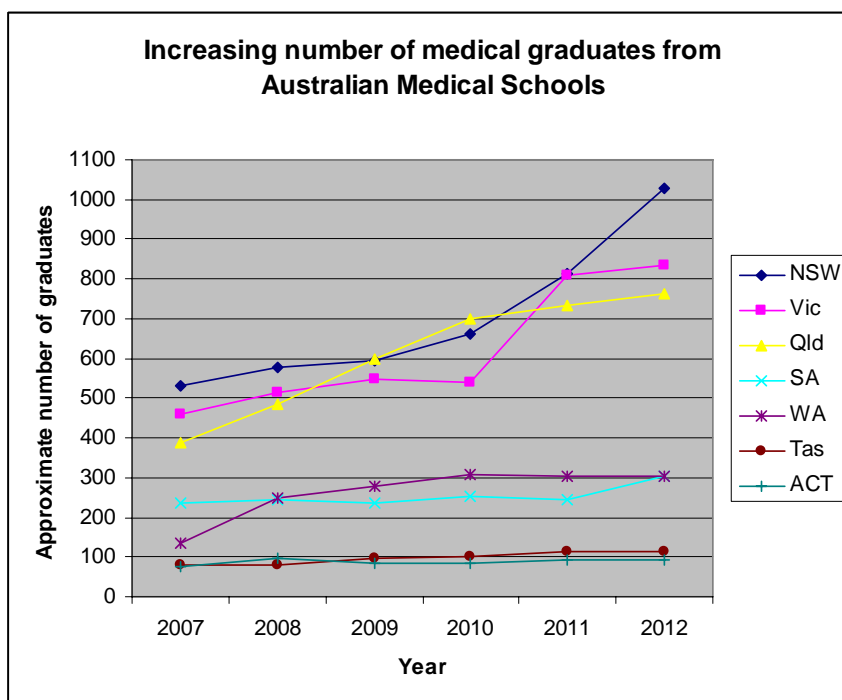
Conditional registration is converted to full registration on notification to the medical board that the intern has satisfactorily completed internship. This notification is generally made by Directors of Medical Services, based on satisfactory attendance during internship and a global assessment of clinical competence. Once again, there are minor variations between jurisdictions.¹

The working party considered a number of emerging issues in preparation of this report:

- a) **Capacity to Expand Internships.** The graph below illustrates the recent expansion of medical school places in Australia. The number of internships required in 2012 will be almost double the number that were needed in 2007.²

¹ CPMEC (2008) *Clinical Training in Prevocational Years Report*

²Medical Deans Australia and New Zealand (2008) *National Clinical Training Review* (page 25)



Each jurisdiction is responding by increasing the number of prevocational training positions: by increasing the number of trainees attached to previously accredited rotations and also by accrediting new rotations – either in institutions or networks that previously offered accredited rotations or in new sites. These new sites include public and private hospitals which had not previously employed interns and a number of other sites, including general practices and specialties which have not previously provided supervised rotations for prevocational trainees. Many of these new positions are in rural, regional or outer metropolitan sites, where the current medical workforce shortage is most acute.

- b) **Capacity for Core Term Requirements.** Medical Boards require interns to complete minimum periods of time in accredited rotations in three ‘core’ disciplines; medicine, surgery and emergency medicine. PMCs in each jurisdiction have developed their own local approach to accreditation of core terms based on broad guidelines provided by Medical Boards. However, the composition of these rotations or their educational goals have not been defined in any detail.

A number of differences have emerged between jurisdictions, most notably for the emergency medicine rotation – eg rotations in general practice with exposure to emergency medicine are accredited in South Australia and accepted as core emergency medicine exposure by the Medical Board of South Australia; Victoria has developed criteria which allow interns to complete 3 of the 8 weeks of the term in Emergency Departments which do not employ a Fellow of the Australasian College of Emergency Medicine.

There is widespread concern about capacity to provide core rotations for the increased number of medical graduates, particularly in emergency medicine and to a lesser extent in surgery. There is a strong consensus among all stakeholders

that experience in emergency medicine should be a mandatory component of the intern year.

- c) **The Australian Curriculum Framework for Junior Doctors** The recent development and wide acceptance of the ACFJD has provided a unique opportunity to make significant improvements to both the composition of internship and to the processes for notification of its satisfactory completion.

There is now a general consensus that clinical experience, learning objectives and appraisal processes for each intern rotation should be guided by the ACFJD. The ACFJD National Steering Group is currently conducting pilot studies of term descriptions and mid- and end of term appraisal processes based on the ACFJD. If this approach is to be adopted it will be necessary to identify which components of the ACFJD, a framework for 2 years of prevocational training, are appropriate for each intern rotation.

Development of a curriculum-based approach to prevocational training has identified a number of deficiencies in the current composition of the intern year. Nearly all Australian interns spend the year providing supervised care to public hospital inpatients. However, most will eventually choose a career which is predominately in ambulatory practice and the casemix in Australian public hospitals is increasingly skewed away from ambulatory medicine. A significant number of ACFJD learning objectives would be much easier to achieve in ambulatory practice, such as general practice, community medicine or specialist consulting. The majority of routine elective surgery is now performed in private hospitals and this has led to a much more limited clinical exposure for interns during core surgical rotations.

- d) **Competency Based Training vs Time Based Training.** The use of ACFJD learning objectives to define satisfactory completion of internship raises the possibility of discontinuing time based training requirements for prevocational training. If it is possible to document competency in all intern-level learning outcomes, is it necessary for interns to complete a mandatory period of clinical experience during the year or to complete mandatory periods of clinical experience in core rotations? A competency based approach to internship may help to shorten the duration of medical training.

Competency based medical training is currently under active investigation, both in Australia and overseas. Opponents have argued that clinical competence is broader than the sum of individual competencies. Competence to practise at a certain level should include capacity for thinking and reasoning, insight into the limits of one's knowledge, and an ability to develop a holistic view of clinical practice, including when and why to use a skill in which competency has been attained or certified. Broad clinical competence is much more difficult to define or certify than competency in a specific skill and time based training may be the best approach to ensuring that trainees achieve it. The following comment is taken from a recent AMC review of the literature on competency based training.

“The AMC accreditation standards recognize that some training organizations are able to specify measurable competencies in some parts of the training program, and that recognition of competence achieved in these areas may allow early exit from the training program. However, while applauding these efforts to define competencies, the AMC indicates that higher level cognitive programs like medicine with multifaceted competencies, such definitions and measurements are difficult’ AMC 2008³

3. Recommendations

The recommendations of the working party are listed as responses to its terms of reference:

- 1. To describe the internship as it currently operates across the states and territories including intern allocation/recruitment processes in each jurisdiction**

See *Internship in Australia* above.

- 2. To provide advice regarding:**

- i) the nature and purpose of internship**

Internship is a period of mandatory general experience after graduation. The purpose of the internship is to provide a period of supervised, work-based training, to develop the skills in clinical management, communication and professionalism that are required for full registration.

- ii) the mix of clinical rotations/terms to be included in an internship**

The working party recommends that 8 to 10 weeks (excluding annual leave, sick leave or approved study or conference leave) of clinical experience in medicine, surgery and emergency medicine should be mandatory for all Australian interns. The working party’s recommendations on the nature of the clinical experience in each of these disciplines are set out in Appendix 3.

The working party makes no specific recommendations for the remaining intern rotations, except to note that exposure to ambulatory health care during prevocational training is desirable.

³ Australian Medical Council, May 2008, Strategic Policy Advisory Committee Background Document, *Competency-based Training in Medical Education: A review of the Literature*, (page 15)

iii) the location (health care setting) of the internship

The working party suggests that any location which is able to provide appropriate, accredited clinical experience is suitable for intern training.

The working party anticipates that it is unlikely that appropriate clinical experience in medicine or surgery can be provided outside hospital settings. Appropriate experience in emergency medicine may be provided in some non-hospital sites.

As discussed in 2 ii), exposure to ambulatory health care during prevocational training is desirable.

iv) any compulsory “core terms” e.g. medicine, surgery, emergency or equivalent

See response to 2 ii).

v) competence versus time based approaches to internship

The working party is not convinced that a competency based approach would ensure that interns acquire the higher level skills in clinical management, communication and professionalism that are required for full registration.

The working party recommends that internship should be completed in not less than one year and should comprise at least 47 weeks of full time equivalent (FTE) clinical experience in accredited rotations (normally over one year), including up to two weeks approved conference or study leave.

3. To provide advice regarding nationally consistent:

i) processes for signing-off each trainee and notifying the medical board for general registration at the successful completion of internship

The working party recommends that “sign off” should be completed by:

- a) a senior clinician involved in supervision and training (eg Director of Clinical Training or Supervisor of Intern Training) and
- b) a senior medical administrator who can comment on the trainee’s attendance and other performance issues during the internship (generally the Director of Medical Services / Chief Medical Officer).

Sign off should be based on review of attendance (including completion of mandatory rotations) and end of term assessments, and a global assessment of whether the intern has the knowledge, skills and attributes required for general

registration. The working party has not made any recommendations on the number of satisfactory end of term assessments required for “sign off”.

The working party recommends that the “sign off” process at each training site should be included in PMC accreditation standards in all jurisdictions.

The working group has drafted a Certificate of Completion of Internship which could be used to notify satisfactory completion of internship to the Medical Board of Australia (Appendix 4)

ii) accreditation of prevocational training institutions and networks

The working party recommends that all clinical experience during internship should be in rotations accredited by the appropriate PMC. This accreditation should be consistent with the national PMAF and should be based on review of:

- orientation
- clinical experience
- levels of supervision and support
- an educational program based on learning objectives mapped to the ACFJD
- mid- and end of term appraisals, which include assessment of achievement of learning objectives

The recommendations of the working party include the addition of two new accreditation standards: the “sign off” process for satisfactory completion of internship (see recommendation 3 i) and processes for identification and remediation of poorly performing interns (see recommendation 3 iv).

The working party also recommends that all clinical experience during the later years of prevocational training should be in PMC accredited rotations.

The working party supports the proposal that all PMCs should be accredited by the AMC. Recent graduates are a particularly vulnerable group and accreditation of PMCs would ensure that the clinical experience of all Australian prevocational trainees was consistent with national standards. Accreditation by the AMC would also help to integrate training across the medical education continuum.

iii) processes for mid-term appraisal and end of term assessment which relate to the learning outcomes included in the Australian Curriculum Framework for Junior Doctors and contribute to the end of year sign off

The working party strongly supports the incorporation of ACFJD learning outcomes in mid-term appraisal and end of term assessment processes. It is not possible to make detailed recommendations until the results of the current pilot studies are available. As discussed above, it will be necessary to identify which components of the ACFJD are appropriate for individual intern rotations.

iv) mechanisms to refer interns to the medical board for unsatisfactory performance or other reasons

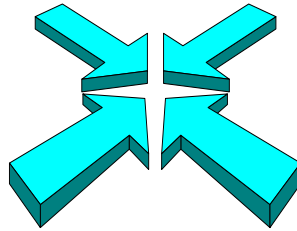
The working party recommends that borderline or unsatisfactory performance should be addressed during the intern year through appropriate remediation agreed at mid- or end of term assessment meetings. The nature of remediation and reassessment will vary according to specific circumstances and the availability of resources in each jurisdiction. Interns continuing to perform at or below borderline levels should not be “signed off” for full registration.

The working party recommends that processes for identification and remediation of poorly performing interns should be included in PMC accreditation standards in all jurisdictions.

Interns who are subject to a formal complaint or considered impaired should be evaluated through separate processes overseen by the Medical Board of Australia. The working party does not anticipate that the establishment of national registration and accreditation will alter current criteria for referral to a medical board. It is expected that the Medical Board of Australia will provide guidance on whether a referral should be to a local or national board. Early communication with the board will continue to be important to maximise support and achieve positive outcomes.

Appendix 1 – CPMEC Response to Exposure Draft of the Health Practitioner Regulation National Law (Bill B)

Confederation of Postgraduate Medical Education Councils



The Confederation of Postgraduate Medical Education Councils (CPMEC) is an association of Postgraduate Medical Councils (PMCs) of each State or Territory in Australia.

In Australia, CPMEC comprises the following organisations:

- Postgraduate Medical Council of Western Australia (PMCWA)
- Postgraduate Medical Council of South Australia (PMCSA)
- Postgraduate Medical Council of Victoria (PMCV)
- Postgraduate Medical Council of Queensland (PMCQ)
- Postgraduate Medical Council of Tasmania (PMCT)
- NSW Institute of Medical Education and Training (IMET)
- Northern Territory Postgraduate Medical Council (NTPMC)

Recently the Education Committee of the Medical Council of New Zealand also became a full member of the CPMEC.

PMCs are responsible for supporting and developing the education and training programs for junior doctors during their prevocational years (generally postgraduate years 1 and 2 (PGY1 and PY2)). A key role for PMCs is accreditation of prevocational training positions; all PGY1 positions in all jurisdictions, and PGY2 positions in some jurisdictions. PMCs also play an important role in the education and training of international medical graduates (IMGs), particularly those working under supervision in hospitals.

CPMEC is pleased to be offered an opportunity to comment on the exposure draft of the *Health Practitioner National Law 2009*, the proposed legal framework for the National Registration and Accreditation Scheme (NRAS) for the Health Professions, which will come into effect on July 1, 2010.

In general CPMEC is very supportive of national registration and accreditation as it relates to prevocational medical training. We would like to make some specific comments and raise some issues for consideration by legislators. These comments are listed under the headings of the *Guide to the Exposure Draft of the Health Practitioner Regulation National Law 2009*, published by the Australian Health Workforce Ministerial Council on June 12, 2009. The comments are restricted to those most relevant to prevocational medical training.

1. Definition of the Accreditation function

CPMEC is of the view that the core accreditation functions as defined in Part 6, Clause 59 of the Exposure Draft need to be expanded. Currently PMCs are responsible for development of standards and assessment of the capacity of every

individual hospital unit with interns to ensure that appropriate training is provided to meet registration requirements of State and Territory Medical Boards. This accreditation process has been critical in protecting and enhancing public safety and the education of junior doctors in Australia.

We believe that definition of the accreditation function should be expanded to include reference to accreditation of such training positions in hospital and other settings, in addition to courses of study. This could be achieved by including accreditation criteria for completion of internship in the definition. The following are specific examples of amendments that could be made to the legislation to accommodate our concerns:

a. Definition of supervised practice

A possible definition could be:

‘Approved supervised practice for a health profession means a period of supervised practice which has been approved by the National Board under section 80 (1)’.

b. Expanded accreditation function

A possible definition could be:

Accreditation function means:

‘Assessing periods of supervised practice to determine whether the experience meets approved accreditation standards’.

This provision could then allow the National Medical Board to ensure that the supervised practice undertaken through the internship is appropriate for general registration. This may be a responsibility the Board delegates to an appropriate organisation, for example the Australian Medical Council (AMC) and the PMCs.

If this aspect is not clarified further then it could be suggested that any period of supervised experience may be sufficient for general registration which would not be in keeping with the objectives and guiding principle of the NRAS.

2. Independent accreditation functions

CPMEC strongly supports the decision to maintain an accreditation process which is independent of government and is based on standards developed by an independent accrediting body (the AMC for medical accreditation) or the accreditation committee of the relevant national board.

The AMC currently oversees accreditation of two of the three phases of medical education; medical school training provided by universities and vocational training provided by Colleges. CPMEC believes that prevocational training should also be accredited by the AMC. An AMC working party is currently investigating the feasibility of implementation of accreditation of PMCs.

In contrast to the other two phases of medical education, accreditation of prevocational training positions is performed at a jurisdictional rather than a national level. CPMEC supports the development and incremental implementation of a set of national accreditation standards for prevocational positions, which include standards incorporating the Australian Curriculum Framework for Junior Doctors. Introduction of a national accreditation process for prevocational positions should be planned in consultation with jurisdictions and PMCs. CPMEC

is close to finalising a national Prevocational Medical Accreditation Framework which will be presented to the relevant accrediting body.

CPMEC would like to raise the issue of funding arrangements for accreditation of prevocational medical positions. In several jurisdictions, accreditation is funded by State Medical Boards. It is critical that transitional arrangements ensure continuation of funding for accreditation of prevocational medical positions in these jurisdictions. This is a particular concern over the next 12 to 24 months as additional funding will be required for accreditation of new prevocational positions following the recent expansion of Australian medical school intakes.

3. Changes to registers

The exposure draft includes a clause providing for a period of provisional registration of up to 2 years as decided by the national board. State Medical Boards currently award provisional registration to medical graduates for 1 year, which is converted to unconditional registration on satisfactory completion of an accredited intern (PGY1) year. However, the processes for documenting satisfactory completion of the intern year vary between jurisdictions and are not based on achievement of educational goals.

CPMEC recommends that provisional registration for the intern year should continue and that the national board should develop a procedure to assess and document satisfactory completion of the intern year. In our view this procedure should be based on workplace based assessments by supervisors and achievement of learning objectives within the Australian Curriculum Framework for Junior Doctors. A CPMEC working party is currently preparing a discussion paper, which will be forwarded to the national board later this year.

CPMEC is concerned that the current wording of the legislation limits the period of provisional registration to 2 years. This does not take into account part-time employment, or time off due to illness, maternity leave, etc. We suggest that the legislation is amended to state that provisional registration should normally not be more than 2 years full time equivalent on conditions to be decided by the Board.

It would also be useful if the criteria for provisional registration (part 7 Division 3 Clause 80 (1) (a)) could clarify that the individual must have a qualification from an approved program of study instead of using the word 'qualified' in this context which could be misleading. We suggest that the clause be amended as follows:

“(a) the individual holds a qualification from an approved program of study required for general registration...”

In relation to IMGs, many of these doctors working in prevocational positions in hospitals are awarded conditional (limited under the proposed legislation) registration by State Medical Boards. CPMEC recommends that a national process is developed to ensure appropriate forms of registration for IMGs, which are based on a robust assessment of clinical skills prior to employment.

4. Support for continuing professional development

CPMEC supports the proposal that annual renewal of registration should be dependent on demonstration of participation in an approved continuing

professional development program as set down by the relevant board. We strongly suggest that national guidelines for professional development programs for prevocational doctors should be developed based on achievement of learning objectives included in the Australian Curriculum Framework for Junior Doctors.

Professional development programs for prevocational doctors are developed and delivered by CPMEC and PMCs, which are primarily funded by the Commonwealth and State governments respectively. It is critical that transitional arrangements ensure that funding for these bodies is continued.

5. Other improvements to quality and safety of health service

a. Mandatory reporting of registrants

CPMEC supports mandatory reporting of registrants who place the public at risk of harm.

b. Criminal history and identity checks

CPMEC supports mandatory criminal history and identity checks for health professionals registering for the first time in Australia and annual declarations by registrants on criminal history matters.

CPMEC is aware of arbitrary variations in requirements for police checks between workplaces which can be onerous. We urge governments to develop uniform processes throughout Australia, which may include additional levels of police checks for practitioners working with children.

c. Simplified complaints arrangements for the public

CPMEC urges governments to work together to ensure that any new complaints arrangements avoid duplication of existing processes. The possibility of having a two tier system for complaints, performance, health and conduct would not be equitable and may reduce the clarity of the scheme for both the public and the registrants.

6. Appointments to National boards / State and Territory boards

CPMEC supports the proposed composition of national boards and the proposed relationships between the national boards and State and Territory boards.

7. Privacy protections for practitioners and consumers

CPMEC supports the proposed privacy protection process.

8. Transitional arrangements

CPMEC supports the proposed transitional arrangements. As discussed above, it is critical that transitional arrangements ensure continuation of funding for:

- accreditation of prevocational medical positions
- professional development programs for prevocational doctors which are developed and/or delivered by CPMEC and PMCs

Should you have any queries in relation to the CPMEC submission please contact our General Manager, Dr Jag Singh at jsingh@cpmec.org.au.

Professor Louis I. Landau
Chair, CPMEC

Appendix 2 - Terms of Reference for a Working Party on *National Registration and the Internship*

1. Background

Australia will soon establish a national medical board and medical register to replace the current state and territory boards and registers.

The Medical Board of Australia is expected to be appointed in mid-2009 and the new national registration scheme will commence on 1 July 2010.

The nature of the internship for medical graduates will be a matter for the new board to decide although there will be a specific category of registration covering interns. The new board will likely be seeking advice on how best to approach the internship from a national perspective. To this end, the CPMEC and its member organisations agreed to convene a Working Party to develop guidance on the structure of the internship in the context of national registration.

2. Title

National Registration and the Internship Working Party

3. Purpose

To provide advice to the CPMEC concerning the structure, format and content of the internship in the context of a national registration scheme for medical practitioners.

4. Membership

Nominee from each Postgraduate Medical Council and the ACT Representative

Nominee from the AMC Working Party on Prevocational Training

Nominee from the Joint Medical Boards Advisory Committee

Nominee from the New Zealand Medical Council

Two junior doctor representatives

Other members at the discretion of the Chair

The Working Party will be chaired by the Deputy Chair of CPMEC and assisted by a smaller writing group.

5. Objectives

4. To describe the internship as it currently operates across the states and territories including intern allocation/recruitment processes in each jurisdiction
5. To provide advice regarding:
 - the nature and purpose of internship
 - the mix of clinical rotations/terms to be included in an internship
 - the location (health care setting) of the internship
 - any compulsory “core terms” e.g. medicine, surgery, emergency or equivalent
 - competence versus time based approaches to internship

6. To provide advice regarding nationally consistent:
- processes for signing-off each trainee and notifying the medical board for general registration at the successful completion of internship
 - accreditation of prevocational training institutions and networks
 - processes for mid-term appraisal and end of term assessment which relate to the learning outcomes included in the Australian Curriculum Framework for Junior Doctors and contribute to the end of year sign off
 - mechanisms to refer interns to the medical board for unsatisfactory performance or other reasons

In carrying out these functions, the Working Party will take into account:

- any work undertaken by the AMC to review the composition of the intern year as part of the discussions on possible accreditation of PMCs by the AMC
- work undertaken by the CPMEC to develop a national accreditation framework
- the nature and purpose of the PGY2 year and beyond
- the recommendations of the Doherty report (*Australian Medical Education and Workforce into the 21st Century, 1988*)
- transitional arrangements for current students
- the work of other organisations or individuals as required

6. Reporting

The Working Party will report to the CPMEC Executive by June 2009.

Appendix 3 - Clinical Experience during the Internship

Mandatory rotations should include the following clinical experience:

1. Clinical experience in medicine

A medical rotation should be a mandatory component of the intern year. The working party recommends that the medicine rotation should be consistent with a set of standards based on achievement of ACFJD learning objectives within three learning areas; clinical management, communication and professionalism. These standards should be the basis for accreditation of all medicine positions. This will allow accreditation of general medical and some subspecialty medical rotations.

The working party recommends that the minimum duration of experience in medicine should ideally be 10 weeks, not including annual leave. However, Postgraduate Medical Councils should have some discretion to recommend a minimum of 8 weeks clinical experience if a rotation is satisfactory in all other ways.

Accreditation of rotations for mandatory experience in medicine should be based on the following standards. There should be:

- Direct supervision by a clinician with appropriate experience in internal medicine.

Clinical management

- Opportunities to assess and contribute to the care of patients admitted to medical units. This should include taking a history, performing a physical examination, developing a management plan, ordering investigations, making referrals and monitoring progress, all under appropriate supervision.
- Clinical exposure to a range of common clinical conditions which are managed in medical units
- Clinical exposure to critically ill patients, either at presentation or as a result of deterioration during admission, which should include experience of assessing these patients and actively participating in their initial investigation and treatment.
- Opportunities to interpret investigations ordered as part of the management plan of patients admitted to medical units.
- Opportunities to observe and perform a range of procedural skills, as outlined in the Australian Curriculum Framework for Junior Doctors.
- Opportunities to develop skills in safe prescribing of medications, including fluids, blood and blood products

Communication

- Opportunities to develop communication skills needed for safe delivery of care through interaction with peers (particularly through handover), supervisors, patients and their families, and other health care workers involved in inpatient and ambulatory care. This should include opportunities to develop skills in obtaining informed consent and discussing poor outcomes and withdrawal of care. This should include opportunities to develop skills in , and in discussing poor outcomes and withdrawal of care.

- Opportunities to develop an appreciation of the interaction of inpatient medicine with subacute, community and ambulatory care facilities, including an appreciation of appropriate discharge destinations and follow up.
- Preparation of discharge summaries.

Professionalism

- Opportunities to develop an understanding of resource allocation in medical units
- Opportunities to understand the roles and responsibilities of various health professionals in the management of each patient and the interaction between them, and to play an active role in the multidisciplinary health care team

2. Clinical experience in surgery

A surgical rotation should be a mandatory component of the intern year. The working party recommends that the surgery rotation should be consistent with a set of standards based on achievement of ACFJD learning objectives within three learning areas; clinical management, communication and professionalism. These standards should be the basis for accreditation of all surgery positions. This will allow accreditation of general surgical and some subspecialty surgical rotations.

The working party recommends that the minimum duration of experience in surgery should ideally be 10 weeks, not including annual leave. However, Postgraduate Medical Councils should have some discretion to recommend a minimum of 8 weeks clinical experience if a rotation is satisfactory in all other ways.

Accreditation of rotations for mandatory experience in surgery should be based on the following standards. There should be:

- Direct supervision by a clinician with appropriate experience in surgery.

Clinical management

- Opportunities to assess and contribute to the care of patients admitted to surgical units. This should include taking a history, performing a physical examination, developing a management plan, ordering investigations, making referrals and monitoring progress, all under appropriate supervision.
- Clinical exposure to all phases of care of a range of common surgical conditions, including preoperative evaluation, operative management and post-operative care. Interns should routinely attend operating theatre sessions during the surgical term.
- Clinical exposure to critically ill surgical patients, either at presentation or as a result of deterioration during admission, which should include experience of assessing these patients and actively participating in their initial investigation and treatment.
- Opportunities to interpret investigations ordered as part of the management plan of patients admitted to surgical units.
- Opportunities to observe and perform a range of procedural skills, as outlined in the Australian Curriculum Framework for Junior Doctors
- Opportunities to develop skills in safe prescribing of medications, including

fluids, blood and blood products

Communication

- Opportunities to develop communication skills needed for safe delivery of care through interaction with peers (particularly through handover), supervisors, patients and their families, and other health care workers involved in inpatient and ambulatory care. This should include opportunities to develop skills in obtaining informed consent, and in discussing poor outcomes and withdrawal of care.

Professionalism

- Opportunities to develop an appreciation of the interaction of inpatient surgical care with subacute, community and ambulatory care facilities, including an appreciation of appropriate discharge destinations and follow up.
- Opportunities to understand the roles and responsibilities of different members of the surgical team in the management of each patient, including pre and post operative care, and to play an active role in the multidisciplinary health care team.
- Preparation of discharge summaries.
- Opportunities to develop an understanding of resource allocation in surgical units

3. Clinical experience in emergency medicine

Emergency medicine should be a mandatory component of the intern year. However, there is concern about the capacity of Emergency Departments in Australian hospitals to provide appropriate experience for all interns as the number of graduates increases.

The working party has attempted to identify the most appropriate balance between:

- the risk of reduced quality and quantity of clinical experience in emergency medicine if there are significant increases in the number of interns attached to each hospital Emergency Department
- the risk of inadequate supervision or insufficient exposure to emergency medicine for interns who do not complete a rotation in a hospital Emergency Department

The working party recommends that emergency medicine rotations in either hospital or alternative settings should be consistent with a set of standards based on achievement of ACFJD learning objectives within three learning areas; clinical management, communication and professionalism. These standards should be the basis for accreditation of all medicine positions.

The working party recommends that the minimum duration of experience in emergency medicine should ideally be 10 weeks, not including annual leave. However, given of the difficulty of providing 10 weeks experience to all of the increased numbers of graduates entering internship over the next 5 to 10 years, Postgraduate Medical Councils should have some discretion to recommend a

minimum of 8 weeks clinical experience if a rotation is satisfactory in all other ways. Emergency medicine experience should not be significantly interrupted by other duties, such as ward cover.

Accreditation of rotations for mandatory experience in emergency medicine should be based on the following standards. There should be:

- Direct supervision by a senior clinician with appropriate experience in emergency medicine. The exact nature of the supervision and the qualifications of the supervisor have not been defined as there are differences between jurisdictions.

Clinical management

- Opportunities for the intern to be the first clinician to assess patients with undifferentiated problems who present for acute care. This assessment should include taking a history, performing a physical examination, developing a management plan, ordering initial investigations and making referrals, all under appropriate supervision.
- Clinical exposure to a range of common clinical conditions which are managed in an emergency setting, including opportunities to devise a management plan, initiate treatment under supervision and participate in decisions to admit patients. Emergency medicine experience should not be significantly interrupted by other duties, such as ward cover.
- Clinical exposure to critically ill patients at the point of first presentation, which should include experience of assessing these patients and actively participating in their initial investigation and treatment. Ideally this should include some exposure to management of resuscitation and trauma, either in an Emergency Department setting or in a high fidelity clinical skills laboratory.
- Opportunities to interpret investigations ordered as part of the initial management plan of patients presenting for acute care.
- Opportunities to observe and perform a range of procedural skills, as outlined in the Australian Curriculum Framework for Junior Doctors.

Communication

- Opportunities to develop communication skills needed for delivery of care in an emergency setting through interaction with peers (particularly through handover), supervisors, patients and their families, and other health care workers involved in inpatient and ambulatory care. This should include opportunities to develop skills in obtaining informed consent, and in discussing poor outcomes and withdrawal of care.
- Preparation of discharge letters or summaries.

Professionalism

- Opportunities to understand the roles and responsibilities of various health professionals in the management of each patient and the interaction between them, and to play an active role in the multidisciplinary health care team
- Opportunities to develop an appreciation of the interaction of emergency medicine with community and ambulatory care facilities, including an appreciation of appropriate discharge destinations and follow up.
- Opportunities to develop an understanding of resource allocation in emergency settings.

APPENDIX 4

Certificate of Completion of Internship

Name of Intern:	
Provisional Registration No:	
Date Internship Commenced:	
Date Due to Complete Internship:	

Clinical Experience

	Medicine	Surgery	Emergency Medicine
Accredited Term Name:			
Training Site:			
Total Number of Weeks: (Not including leave)			

	Rotation 4 (if applicable)	Rotation 5 (if applicable)	Rotation 6 (if applicable)	Rotation 7 (if applicable)
Accredited Term Name:				
Training Site:				
Total Number of Weeks: (Not including leave)				

Leave Taken

	Total Annual Leave	Total Sick Leave	Other Leave (e.g. study or conference, please state)
Total number of days taken during internship:			
Please provide comments if more than 5 weeks annual leave, more than 2 weeks total sick leave or other leave has been taken during internship.	Comments:		

NOTE: If the internship has been completed satisfactorily please complete the next page. If the internship has not been completed satisfactorily please contact the Medical Board of Australia.

Declaration by the Applicant

To: THE MEDICAL BOARD OF AUSTRALIA

I confirm that the details provided in my Record of Completion of the Medical Internship are accurate and that I will have completed at least 47 weeks of full time accredited supervised practice on: _____ (insert date).

Signed: _____ Name: _____

Date: _____ Registration No. _____

Address: _____

Declaration by the Director of Clinical Training (or equivalent)

To: THE MEDICAL BOARD OF AUSTRALIA

I confirm that the details provided in the Record of Completion of the Medical Internship for the intern named above are accurate.

I have reviewed the intern's end of term assessments and consider that the intern has achieved the relevant learning objectives in the Australian Curriculum Framework for Junior Doctors.

Signed: _____ Name: _____

Position: _____

Date: _____

Declaration by the Director of Medical Services (or equivalent)

To: THE MEDICAL BOARD OF AUSTRALIA

I confirm that the details provided in the Record of Completion of the Medical Internship for the intern named above are accurate.

The intern will have completed at least 47 weeks of full time accredited supervised practice on: _____ (insert date), including at least 8-10 weeks in medicine, surgery and emergency medicine.

Signed: _____ Name: _____

Position: _____ Date: _____