

National Framework for Prevocational Medical Training

Prevocational training in Australia has long needed reform.¹ Internship in postgraduate year 1 (PGY1) was variably accredited by state and territory medical registration boards and then prevocational medical councils (PMCs), which were established in the 1980s and 1990s. In 2013, the Australian Medical Council (AMC) introduced a national framework for medical internship on behalf of the Medical Board of Australia (MBA). This was enabled by a new national registration scheme.² Many, but not all, PMCs have also accredited postgraduate year 2 (PGY2) posts. The AMC began accrediting PMCs almost three decades after medical schools and after a decade of college accreditation.

The structure of Australian internship, with mandatory terms in medicine, surgery and emergency medical care, has not changed in decades, despite significant changes in medical practice and health care needs. Interns have increasingly been performing more administrative tasks to maintain hospital throughput with fewer opportunities to use or develop their clinical skills.³ PGY2 rosters have generally been designed to meet hospital workforce requirements rather than the needs of prevocational doctors. The United Kingdom and New Zealand have introduced significant reforms focusing on educational value and generalist experience (<https://foundationprogramme.nhs.uk/programmes/2-year-foundation-programme/>).⁴

The 2015 review of medical intern training commissioned by the Council of Australian Governments (COAG) found that internship had not adapted to changes in the health system, was not aligned with societal health care needs and played a limited role in supporting generalism.³ The reviewers noted variable learning experiences and supervision, and recommended expansion of training beyond public hospitals. They suggested a 2-year capability and performance framework with robust workplace-based assessment but recommended that completion of PGY1 should remain the point of general registration. They also suggested an AMC-auspiced certificate of satisfactory completion for PGY2 and investigation of options for an e-portfolio.

In 2018, COAG accepted most of the review's 20 recommendations.⁵ As the AMC had already established a working party for a scheduled 5-year review of the 2014 framework, COAG requested that the AMC working party address the relevant recommendations. The working party included expertise in medical education and medical administration, prevocational doctors, supervisors and PMC representatives.

Four subgroups were established to oversee the key framework components: training and assessment, training environment, quality assurance and e-portfolio. There was also a reference group with

representation from all key stakeholders. The working party reported to AMC's Board of Directors through the Prevocational Standards Accreditation Committee. There was a second reporting channel to the Health Chief Executives Forum (HCEF, previously the Australian Health Ministers Advisory Committee).

The new framework was developed through four rounds of public consultations: an initial consultation on scope in 2019 and three consultations on draft framework components in 2020 and 2021. There were more than 150 meetings, presentations and workshops with stakeholders (including prevocational doctors, medical students, consumers, postgraduate medical councils, medical educators, specialty colleges, health services, and state and Commonwealth health departments). The final framework documents, including high level specifications for a national e-portfolio, were published in August 2022. Implementation commenced in January 2024.⁶

The goals of the new framework

The framework has been developed to address the issues identified by the 2015 review of medical intern training³ and the scoping consultation. Its high level goals are:

- deliver a national, 2-year, longitudinal, work-based training program providing broad generalist experience;
- align the training with the health needs of the Australian population;
- broaden prevocational training by increasing the focus on Aboriginal and Torres Strait Islander health concerns;
- improve supervision, feedback and assessment;
- renew focus on clinical work; and
- improve trainee wellbeing.

What's changing?

Training and assessment

The previous AMC intern outcome statements were revised to the prevocational outcome statements, which better align prevocational training with community health needs, including a significant strengthening of Aboriginal and Torres Strait Islander-related outcomes to promote culturally safe practice.

A robust, clinically focused assessment process has been developed, which includes work-based assessments of four entrustable professional activities⁷ (EPAs; clinical assessment, recognition and care of the acutely unwell patient, prescribing, and team communication [documentation, handover and

Brendan Crotty^{1,2}

Nicholas J Glasgow^{3,4}

Jo Burnand⁵

Georgia Cooke⁶

Katrina Anderson³

Kirsty White¹

Sarah Vaughan¹

Madeleine Novak¹

Andrew H Singer^{7,8}

¹ Australian Medical Council, Canberra, ACT.

² Deakin University, Geelong, VIC.

³ Australian National University, Canberra, ACT.

⁴ Clare Holland House, Canberra, ACT.

⁵ NSW Health Education and Training Institute, Sydney, NSW.

⁶ Princess Alexandra Hospital, Metro South Health, Brisbane, QLD.

⁷ Australian Government Department of Health, Canberra, ACT.

⁸ Canberra Hospital and Health Services, Canberra, ACT.

brendan.crotty@deakin.edu.au

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Overview of framework program and term requirements

	Postgraduate year 1	Postgraduate year 2
Length	Minimum 47 weeks	Minimum 47 weeks
Structure	Minimum of 4 terms (of at least 10 weeks)	Minimum of 3 terms (of at least 10 weeks)
Specialties	Maximum 50% any specialty and 25% subspecialty	Maximum 25% subspecialty in a year
Embedded in clinical teams	At least 50% of the year	At least 50% of the year
Service terms: relief and nights	Maximum 20% of the year	Maximum 25% of the year
Term content: clinical experiences	Undifferentiated illness	Undifferentiated illness
	Chronic illness	Chronic illness
	Acute and critical illness	Acute and critical illness
	Perioperative/procedural	

referrals)), mandatory mid-term and end-of-term assessments and the creation of assessment review panels (ARPs).

All term descriptions and EPAs have been mapped to the new prevocational outcome statements and progress against these outcome statements will be tracked in the e-portfolio when it is introduced. There will be significantly improved feedback through term and EPA assessments and earlier detection and support of the small minority who are not progressing as expected.

Training environment

AMC standards for intern training programs and terms have been revised and extended to PGY2.

New rotation requirements have been introduced (exposure to patients with: undifferentiated illness; chronic illness; and acute and critical illness; and to peri-operative/procedural care; [Box](#)) to ensure different types of clinical experience while preserving breadth of clinical exposure, and to set limits on service and ward-based terms. Each term will be classified as providing one or two types of experience. There must be exposure to all four types of clinical experience during PGY1 and to three types during PGY2. A mandatory community term was strongly supported by the working party and a large majority of stakeholders but was not feasible in 2024. However, increased flexibility should enable training beyond public hospitals.

Mandatory supervisor training will be introduced over the first 3 years of operation, including training for EPA assessments. Health services are required to:

- provide education and training programs, including training in culturally safe practice;
- offer programs of support for doctors who are not progressing as expected;
- proactively assess and support prevocational doctor wellbeing and career development; and
- provide support for Aboriginal and Torres Strait Islander doctors to meet cultural obligations.

It is anticipated that the changes outlined in the previous two sections (training and assessment, and training environment) will assist with the sometimes stressful transition from medical school to prevocational training.

Certifying completion

ARPs will judge whether prevocational doctors have reached the expected standard — that is, achieved the prevocational outcome statements — at the end of each year. The ARPs will have access to all mid-term and end-of-term assessment outcomes and EPA assessments, as well as any additional learning activities completed during the year. There is no requirement to pass a minimum number of assessments. Panel judgements will be assisted by the tracking of progress against outcomes when the e-portfolio is introduced. PGY1 doctors who reach the expected standard will be recommended for general registration. PGY2 doctors who reach the expected standard will receive a certificate of completion from the AMC.

Accreditation (quality assurance)

From 2024, all prevocational training providers will be accredited against the new standards by their local PMC. PMCs will also be accredited against the new framework from 2024.

e-Portfolio

The e-portfolio (officially named Clinical Learning Australia) will contain each prevocational doctor's record of learning and will be the vehicle for all assessments, most of which will be recorded on a mobile device. The e-portfolio will track individuals' progress against the prevocational outcome statements and against assessment and clinical experience requirements, generating reminders for supervisors, medical education units and prevocational doctors.

HCEF has established a National e-Portfolio Board to oversee development, which has used the detailed specifications developed by the project for a tender process. The e-portfolio has been released and

is available for use for the rest of 2025. It will be mandatory for the 2026 clinical year.

Medical Board of Australia registration standard

The previous MBA registration standard for granting general registration has been replaced with a new standard reflecting the new framework.⁸ PGY1 and PGY2 doctors completing accredited training programs are exempt from MBA continuing professional development requirements.

Implementation

All states and territories introduced the new framework for PGY1 doctors in January 2024. New South Wales and the ACT also introduced the framework for PGY2 doctors. Other states and territories implemented PGY2 in January 2025. As EPA assessments have been designed for the e-portfolio, they will not be mandatory until the e-portfolio is delivered. However, many health services have commenced EPA assessments using paper-based forms or existing electronic learning management systems.

A suite of resources has been developed to support the new framework, including guides for prevocational doctors and their supervisors, FAQs (frequently asked questions), and slide packs, online modules and videos addressing specific components of the framework (assessment, EPAs, supervision, feedback, and Aboriginal and Torres Strait Islander components).⁶ Additional resources will be produced to support the e-portfolio.

What are the gaps?

In addition to delays in development of the e-portfolio and implementation of EPAs, there are two significant gaps.

The workforce crisis in Australian general practice is well documented⁹ and seems unlikely to be resolved without including community terms during the prevocational years, when most make their career choices.¹⁰ In the United Kingdom and New Zealand, prevocational training includes mandatory community terms.⁴ There was strong support for community terms during AMC consultations but agreement on requirements and funding for community terms is particularly challenging in Australia's federated health system. The AMC will consult again on including mandatory community terms in the first revision of the framework.

Improving supervision is constrained by relative under-resourcing of prevocational training. Mandatory training for term supervisors will have some impact but the goal should be appropriate recognition of the time and educational requirements of prevocational supervision.

Evaluation

The AMC plans a three-phase evaluation of the framework:

- monitor implementation through annual progress reports from, and scheduled accreditations of, postgraduate medical councils by the Prevocational Accreditation Committee;
- undertake a targeted review of key framework components in 2025 and 2026 (through an online survey, stakeholder focus groups and review of progress reports and accreditation assessments); and
- undertake a 5-year review of the framework, scheduled for 2029, including an assessment of progress towards meeting the goals of the framework and the recommendations of the 2015 review of medical intern training.

Minor revisions of the framework may be introduced after the targeted review. A more detailed revision will take place after the 5-year review.

Conclusion

The new national prevocational medical education framework has been designed to improve the quality of prevocational training, make it more relevant to modern health practice and improve patient care. It is the result of extensive consultation with doctors, health services, jurisdictions and PMCs, and is the most significant reform to Australian prevocational training in the last 50 years.

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