



A Review of Prevocational Training Requirements for Doctors in New Zealand: Stage 2

A second consultation paper on the proposed changes to prevocational training

Medical Council of New Zealand

Protecting the public, promoting good medical practice
Te tiaki i te iwi whānui me te whakatairanga pai i te mahi e pā ana ki te taha rongoā

February 2013

Foreword

The prevocational years (postgraduate year 1 and postgraduate year 2) are a crucial link in the training of doctors. They are the first real foray into independent professional life. They bridge the gap between medical school and vocational training. They help establish young doctors' careers and lead them into supervised practice in the application of their growing knowledge and skills.

The Medical Council of New Zealand (the Council) is currently responsible for regulating the first post graduate year and the training within that. We have been aware of feedback that the nature of both of the first 2 years in relation to experience and training can be unsatisfactory. Many have questioned whether they will equip our recent medical graduates to function well in our changing healthcare landscape. Our recent workforce reports have clarified an urgent need for change.

This second consultation paper suggests innovative, exciting improvements. It builds on the first consultation and sets out the really excellent work of the group set up to develop curriculum and assessment.

There is a genuine opportunity here for real change and development. It could help shape the nature of practice in New Zealand for many years to come. It could provide the means of ensuring quality in training during these years and the attractiveness of working in New Zealand.

Please get involved. Help us get it right and get it implemented. In the end, it is the quality of care delivered to the patients of New Zealand that this is about.

It is exciting to think that after years of talking about these issues something tangible can emerge that will enhance the quality of medical training in these prevocational years, and hence improve health care for New Zealanders.

I wish to thank the hard working team that produced this document. Joan Crawford and her team at the Council have done a great job. Professor John Nacey as Chair of this Working Group and the Council Education Committee has provided wonderful leadership and direction. It's a good read. Please let us know your thoughts.

A handwritten signature in black ink, appearing to read 'John Adams', written in a cursive style.

Dr John Adams
Chairperson
Medical Council of New Zealand

Contents

Foreword.....	2
Contents.....	3
Executive summary	5
Introduction	6
Oversight of prevocational training	6
Stakeholder collaboration.....	7
Scope of this paper	7
Background	7
The Council’s statutory role	7
Prescribed qualification	8
Consultation: Stage 1 (May 2011).....	8
Council decision – December 2011.....	9
Structure of prevocational training.....	10
The Trainee Intern year.....	10
Issues.....	10
Objectives	11
The Council’s proposals	12
1. Draft curriculum framework.....	12
Purpose of curriculum framework	12
Learning outcomes	13
Approach to drafting the curriculum framework.....	13
Advantages – Curriculum framework.....	13
Considerations – Curriculum framework	14
2. Professional development plan for PGY2	14
Programme requirements for PGY2	14
Australian graduates.....	15
International Medical Graduates (IMGs).....	15
Advantages – PDP for PGY2.....	15
Considerations – PDP for PGY2	15
3. Draft framework for assessment in PGY1 and PGY2	16
Advantages – Framework for assessment in PGY1 and PGY2.....	17
Considerations – Framework for assessment in PGY1 and PGY2.....	18
4. Record of learning (e-portfolio).....	18
Multisource feedback.....	19
Advantages – Record of learning (e-portfolio).....	20
Considerations – Record of learning (e-portfolio).....	20
5. Required experience.....	20
Current requirements.....	20
Clinical attachments	20
Standards for accreditation of training providers	21
Advantages – Accreditation of clinical attachments	21
Considerations – Accreditation of clinical attachments.....	21
6. Clinical settings	22
Mutual recognition with Australia.....	22
Advantages – clinical settings.....	22
Considerations – clinical settings	22
7. Summary - requirements for a general scope of practice	23
Evaluation	23
Timeframe for implementation	23
A request for comment.....	24

Acknowledgements..... 26
Bibliography 27
Appendix A New Zealand Curriculum Framework for Prevocational Medical Training 28
Appendix B Recertification requirements for doctors registered in a general scope of practice 47

Executive summary

The Medical Council of New Zealand (Council) is a statutory body that operates under the Health Practitioners Competence Assurance Act 2003 (HPCAA). The Council's purpose is to ensure that doctors are competent and fit to practise medicine in order to protect the health and safety of the public.

The Council initiated a review of prevocational training in late 2010. This is a second stage of the review. This consultation paper focuses on issues relating to the education and training of Interns, specifically the first two postgraduate years, PGY1 and PGY2.

The Council has identified a number of problems that would benefit from further improvement and development, and these include:

- The need to balance increasing service demands with increasing training requirements.
- Ensuring Interns obtain the broad based core competencies needed for medical practice in New Zealand.
- The need for better vertical integration on the continuum of training, and the transitions between medical school, prevocational training, and vocational training.
- The hiatus in training during PGY2.
- The need for training to be less hospital focussed, given the move to more community based practice in the future.
- The need for greater accountability by services training providers.
- To meet the safety concerns of locums.

A number of changes to prevocational training are being proposed by the Council. The proposals include the setting of learning outcomes (within a curriculum framework) and methods of assessment, changes to clinical attachments, and a greater focus on ongoing quality education and training through PGY1 and PGY2 by the use of a Professional Development Plan (PDP). The changes ensure more effective integration at both ends of the medical education continuum. This includes the transition between medical school and PGY1 and between prevocational training and vocational training. The proposals aim to promote good medical practice, and ensure safety and quality of patient care.

The Council seeks your feedback on the proposals and questions raised in this consultation paper.

Introduction

Medical education and training are a continuum, beginning with entry to university, proceeding through the prevocational years and vocational training, then continuing with lifelong learning through professional development activities.

The Intern years including both postgraduate year 1 and postgraduate year 2 allow newly qualified medical graduates to consolidate and further develop the clinical and professional skills acquired through the undergraduate years at medical school. This is achieved through completing attachments that provide a range of clinical experience, under the close supervision of senior doctors and more senior trainees.

There have been numerous reports over recent years exploring issues related to medical education, training and the health workforce. This includes reports from the Medical Training Board (2008 and 2009) and the RMO Commission (2009). Building on these reports, and supplemented by information the Council has gained through its hospital accreditation visits, the Council has identified a number of areas within with the current prevocational training arrangements that would greatly benefit from further improvement and development.

The Council initiated a review of prevocational training in late 2010. This focussed on issues relating to the education and training of doctors during PGY1 and PGY2. The review has been undertaken by the Council with the support of HWNZ.

The intention of the Council is to enhance and further develop the education and training of doctors during PGY1 and PGY2. This will ensure our Interns in PGY1 and PGY2 receive the quality education and training experience they require. This paper will refer to the doctors in those years of their training as 'Interns'.

The purpose of this consultation paper is to stimulate discussion and receive your feedback about a number of changes the Council is proposing to make to prevocational training, specifically for Interns during the PGY1 and PGY2.

Oversight of prevocational training

The Council, under the HPCAA has the authority to set competence and recertification programmes for doctors working to achieve general registration and to recertify once general registration has been achieved. The Council's role is primarily about the setting of standards and this includes the provision of a curriculum framework for the PGY1 and PGY2.

HWNZ funds both prevocational and vocational trainees. Decisions made by HWNZ regarding the funding and therefore the ability of DHBs to provide accredited runs may impact on the ability of Interns to meet the Council's standards relating to prevocational training.

This highlights the important relationship between the Council in its role as regulator and HWNZ in its role as funder. Each organisation has separate, albeit related, areas of responsibility.

A combined Steering Committee of the Council and HWNZ has been established to provide oversight and collaboration regarding matters pertaining to prevocational training. This allows issues to be discussed and consensus reached but final decisions regarding standards or funding are retained by the respective governance body.

Stakeholder collaboration

To ensure appropriate input throughout the review process the Council formed a working group that could help inform the review and provide expert advice. The working group comprises members with high levels of experience and expertise in medical education, Intern training, service provision, and medical regulation. The primary objective of the working group was to develop a succinct curriculum framework relevant to PGY1 and PGY2 that could be used as a basis for further consultation with stakeholders. The draft curriculum framework was completed following meetings of the working group throughout 2012. In addition, the working group provided valuable input into a framework for assessment that could be used to monitor and guide the Intern's progress.

The Council recognises that there are many stakeholders who each have an important role in service delivery, training, and support of Interns. The Council supports greater collaboration between the different organisations and groups involved in prevocational training and recognises the importance of consensus in order to achieve the desired outcomes. In recognition of this the Council established a Stakeholder Advisory Group thereby providing a forum through which the Council and HWNZ can regularly engage with stakeholders about prevocational training. The Stakeholder Advisory Group met in November 2012 and provided initial feedback about the Council's proposed changes. The feedback has informed this consultation paper.

Scope of this paper

This is the second stage of the review of prevocational training. For this stage of the review, the following aspects of prevocational training are considered:

1. Curriculum framework
2. Requirements for PGY2
3. Framework for assessment
4. Record of learning (e-portfolio)
5. Required experience
6. Clinical settings
7. Requirements to gain registration in a general scope of practice.

The Council recognises that elements of supervision and accreditation are fundamental to the success of the proposed changes to prevocational training. Subsequent stages of the review will focus on:

- Training and support for supervisors
- Standards for accreditation of training providers
- Standards for accreditation of individual clinical attachments.

Background

The Council's statutory role

The Council is the statutory body regulating doctors under the HPCAA. The Council is responsible for protecting the health and safety of the public by providing mechanisms to ensure that doctors are competent and fit to practise medicine. The Council has a number of functions and responsibilities under the HPCAA that include to:

- describe and gazette scopes of practice
- prescribe and gazette qualifications for each scope of practice
- accredit and monitor educational institutions or programmes of study
- promote education and training in the profession

- ensure doctors registered are fit to register and competent to practise within the scope in which they are registered.

Prescribed qualification

The current prescribed qualification for a general scope of practice (section A of the gazetted notice) for New Zealand or Australian graduates is that a doctor must satisfy the following:

Hold a primary medical degree from a New Zealand or Australian university medical school and have completed an internship in New Zealand or Australia.

If the doctor completes an internship in New Zealand, the following requirements must be met before the doctor is eligible for registration in a general scope of practice:

- work in a New Zealand hospital that has been accredited by the Council
- complete at least four 3 month attachments, including:
 - one category A medical attachment
 - one category A surgical attachment
 - two other attachments, which may be category A or B attachment
 - have three consecutive attachments immediately prior to applying for registration in a general scope where the doctor's performance is assessed to be of a satisfactory standard; two of these attachments must be in different disciplines
 - work no less than 10 weeks (or 10 weeks full time equivalent out of each attachment)
 - be certified in advanced cardiac life support as required by the Council's policy
 - be recommended for registration in a general scope by the Intern Supervisor.

It is the Council's responsibility to ensure that the satisfactory completion of requirements set for New Zealand or Australian medical graduates to gain a general scope of practice (during their provisional registration period) provides assurance of their competence to practise within that scope. The Council achieves this by setting the training and education requirements to be satisfactorily completed in the provisional period (PGY1). These requirements should provide an opportunity for Interns to further learn, develop and demonstrate clinical and professional skills under the supervision of senior doctors through an exposure to differing clinical settings. The achievement of these requirements provides assurance to the Council, and the public, of the competence of each doctor and helps ensure public safety.

Consultation: Stage 1 (May 2011)

In the first stage of the review (December 2010), a subgroup of the Council's Education Committee formed a working group. Membership included Professor John Collins who published *Foundation for Excellence: an Evaluation of the Foundation Programme* in the United Kingdom.¹ The group provided expert advice and assisted in the preparation of the first stakeholder discussion document (May 2011). This document *Prevocational training requirements for doctors in New Zealand: a discussion paper on options for an enhanced training framework* outlined the issues and drivers behind the need for a change to the prevocational training framework.² The document raised a number of questions and proposed possible options for change and was released to key stakeholders and the wider medical profession in May 2011.

¹ Medical Education England. *Foundations for Excellence: An Evaluation of the Foundation Programme*. Oxford: Medical Education England; 2010.

² Medical Council of New Zealand, *Prevocational training requirements for doctors in New Zealand: a discussion paper on options for an enhanced training framework*, Wellington, Medical Council of New Zealand, 2011.

This consultation process was intended to be the first stage of the review of prevocational training. The discussion paper primarily considered the structural issues of the framework. The Council acknowledged that the elements of curriculum, supervision, assessment, and accreditation were fundamental to the success of the prevocational training framework, and suggested that these would be reviewed in subsequent stages of the review.

However, it was clear from the feedback that the Council needed to immediately focus on the quality of the prevocational training experience. The Council was urged to introduce quality based learning, as this would provide the greatest benefit. The structural issues relating to the length of each clinical attachment and the length of the provisional registration period were viewed as less important. A common theme in the feedback was that quality aspects need to be integrated into the Council's approach from the beginning, otherwise changes in structure may provide little benefit.

Council decision – December 2011

At its meeting on 13 December 2011, the Council considered the feedback received through the consultation process along with recommendations from the Council's Education Committee. The Council made a number of decisions in the following key areas, each fundamental to the improvement of the quality of prevocational training, and thereby ensuring public safety and quality of care:

- Curriculum and learning objectives:
 - To request approval from Confederation of Postgraduate Medical Councils (CPMEC) for the use of the Australian Curriculum Framework for Junior Doctors (ACF) as a basis for the development of a New Zealand curriculum framework, to be used for further consultation.
 - To establish a working group of individuals with a high level of interest and expertise in medical education, including curriculum development and assessment, with the primary objective of developing a draft curriculum framework based on the Australian model.
 - To ensure that the draft curriculum is relevant and is specific about what needs to be achieved at the end of both PGY1 and PGY2.
 - To facilitate discussion with the Council of Medical Colleges to identify required learning objectives and competencies necessary for entry into vocational training programmes, and allow for recognition of prior learning when entering vocational training.
 - To review and strengthen standards for accrediting individual clinical attachments, and link the standards to the learning outcomes in the curriculum framework.
- Requirements for PGY2:
 - To propose that satisfactory completion of PGY1, when applying for a general scope of practice, Interns are to provide Council with a structured learning plan for PGY2 that has been agreed to by their colleague and the service provider. The learning plan is to be approved by Council as a competence programme or recertification programme.
- Clinical settings:
 - The learning outcomes in the curriculum framework will require Interns to be exposed to different clinical settings (inpatient, outpatient, and community based) in order to gain the required competencies. A prescribed portion of experience will be required to ensure the variety of clinical settings. This will require exploring with HWNZ, DHBs and other stakeholders how to fund and establish general practice, accident and medical practice, emergency medicine and other clinical attachments in the community.
- Elements of assessment:
 - To determine the most effective method for tracking, assessing and recording skills and knowledge acquired during PGY1 and PGY2.

- Accreditation of providers
 - To review and strengthen standards for accreditation for providers of prevocational training.
- Supervision requirements
 - To establish a framework that will ensure an accessible training programme for supervisors that covers the curriculum, assessment, provision of feedback, and dealing with poor performers.
 - To engage with the MOH, HWNZ, NHB, Quality and Safety Commission, and DHBs to explore funding models for the training of prevocational training supervisors.
 - That particular emphasis should be placed on making training providers and DHBs accountable for the provision of the required time and support for SMOs to adequately supervise and assess Interns, provide feedback and attend training sessions.

Structure of prevocational training

The Council received welcome feedback about its proposals to change the structure of prevocational training. There were arguments for and against changing the length of attachments from three months to four, and changing the length of the internship from one year to two. Responses emphasised that attention needed to be paid to improving the quality of training, rather than the length of the attachment or internship. *“Why extend a bad experience from 3 months to 4”* was typical of many comments. After considering the feedback the Council agreed to focus on improving the quality of the training experience, rather than the structure, and made two key decisions about the structure of prevocational training:

- **The length of each attachment will remain at 3 months.**
- **The length of the internship (the period registered in a provisional general scope of practice) will remain at 12 months.**

The Trainee Intern year

The Council has been exploring the potential for medical students to hold a limited form of registration in their Trainee Intern year. Following initial discussion between the Council and stakeholders including, universities, DHBs, and medical colleges, there has been general agreement that some form of limited registration for those in the Trainee Intern year would be beneficial. Some of the benefits identified would be:

- An improved continuum of education for Trainee Interns, in particular the transition between Trainee Intern and Intern years.
- An improved learning experience by ensuring that clinical responsibilities are well defined and appropriate supervision is provided.
- Improved patient care and protection of the public.

Some changes to the HPCAA are likely to be needed to allow for a limited form of registration of medical students, to ensure that only specific aspects of the HPCAA apply to these registrants. Therefore progress with this work is partly dependent on the review of the HPCAA. Once we have progressed this work, the Council intends to consult with stakeholders and the profession.

Issues

A series of themes have emerged from previous reports, and through the Council’s hospital accreditation visits. These include:

- ***The need to balance increasing service demand with increasing training requirements:*** There are inherent tensions between service delivery and the training requirements of Interns. This is placing the traditional apprenticeship model of training under increasing pressure. Rather than gaining valuable experience in diagnosis and treatment many Interns have reportedly felt that they were regarded as ‘units of labour’ to be deployed to cover service need including low level administrative tasks.
- ***The need to obtain broad based core competencies:*** A great deal of New Zealand’s population is located in regional centres and is disproportionately increasing in age meaning that there will be a growing proportion of people with long-term age-related conditions. The impact of geographic location and age demographics will require our Doctors to have a particular set of core general competencies in order to provide the necessary services.
- ***The need for better vertical integration on the continuum of training:*** It is accepted that medical education is a continuum with important transitions between undergraduate medicine, prevocational training, and vocational training. However, there is currently a lack of integration along this continuum. In part this is due to the number of organisations involved in medical education and training. Prior to the establishment of HWNZ no single agency had oversight of, or the ability to influence, the education continuum as a whole system.
- ***The need for training to be less hospital focussed:*** With the current and projected increase in the incidence of age-related and chronic conditions a greater share of medical services will need to be provided in community settings with a focus on prevention and long-term management.
- ***The need to remove the hiatus in training:*** Despite the fact that most doctors do not enter vocational training until they have completed at least two postgraduate years, there is no regulated requirement for formal training in place for doctors during their second postgraduate year (PGY2). This can be seen as a ‘lost’ year.
- ***The need for greater accountability by services training providers:*** There is currently no accountability mechanism, such as key performance indicators, linked to the funding provided for prevocational training. It is therefore impossible to determine to what extent funding is actually invested in training.
- ***The need to meet the safety concerns of locums:*** A PGY2 locum may have limited or no experience in the area of medicine in which they undertake the locum and supervision could be from a distance, or nonexistent. This raises concerns over the safety and quality of services PGY2 locums are providing and the training they receive.

Objectives

The Council has agreed to the following key objectives for prevocational training:

- PGY1 and PGY2 will build on the education and training that doctors receive at medical school.
- PGY2 will further extend competencies relevant to vocational training.
- Education and training requirements are of equal importance to service provision.
- Training will be primarily experience-based.
- Doctors will have access to training in a number of clinical settings.
- Specific learning objectives established for each attachment will ensure broad based training and be consistent with the competencies required for general registration.
- All senior doctors should participate in the supervision and training of Interns.

The Council's proposals

1. Draft curriculum framework

Prevocational medical training spans the two years following graduation from medical school and includes PGY1 and PGY2. The draft *New Zealand Curriculum Framework for Prevocational Medical Training* is an educational template outlining the learning outcomes required for doctors during these two prevocational years. (Please see Appendix A) These outcomes are to be achieved through the completion of clinical attachments, educational programmes and individual learning, in order to promote safe quality healthcare.

Purpose of curriculum framework

The implementation of a curriculum framework will ensure that there are clear expectations for all involved in prevocational training. Specific attachment objectives, linked to the curriculum framework will allow for a clear and common understanding for Interns, supervisors and training providers, of what needs to be achieved and assessed. It will allow for more effective vertical integration at both ends of the continuum of education and training. This includes the transition between medical school and PGY1, and also between the prevocational years and vocational training.

A curriculum framework allows for increased collaboration and integration across postgraduate medical training for different specialties. This is an opportunity for identification and agreement to a set of common competencies recognised by all the medical colleges as necessary for entry into any vocational training programme. Specific competencies gained and extended during PGY2 could be counted towards vocational training. It is important that the postgraduate medical colleges provide input to the set of generic learning objectives. Once agreement is reached, the competencies gained during the intern years, could be recognised as contributing towards vocational training requirements.

When commencing new attachments, *The New Zealand Curriculum Framework for Prevocational Medical Training* provides a useful guide for discussing the learning opportunities that may be available from a given attachment. It may help to identify particular skills and procedures that may be learnt during the attachment and to plan in advance to achieve such training.

A curriculum framework can be used as a tool for tracking and assessing progress towards gaining a general scope of practice, in addition to achievement of a professional development plan and entry into vocational training.

The *New Zealand Curriculum Framework for Prevocational Medical Training* aims to:

- build on undergraduate medical education by instilling in recently graduated doctors the attributes of professionalism, communication and the importance of patient care
- provide generic training that ensures PGY1 and PGY2 Interns develop and demonstrate a range of essential interpersonal and clinical skills for managing patients with both acute and long-term conditions, regardless of the specialty
- provide the opportunity to develop leadership, team working and supervisory skills in order to deliver care in the setting of a contemporary multidisciplinary team and to begin to make independent clinical decisions with appropriate support
- provide both PGY1 and PGY2 Interns with a variety of workplace experience during their prevocational training in order to best inform career choice.

Learning outcomes

The *New Zealand Curriculum Framework for Prevocational Medical Training* can be used to guide an Intern's continuum of learning from medical school through to PGY1 and PGY2.³ It outlines the desired learning outcomes, and recognises that proficiency in achievement of the capabilities will occur at different stages in training.

Review of progress will be assisted by Interns keeping a logbook that they can discuss and review with their Intern Supervisor and the clinical supervisor in each attachment (see draft framework for assessment in PGY1 and PGY2).

When commencing new clinical attachments, the *New Zealand Curriculum Framework for Prevocational Medical Training* provides a useful guide for discussing the learning opportunities that may be available within a particular clinical attachment. It may help to identify particular skills and procedures that may be learned during the attachment and to plan in advance to achieve such training.

At the completion of PGY1 Interns should have gained the necessary competencies to gain registration in a general scope of practice. During PGY2 Interns need to continue with structured learning to ensure they are competent to enter vocational training or to work in independent practice in a collegial relationship with a senior doctor at the end of PGY2.

Approach to drafting the curriculum framework

In 2008, the Medical Training Board (MTB) developed a draft curriculum framework, *the New Zealand Education Framework for Prevocational Training*. This was reviewed by the 2012 working group and informed the draft curriculum framework.

The working group also reviewed the *Australian Curriculum Framework for Junior Doctors* (ACF). Using the ACF as a basis the working group drafted the *New Zealand Curriculum Framework for Prevocational Medical Training*, focusing on the competencies required for medical practice in New Zealand. It is broken into the following five sections:

- Professionalism.
- Communication.
- Clinical management.
- Clinical problems and conditions.
- Procedures and interventions.

The learning outcomes in each section are divided into:

- An essential list of core skills a Intern needs to achieve by the end of PGY1, while recognising the limits of their personal capabilities.
- Skills and competencies that a doctor should develop and consolidate by the end of PGY2.

Advantages – Curriculum framework

The curriculum framework will:

- consolidate and further develop the clinical and professional skills gained through the undergraduate years
- continue through PGY1 and PGY2 to ensure a continuum of learning
- provide a clear and common understanding for Interns, supervisors, and employers, of what needs to be achieved and assessed

³ Medical Council of New Zealand, *New Zealand Curriculum Framework for Prevocational Medical Training*, Wellington, 2012.

- provide a useful guide for supervision meetings, when discussing learning opportunities.

Considerations – Curriculum framework

The following needs to be considered:

- The curriculum framework should not be viewed as an exhaustive list of skills and competencies that Interns need to achieve, but rather an indicative list to guide Interns and those involved in training.
- Interns will need to maintain a logbook which can be discussed with supervisors (see framework for assessment).
- The effective implementation of the curriculum framework is dependent on the commitment of all those involved in prevocational training, including senior doctors who supervise Interns.
- Agreement will need to be reached by all postgraduate medical colleges to the common set of competencies required to enter vocational training in any area of medicine.

Proposal 1:

The Council proposes that the *New Zealand Framework for Prevocational Medical Training* is implemented, to guide the continuum of learning through PGY1 and PGY2. The curriculum framework should not be viewed as an exhaustive list of skills and competencies that Interns need to achieve, but rather an indicative list to guide Interns and those involved in training.

Question 1:

Are there any significant changes that you think should be made to the draft *New Zealand Framework for Prevocational Medical Training*?

2. Professional development plan for PGY2

Although the Council agreed that the length of the provisional registration period would remain at 12 months, concerns remain about the lack of structure and quality of learning for PGY2. The use of a professional development plan (PDP) during PGY2 would provide greater structure and help to ensure ongoing quality learning.

A PDP is a short planning document, compiled by an Intern, in collaboration with the Intern Supervisor, with input from the supervisor of each clinical attachment. The PDP considers current learning and CPD needs, looks at how these might be met and lists objectives for the future. It helps an intern to structure and focus training needs, strengthen existing skills, and develop new ones. The PDP will focus on the Intern's career plan and intention for vocational training.

Programme requirements for PGY2

It is proposed that when applying for a general scope of practice each Intern will provide a PDP that will be approved as an individual competence programme to be completed during PGY2.

High level criteria for competence programmes will be set by the Council and will have flexibility to allow for a variety of learning. Interns who have gained a general scope of practice will be required to work in accredited attachments. These attachments will provide an ongoing learning environment, and an appropriate level of support. The Council recognises that some doctors enter vocational training at the end of PGY1, and there is allowance for this in the framework.

An endorsement will be included on the practising certificate of each Intern during their PGY2, under the competence provision of the HPCAA. This will remain on the practising certificate until the end of

PGY2, and satisfactory completion is indicated by sign off by a Council nominated Intern supervisor, or Director of Clinical Training.

Australian graduates

Australian graduates who have completed an internship in New Zealand or Australia (registered through the gazetted pathway 1), will be subject to the same requirements as New Zealand graduates during the 12 months immediately after gaining general registration. This will only apply for their PGY2 year. NZREX candidates will continue to be required to be subject to the same requirements as NZ graduates (as will Australian graduates).

International Medical Graduates (IMGs)

The requirements listed above do not apply to international medical graduates (IMGs) as they are required to work under the Council approved supervision to gain their general scope of practice. Doctors that gain registration down the Comparable Health System pathway, must have practised for 36 out of the last 48 months in a country that Council has determined is a comparable health system, and are therefore unable to gain registration in New Zealand during their second postgraduate year. Doctors who gain registration down the Competent Authority pathway, who have graduated with a United Kingdom or Irish medical degree and completed their internship and gained general registration in the United Kingdom or Ireland, are required to work under Council approved supervision for six months.

Once registered in a general scope of practice IMGs are required to either join the Council approved recertification programme for general scope registrants called *inpractice* which is administered by bpac^{nz}, (please see Appendix B), or join a Council accredited vocational training programme.

Advantages – PDP for PGY2

Advantages of the use of a PDP during PGY2 are:

- It will assist an intern to structure and focus current and future training needs.
- The PDP will focus on the Intern's career plan and intention for vocational training
- The principles of lifelong learning will be established early in the Intern's career.

Considerations – PDP for PGY2

The following needs to be considered:

- The Council has yet to decide whether the role of the Intern supervisor should be extended to incorporate oversight of the education for PGY2s, or whether to make alternative appointments, for example the Director of Clinical Training.
- Consideration will also need to be given to situations when doctors leave New Zealand at the end of PGY1 to either practise overseas, or have a break from practice (for example maternity leave, parental leave, or travel).

Proposal 2:

The Council proposes that an Intern must have a PDP approved (to be completed during PGY2) at the time of applying for a general scope of practice. Council also proposes that an endorsement be placed on the practising certificates of PGY2s indicating that a PDP is being completed.

Question 2:

What do you perceive to be the advantages and disadvantages to Interns completing a PDP during PGY2?

3. Draft framework for assessment in PGY1 and PGY2

Once the curriculum framework and learning outcomes have been set, Interns will need to demonstrate that they are meeting the standards. The Council wants to ensure that the assessment process is not overly bureaucratic or excessive, but at the same time the Council needs to ensure adequate assessment occurs for assurance of competence and performance. The assessment framework needs to take into account the impact on both the Intern and the supervisor providing supervision. It needs to be practical and easily implemented. Skills, competencies and performance will each require some form of assessment.

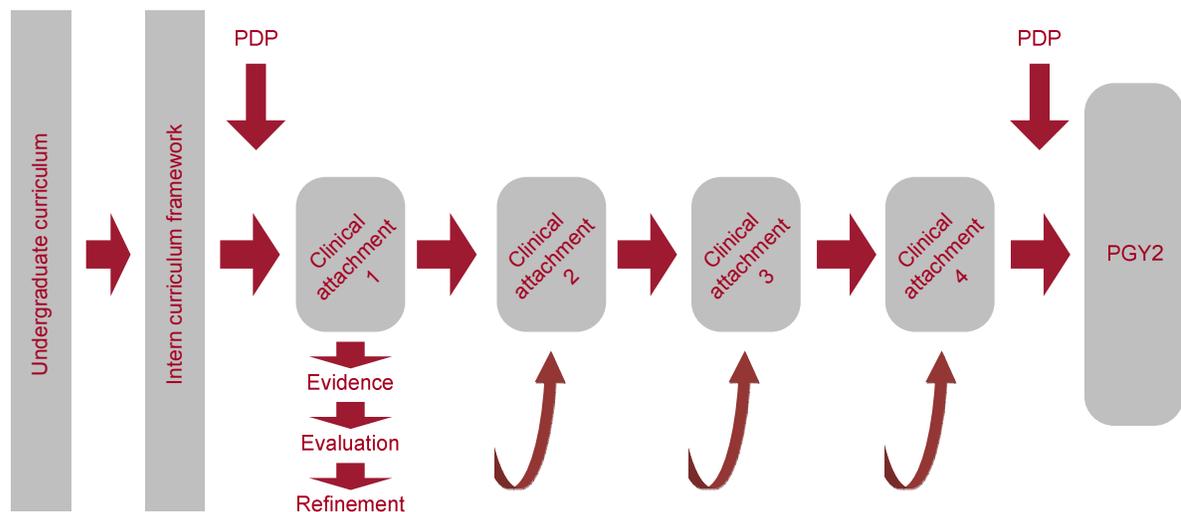
The working group has drafted a framework for assessment for Interns in PGY1 and PGY2. The goals of the proposed framework for assessment are:

- To nurture a culture of learning.
- To ensure defined generic skills and professionalism competencies are attained at a defined level and are being further developed.
- To ensure a set of specific skills in procedures and interventions is attained at a defined level and is further developed.
- To identify and assist those who not yet ready to proceed to the next level of training.

The PDP will form the centrepiece of learning for Interns through both PGY1 and PGY2. The process focuses on encouraging ongoing improvement over the course of the full year, with each clinical attachment building on the learning and identified gaps from the last attachment. In this way the PDP is evaluated and refined, informing each clinical attachment, and building from one attachment to the next (Figure 1).

The PDP will be owned by the Intern, and will be accessible to the Intern Supervisor and the supervisor from each clinical attachment. It will assist the Intern and Intern Supervisor to reflect on achievements to date and provide evidence of skills gained.

Figure 1

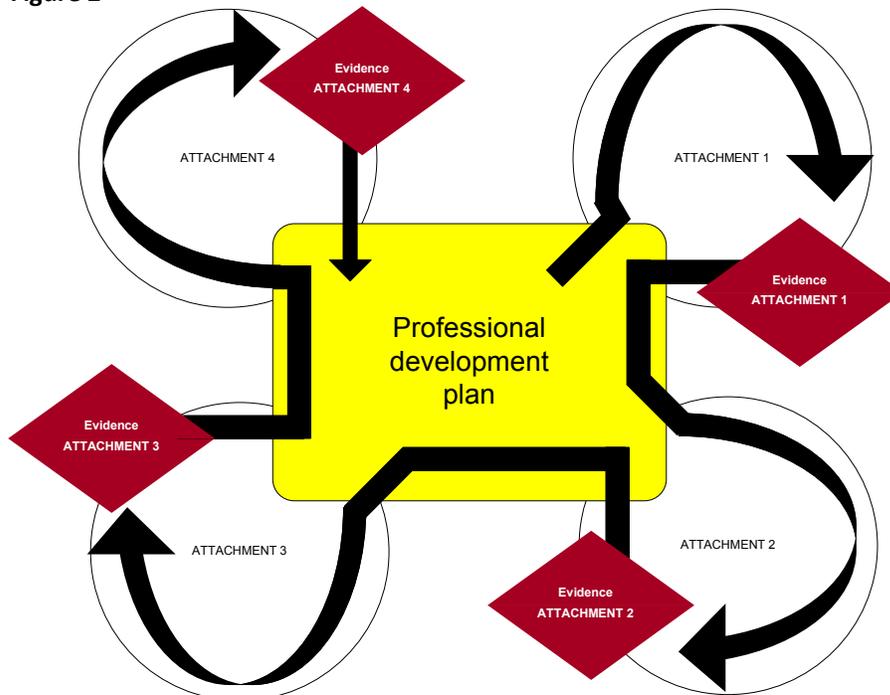


At the beginning of the PGY1 year, the Intern Supervisor will meet with the Intern to discuss learning objectives for the year, focusing on the learning outcomes in the curriculum framework. The discussion will be informed by what the Intern has already learnt during the Trainee Intern year, focusing on the gaps, and what has not yet been achieved. The PDP will also focus on the Intern's

career plan and intentions for vocational training. The PDP will be specific and targeted to each Intern.

Further areas to work on will arise from a discussion between the Intern and the attachment supervisor near the end of each attachment. This will be informed by the curriculum framework, the Intern's record of learning, what has been achieved in the attachment, and what has been identified that requires further learning. The Intern Supervisor would periodically inform both sets of discussions. The implication of this is that information must be passed on from attachment to attachment, and this would be mediated primarily by the Intern (Figure 2).

Figure 2



The framework for assessment will identify Interns who are under performing at an early stage and provides a template for a remediation plan. An Intern who repeatedly has the same identified areas requiring improvement would require greater support and a more personalised educational programme focusing on the areas identified. There will need to be a documented process for managing poor performance to ensure appropriate support for the Intern, and patient safety.

The framework for assessment provides regular, formal and documented feedback to Interns on their performance within each attachment. Supervision reports will be developed to assist with this process.

Interns will also receive timely, progressive and informal feedback from all supervisors during each clinical attachment.

Interns are encouraged to take responsibility for their own performance, and to see feedback from their supervisors in relation to their performance.

Advantages – Framework for assessment in PGY1 and PGY2

Advantages of the proposed framework for assessment are:

- A focus on improvement over the course of the year

- A natural fit with workplace learning and preparation for lifelong CPD.
- A model of assessment for learning, rather than assessment of learning
- Learning is tailored to identified needs.

Considerations – Framework for assessment in PGY1 and PGY2

The following needs to be considered:

- The quality of training and education for the prevocational period is highly dependent on the quality of supervision and teaching provided. The framework for assessment depends on those assessing Interns having the relevant capabilities and understanding of the processes required. An appropriate framework for training of supervisors will need to be developed.
- Implementation of the framework for assessment will mean that supervisors need to have adequate time available to undertake their responsibilities, providing supervision, training, assessment and support for Interns. This is both in terms of dedicated time, for example for supervision meetings to discuss progress, but also building training opportunities into day to day practice.
- All senior doctors have a professional responsibility to actively participate in the training of Interns. However this is dependent on training providers providing allocated protected time for teaching and supervision responsibilities.
- Fostering a culture that emphasises the importance of learning and providing mentorship and supervision is crucial for the success of the implementation of the framework for assessment.
- Consideration needs to be given to who makes recommendations about whether each Intern has met the required standard. One option is for a panel to be formed that may include the local Intern Supervisor, but might also include the CMO (or a delegate), an Intern Supervisor from another service or a representative from MCNZ.

Proposal 3:

The Council proposes to implement the framework for assessment, as described in this paper, for the Intern years (PGY1 and PGY2).

Question 3:

Are there any changes you think could be made to improve the framework for assessment?

4. Record of learning (e-portfolio)

A nationally consistent means of tracking and recording skills and knowledge acquired at different levels will aid the transition of the doctor along the continuum of learning. A record of learning, maintained in an e-portfolio will help to track the progress made in each attachment, and would also help to capture overall learning. The evidence maintained in the record of learning will help to identify future learning needs.

The proposed record of learning (e-portfolio) is an important aspect of assessment and ideally this would be started in medical school, at least in the Trainee Intern year and continued into PGY1 and PGY2.

The e-portfolio will maintain a comprehensive record of each Intern’s learning and will capture:

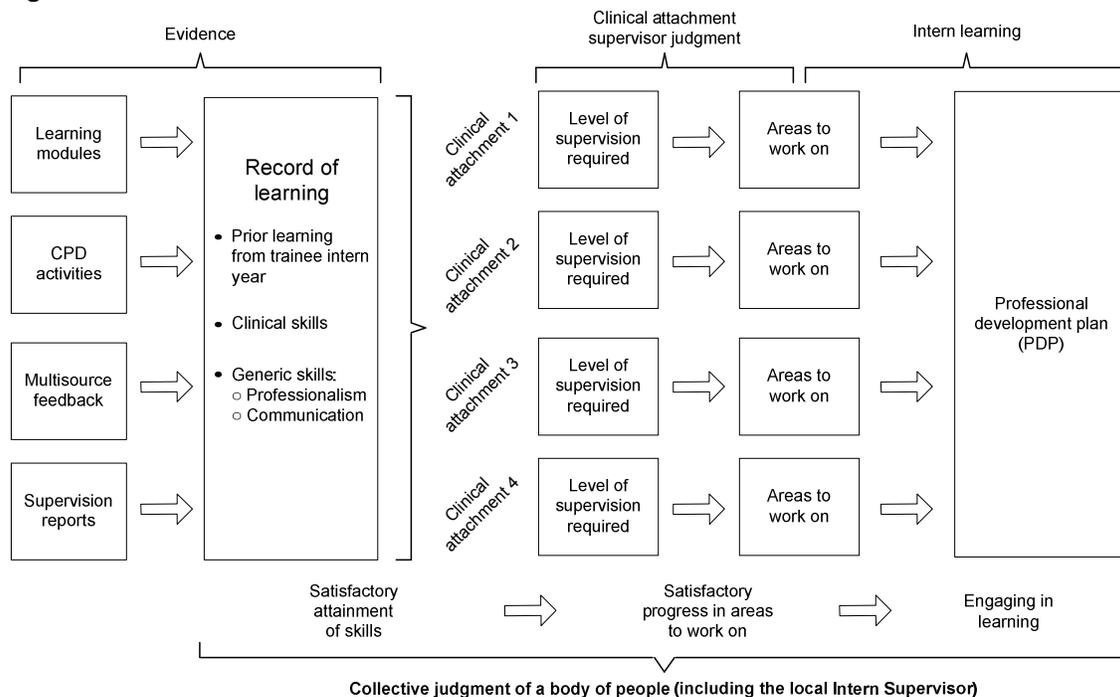
- Skills acquisition (logbook), including those skills from prior learning (TI year). This should be completed by the Intern and endorsed by the supervisor.
- CPD activities for example, audits, presentations, and attendance at grand rounds.
- Supervision reports for each attachment, completed and signed by the ‘attachment’ supervisor with contribution and sign off from the Intern Supervisor.

- A record of generic skills (professionalism and communication) which may be informed by multisource feedback and / or supervision reports.

Skills acquired will be recorded in a skills logbook that forms part of the record of learning. Responsibility for recording skills will lie with the Intern, rather than the supervisor, although the skills logbook will inform discussion between the two.

The record of learning (e-portfolio) would be owned by the Intern, and would be accessible to the Intern Supervisor and supervisor of each clinical attachment. It will assist the Intern and Intern Supervisor to reflect on achievements to date and provide evidence of skills gained. (Figure 3)

Figure 3



Multisource feedback

Assessment of generic skills and professionalism is likely to come from feedback from members of the health care team. Currently the attachment supervisors ask other members of the health care team for feedback about the Intern and incorporate that feedback when completing the supervision report. The Council is proposing that a formal multisource feedback process is used to assess communication and professionalism skills. Multisource feedback includes colleague and patient questionnaires that allow a colleague or patient's view of skills, behaviour and performance to be systematically collected to:

- to identify strengths and areas for improvement to inform professional development
- to provide reliable feedback on important qualities of a doctor that are difficult to get by other means, including communication skills, professionalism, cultural competence and interpersonal skills, assessed in the context of day to day practise.

There are a number of potential difficulties of implementing multisource feedback for Interns. The time it will take for individual members of the multidisciplinary team to provide feedback may pose challenges, particularly if required to provide feedback for a number of Interns at one time. However the Council thinks the use of a formal multisource feedback process is an effective method of collecting information that may not otherwise be available.

Advantages – Record of learning (e-portfolio)

The e-portfolio provides:

- a nationally consistent means of tracking and recording skills and knowledge.
- a method for Interns, Intern Supervisors, and supervisors of clinical attachments to track the progress made in each attachment and capture overall learning.
- a record of learning that will help to identify each Intern's future learning needs.

Considerations – Record of learning (e-portfolio)

The following needs to be considered:

- How the e-portfolio will be implemented across the country so the system is consistent throughout all DHBs and training providers in New Zealand.
- How implementation and maintenance of a national e-portfolio system will be funded.
- The logistics of including multisource feedback as a tool for assessment in the e-portfolio. The reason for this is that its validity is dependent on feedback from a large number of patients and colleagues.

Proposal 4:

- a) The Council proposes that a record of learning, in the form of an e-portfolio, is implemented to ensure a national consistent means of tracking and recording skills and knowledge acquired during the Intern years (PGY1 and PGY2). This will better aid doctors' transition along the continuum of learning.
- b) The Council proposes that a formal multisource feedback process is used to assess communication and professionalism.

Question 4:

- a) Do you agree with the concept of a nationally consistent record of learning in the form of an e-portfolio? Are there any further considerations that need to be incorporated?
- b) What are the benefits and challenges that you think would arise from the use of a multisource feedback tool?

5. Required experience

Current requirements

Currently Interns must complete four three month attachments:

- one category A medical attachment
- one category A surgical attachment
- two other attachments, which may be category A or B.

Clinical attachments

The Council is proposing that specific attachments (category A and B runs) will no longer be required. Instead, the learning outcomes in the curriculum framework will need to be achieved through the completion of four Council accredited clinical attachments. When assigning an Intern to the clinical attachments over the course of PGY1 the Intern Supervisor must ensure that the attachments provide the learning opportunities required by the Intern and therefore meet the learning outcomes.

A more robust process of setting standards and accrediting individual clinical attachments will be put in place. The standards for accreditation will be linked to the learning outcomes in the curriculum framework to ensure every clinical attachment provides a quality learning experience. This is in addition to, and separate from the general standards for accreditation of training providers.

The standards will recognise that interns can complete supervised attachments in a variety of health care settings, including hospitals, primary care, and other community based settings (see Proposal 6). The attachments an intern will complete will be driven by the objectives in the curriculum framework, and their PDP.

Relief attachments have generally been regarded as having little educational benefit. However, it is possible for relief attachments to be structured in such a way as to reinforce the generic learning themes. Specific learning objectives could be established for relief attachments encompassing communication, interpersonal skills, professionalism and ethics, to ensure these attachments are of educational value. Setting robust standards for attachments will ensure that every attachment, including relief attachments, and locum positions during PGY2 will provide a quality learning experience.

The standards will provide clarity and transparency for Interns, individual attachment supervisors and Intern supervisors on what learning opportunities need to be provided in each attachment. Clear and explicit supervision arrangements will need to be in place for each attachment.

It is proposed that during PGY1 and PGY2 Interns will only be able to work in clinical attachments that meet the Council's standards and have been accredited.

Standards for accreditation of training providers

The Council intends to review the standards for accreditation of services providing prevocational training in the next stage of this review. The standards will focus on the requirements to support Interns to meet the learning outcomes, and will recognise the importance of integration of the systems for education, support and supervision of Interns. The standards will recognise that each training provider will have an organisational structure that includes appropriately qualified staff to meet the objectives of the programme. The standards will allow each training provider or group of training providers to develop an educational programme appropriate for their organisation.

Advantages – Accreditation of clinical attachments

The attachments an Intern will complete will be driven by the objectives in the curriculum framework, and their PDP. Setting robust standards for attachments will ensure that every attachment, including relief attachments, and locum positions during PGY2, will provide a quality learning experience.

Considerations – Accreditation of clinical attachments

The PDP will need to be constructed so the Intern has an opportunity to accumulate the set of skills needed to satisfy the learning outcomes in the curriculum framework to gain a general scope of practice by the end of PGY1. This will help to determine what accredited attachments the Intern needs to complete. To ensure an appropriate mix of attachments, the Intern Supervisor will need to agree upon the assortment of attachments each Intern will complete.

Proposal 5:

The Council proposes to no longer require specific attachments (category A and B runs) to be completed during the provisional general period. Instead Council proposes to set robust processes in place for setting standards and accrediting individual attachments for PGY1 and PGY2, ensuring that each attachment provides quality learning experience.

Question 5:

- a) Do you support the proposal to set standards and accredit individual attachments? What benefits and challenges do you think may arise from this change?
- b) What will be the advantages to PGY2 Interns being required to work in clinical attachments that are accredited? Do you perceive any challenges to this proposal?

6. Clinical settings

It is recognised that with the current and projected increase in the incidence of age-related and chronic conditions, and the changing models of care, a greater share of medical services will need to be provided in the community. Regardless of whether an Intern is planning to specialise in general practice or another vocational scope, gaining some experience in a community setting will benefit them in the future.

The Council recognises that there are a number of logistical barriers to mandating a requirement for all Interns to complete an attachment in a community based setting at this time. However, the Council wishes to signal the importance of a move towards greater exposure for Interns to the community setting.

The Council proposes that Interns will be required to spend a minimum of 12.5% of time over PGY1 and PGY2 in community based or outpatient settings. This can be achieved in two different ways:

1. The completion of one attachment over the 2 years (PGY1 and PGY2).
2. The completion of a selection of attachments, of which each has a portion of time allocated to the outpatient or community based setting (adding up to an average of 4 hours per week over the 2 years). This time would need to be defined as part of the accreditation of the individual attachments.

Mutual recognition with Australia

There is mutual recognition by the Medical Board of Australia and the Council for doctors who have gained a primary medical qualification in Australia or New Zealand, and have gained general registration in either country. The Australian Medical Council (AMC), on behalf of the Medical Board of Australia (MBA) is currently reviewing standards for internship and accreditation.

The outcomes that the AMC is seeking and those the Council are seeking in its review of prevocational training are essentially the same, however the pathways each organisation is taking are slightly different. The Council emphasises the importance of each jurisdiction maintaining mutual recognition of the Australian and the New Zealand internship, and some degree of equivalence, despite some differences in approach. The Council, the AMC and the MBA continue to meet and communicate about proposed changes in each jurisdiction.

Advantages – clinical settings

Working in general practice or a community setting will:

- provide exposure to a broad range of generic skills and competencies
- provide exposure to the ‘undifferentiated patient’
- equip Interns to be able to better interface between primary and secondary care.

Considerations – clinical settings

There are a number of logistical challenges to the implementation of attachments in community settings, and it may take some time to achieve this.

The importance of exposure to the ‘undifferentiated patient’ is recognised and will be achieved in New Zealand through a variety of mechanisms:

- Emergency medicine and general practice electives during the trainee Intern year.
- The learning outcomes in the curriculum framework ensuring exposure to the undifferentiated patient, and linking these to the accreditation standards of individual attachments.
- A requirement that each Intern spends at least 12.5% of their time during PGY1 and PGY2 in a community based or outpatient setting (as described below).

- Completion of emergency medicine attachments (acknowledging the high demand for these).

Proposal 6: The Council proposes that Interns be required to spend at least 12.5% of their time over PGY1 and PGY2 in community based and outpatient settings. This is equivalent to completing one attachment over the two year period, or alternatively a selection of attachments, each of which has a portion of time allocated to the community or outpatient setting.

Question 6:

Do you support Council's proposal to increase Intern experience in community based and outpatient settings to at least 12.5% over PGY1 and PGY2?

Please provide your reasons.

7. Summary - requirements for a general scope of practice

Taking into account the proposals discussed in this paper, the Council proposes that the following requirements will need to be met in order for an Intern to be approved a general scope of practice:

1. The (satisfactory) completion of four accredited clinical attachments.
2. The attainment of (all) learning outcomes outlined in the New Zealand Curriculum Framework for Prevocational Medical Training.
3. Completion of a minimum of 10 weeks in each attachment.
4. A recommendation for registration in a general scope of practice by an approved panel (to include the Intern Supervisor).
5. Approval of a PDP for PGY2, which will be completed during PGY2.

Any change to the existing requirements would be formally published by the Council as a change to the 'prescribed qualification' for registration in a general scope via the Australian/New Zealand Intern pathway 1.

Summary questions

- a) Do you have any feedback about the requirements to gain general registration in a general scope of practice?
- b) Are there any other comments you wish to make about any aspect of what the Council is proposing?

Evaluation

It is the Council's intention to evaluate the effectiveness of any changes it makes to prevocational training. A programme of evaluation will be determined once final decisions have been made.

Timeframe for implementation

Final changes to prevocational training will depend on the feedback the Council receives about the proposals outlined in this consultation paper. The Council will consider the feedback received through the consultation process at its meeting in July 2013.

There are a number of considerations to take into account when determining a timeframe for implementation of change. The Council understands the need to allow time to plan for changes that will affect the way interns are trained and the clinical attachments they undertake as part of their training. Furthermore, the Council recognises that the role of supervisors during prevocational training is crucial, and wants to ensure that support and training is in place for supervisors before any changes take effect.

Therefore, any major changes that the Council decides upon are likely to take effect in the intern year beginning at the end of November 2014. This will allow a period of planning and transition through the remainder of 2013 and 2014.

A request for comment

The Council is seeking comment on this consultation paper and would welcome your views. The closing date for comment is **5pm Monday 6 May 2013**. You may provide submissions by either using the online form on the homepage of our website www.mcnz.org.nz or by emailing your submission to prevocationalconsultation@mcnz.org.nz.

In responding, Council is particularly interested to obtain your views on the proposals and questions below:

1. The Council proposes that the *New Zealand Framework for Prevocational Medical Training* is implemented, to guide the continuum of learning through PGY1 and PGY2. The curriculum framework should not be viewed as an exhaustive list of skills and competencies that Interns need to achieve, but rather an indicative list to guide Interns and those involved in training.

*Are there any significant changes that you think should be made to the draft *New Zealand Framework for Prevocational Medical Training*?*

2. The Council proposes that an Intern must have a PDP approved (to be completed during PGY2) at the time of applying for a general scope of practice. Council also proposes that an endorsement be placed on the practising certificates of PGY2s indicating that a PDP is being completed.

What do you perceive to be the advantages and disadvantages to Interns completing a PDP during PGY2?

3. The Council proposes to implement the framework for assessment, as described in this paper, for the Intern years (PGY1 and PGY2).

Are there any changes you think could be made to improve the framework for assessment?

4. a) The Council proposes that a record of learning, in the form of an e-portfolio, is implemented to ensure a national consistent means of tracking and recording skills and knowledge acquired during the Intern years (PGY1 and PGY2). This will better aid doctors' transition along the continuum of learning.

Do you agree with the concept of a nationally consistent record of learning in the form of an e-portfolio? Are there any further considerations that need to be incorporated?

- b) The Council proposes that a formal multisource feedback process is used to assess communication and professionalism.

What are the benefits and challenges that you think would arise from the use of a multisource feedback tool?

5. The Council proposes to no longer require specific attachments (category A and B runs) to be completed during the provisional general period. Instead Council proposes to set robust processes in place for setting standards and accrediting individual attachments for PGY1 and PGY2, ensuring that each attachment provides quality learning experience.
 - a) Do you support the proposal to set standards and accredit individual attachments? What benefits and challenges do you think may arise from this change?
 - b) What will be the advantages to PGY2 Interns being required to work in clinical attachments that are accredited? Do you perceive any challenges to this proposal?
6. The Council proposes that Interns be required to spend at least 12.5% of their time over PGY1 and PGY2 in community based and outpatient settings. This is equivalent to completing one attachment over the two year period, or alternatively a selection of attachments, each of which has a portion of time allocated to the community or outpatient setting.

Do you support Council's proposal to increase Intern experience in community based and outpatient settings to at least 12.5% over PGY1 and PGY2?

7. Do you have any feedback about the requirements to gain general registration in a general scope of practice?

Are there any other comments you wish to make about any aspect of what the Council is proposing?

Acknowledgements

The Council would like to thank the members of the Prevocational Training Working Group and the Stakeholder Advisory Group for their contribution to this review of prevocational training. The members of the groups are:

Prevocational Training Working Group

- Prof John Nacey (Chair), MCNZ Education Committee Chair; CPMEC Board member
- Dr Ken Clark, Chair, Chair of National DHB, Chief Medical Officer Group
- Prof Pete Ellis, MCNZ Education Committee member and Deputy Chair of MedSac
- Dr Jonathan Foo, Doctors in Training Council, New Zealand Medical Association
- Dr Alex Lee, MCNZ Education Committee member
- Dr Lyndy Matthews, Chair of Council of Medical Colleges
- Dr Heidi Mayer, RNZCGP
- Prof Phillippa Poole, Chair of Prevocational Training Committee, NORTH
- Dr John Thwaites, Intern Supervisor, Christchurch
- Prof Tim Wilkinson, Associate Dean (Medical Education), University of Otago
- Dr John Adams, Chair of MCNZ
- Mr Philip Pigou, Chief Executive, MCNZ
- Ms Joan Crawford, Strategic Programme Manager, MCNZ

Stakeholder Advisory Group

- Dr Jeff Brown, President, Association of Salaried Medical Specialists
- Phillip Chao, President, New Zealand Medical Students' Association
- Dr Ken Clark, Chair, National DHB Chief Medical Officer Group
- Prof Peter Crampton, Pro-Vice Chancellor, Faculty of Medicine, Otago Medical School
- Dr Tana Fishman, Royal New Zealand College of General Practitioners
- Dr John Fraser, Dean, Auckland Medical School
- Dr Emily Gill, Chair, NZ Medical Association, Doctors in Training Council
- Prof Des Gorman, Executive Director, Health Workforce New Zealand
- Dr Lyndy Matthews, Chair, Council of Medical Colleges
- Dr Deborah Powell, National Secretary, Resident Doctors Association
- Mr Ian Powell, Executive Director, Association of Salaried Medical Specialists
- Dr Jim Primrose, Chief Adviser, Ministry of Health
- Dr Kevin Snee, Lead CEO, National DHB CEO Group
- Dr Curtis Walker, President, Resident Doctors Association
- Ms Brenda Wraight, Director, Health Workforce New Zealand
- Dr John Adams, Chair, Medical Council of New Zealand
- Prof John Nacey, Chair, Prevocational Working Group
- Philip Pigou, Chief Executive, Medical Council of New Zealand
- Joan Crawford, Strategic Programme Manager, Medical Council of New Zealand

Confederation of Postgraduate Medical Education Councils

The MCNZ would also like to acknowledge and thank the Confederation of Postgraduate Medical Education Councils (CPMEC) for allowing us to use the *Australian Curriculum Framework for Junior Doctors (ACF)* as a basis for the *New Zealand Curriculum Framework for Prevocational Medical Training*.

Bibliography

Medical Council of New Zealand, *Prevocational training requirements for doctors in New Zealand: a discussion paper on options for an enhanced training framework*, Wellington, 2011.

Medical Council of New Zealand, *New Zealand Curriculum Framework for Prevocational Medical Training*, Wellington, 2012.

Medical Education England, *Foundations for Excellence: An Evaluation of the Foundation Programme*, Oxford, 2010.

New Zealand Curriculum Framework for Prevocational Medical Training

Prevocational medical training spans the two years following graduation from medical school and includes both postgraduate year 1 (PGY1) and postgraduate year 2 (PGY2). The *New Zealand Curriculum Framework for Prevocational Medical Training* is an educational template outlining the learning outcomes required for doctors during these two prevocational years. These outcomes are to be achieved through the completion of clinical attachments, educational programmes and individual learning, in order to promote safe quality healthcare.

Purpose

The *New Zealand Curriculum Framework for Prevocational Medical Training* aims to:

- build on undergraduate education by instilling in recently graduated doctors the attributes of professionalism, communication and the importance of patient care
- provide generic training that ensures PGY1 and PGY2 doctors develop and demonstrate a range of essential interpersonal and clinical skills for managing patients with both acute and long-term conditions, regardless of the specialty
- provide the opportunity to develop leadership, team working and supervisory skills in order to deliver care in the setting of a contemporary multidisciplinary team and to begin to make independent clinical decisions with appropriate support
- provide both PGY1 and PGY2 doctors with a variety of workplace experience during their prevocational training in order to best inform career choice.

Learning outcomes

The *New Zealand Curriculum Framework for Prevocational Medical Training* can be used to guide a doctor's continuum of learning from medical school through to PGY1 and PGY2. It outlines the desired learning outcomes, however it is recognised that proficiency in achievement of the capabilities will occur at different stages in training.

At the end of PGY1 doctors should have gained the necessary competencies to gain registration in a general scope of practice. During PGY2 doctors should continue with structured learning to ensure they are competent to enter vocational training or to work in independent practice in a collegial relationship with a senior doctor at the end of PGY2.

When commencing new attachments, the *New Zealand Curriculum Framework for Prevocational Medical Training* provides a useful guide for discussing the learning opportunities that may be available from a given attachment. It may help to identify particular skills and procedures that may be learnt during the attachment and to plan in advance to achieve such training.

The learning outcomes in the *New Zealand Curriculum for Prevocational Medical Training* are underpinned by two central concepts:

Patient safety

Patient safety must be at the centre of healthcare and depends on both individual practice and also effective multidisciplinary team work.

Personal development

Throughout their careers, doctors should strive to improve their performance to ensure their progression from competent, through proficient to expert, with the aspiration always to provide the highest possible quality of healthcare.

PGY1 and PGY2 doctors must continuously work to improve performance. They are expected to develop critical thinking and professional judgement, especially where there is clinical uncertainty. PGY1 and PGY2 doctors should regularly reflect on what they perform well and which aspects of performance could be improved in order to develop skills, understanding and clinical acumen.

Who should use the *New Zealand Curriculum Framework for Prevocational Medical Training*

The *New Zealand Curriculum Framework for Prevocational Medical Training* is intended to be used by PGY1 and PGY2 doctors, prevocational educators, supervisors, employers, and those responsible for quality assurance, quality management and quality control.

How to use the *New Zealand Curriculum Framework for Prevocational Medical Training*

The *New Zealand Curriculum Framework for Prevocational Medical Training* assumes that PGY1 and PGY2 doctors will be proactive in managing their continuing education and career development. PGY1 and PGY2 doctors should work closely with their supervisors and multidisciplinary team to ensure maximum benefit from learning opportunities in the prevocational years.

The New Zealand Curriculum Framework is split into five sections:

- **Professionalism**
 - Doctor and society
 - Professional behaviour
 - Teaching, learning and supervision
- **Communication**
 - Patient interaction
 - Working in teams
 - Managing information
- **Clinical management**
 - Safe patient care
 - Patient assessment
 - Emergencies
 - Patient management
- **Clinical problems and conditions**
- **Procedures and interventions**

The learning outcomes within each of the sections are broken into:

- An essential list of core skills a doctor needs to gain by the end of PGY1, while recognising the limits of their personal capabilities.
- Skills and competencies that a doctor should develop and consolidate by the end of PGY2. Competencies should be extended with the acquisition of new skills including those relevant to future vocational training.

Professionalism

Doctors should be able to provide safe treatment to patients by practising medicine in a professional manner. The following outcome statements apply to all aspects of professionalism.

PGY1

By the end of PGY1 doctors are able to practise medicine in a professional manner, while recognising the limits of their personal capabilities. They should be able to recognise complex or uncertain situations and seek advice appropriately.

Doctor and society

Access to healthcare

- Demonstrate a non-discriminatory approach to patient care
- Identify how access to and use of healthcare is influenced by the patient's ethnicity and education
- Identify how physical or cognitive disability can limit patients' access to and use of healthcare services
- Provide access to culturally appropriate healthcare

Cultural competence

- Demonstrate an awareness of the general beliefs, values, behaviours and health practices of particular cultural groups most often encountered, and demonstrate knowledge of how this can be applied in the clinical situation
- Demonstrate an awareness of the limitations of their knowledge and an openness to ongoing learning and development in partnership with patients
- Demonstrate an awareness that cultural factors influence health and illness, including disease prevalence and response to treatment
- Demonstrate respect for patients and an understanding of their cultural beliefs, values and practices
- Develop a rapport and communicate effectively with patients of other cultures
- Elicit the cultural issues which might impact on the doctor-patient relationship
- Seek appropriate cultural advice
- Understand their own cultural values and the influence these may have on their interactions with patients
- Work with the patient's cultural beliefs, values and practices in developing a relevant management plan

Health promotion

- Advocate for healthy lifestyles and discuss environmental and lifestyle risks to patient health
- Evaluate the positive and negative aspects of health screening and prevention when making healthcare decisions
- Use a non-judgemental approach to patients' lifestyle choices, for example discuss options, offer choices

Health and work

- Understand and promote the use of work as a part of safe treatment and rehabilitation
- Understand the key relationship between employment status and health status and be able to help formulate a safe plan to either stay at work or return to work

Healthcare resources

- Identify the impact of resource constraint on patient care
- Use healthcare resources wisely to achieve the best outcomes

Māori patients and their whānau

- Ask patients about their ethnic background
- Ask patients about their preferences and be willing to follow their lead
- Demonstrate a willingness to develop a rapport with Māori patients
- Demonstrate an awareness of the general beliefs, values, behaviours and health practices of Māori, and demonstrate knowledge of how this can be applied in the clinical situation
- Ensure that patients understand their condition and treatment plan
- Involve whānau when a patient brings them to a consultation
- Seek appropriate cultural advice
- Show awareness of the health disparities that exist in Māori communities and their origins

Medicine and the law

- Complete required medico-legal documentation appropriately
- Comply with the legal requirements in patient care, for example Mental Health Act 1992, Privacy Act 1993, death certification, coronial legislation
- Liaise with legal and statutory authorities, including mandatory reporting where applicable

Pacific patients and their families

- Demonstrate an awareness of the general beliefs, values, behaviours and health practices of Pacific peoples, and demonstrate knowledge of how this can be applied in the clinical situation
- Show awareness of the family based decision making that may apply
- Show awareness of the health disparities that exist in Pacific communities

Professional standards

- Adhere to professional standards and professional codes of conduct
- Comply with the legal requirements of being a doctor, for example maintaining registration
- Maintain professional boundaries
- Respect patient privacy and confidentiality

Professional behaviour

Doctors as leaders

- Commit to improving the performance of others and the system in which they work
- Exhibit the qualities of a good leader and take the leadership role when required
- Show an ability to work well with and lead others

Ethical practice

- Accept responsibility for ethical decisions
- Behave in ways which acknowledge the ethical complexity of practice and follow professional and ethical codes
- Consult colleagues about ethical concerns
- Show integrity, honesty and moral reasoning

Personal well-being

- Balance availability to others with care for personal health, managing fatigue, stress and illness
- Behave in ways which mitigate the potential risk to others from own health status, for example infection
- Have own GP
- Show awareness of and optimise personal health and well-being

Professional development

- Commit to improving performance
- Participate in a variety of continuing education opportunities

Practitioner in difficulty

- Identify the support services available
- Recognise the signs of a colleague in difficulty
- Refer appropriately and respond with empathy

Professional responsibility

- Act as a role model of professional behaviour both within the workplace and outside including the appropriate use of social media
- Demonstrate accountability for their practice
- Demonstrate reliability and fulfil obligations
- Demonstrate respectful and effective interactions with others in the health system
- Maintain an appropriate standard of professional practice and work within personal capabilities
- Reflect on and learn from personal experiences, actions and decision-making

Time management

- Demonstrate punctuality
- Prioritise workload to maximise patient outcomes and health service functions

Teaching, learning and supervision**Assessment and feedback**

- Participate in feedback and assessment processes
- Provide constructive, timely and specific feedback based on observation of performance
- Seek and respond to feedback

Self-directed learning

- Commit to continuous improvement of performance through lifelong learning
- Develop research skills
- Establish and use current evidence based resources to support learning
- Identify and address personal learning objectives
- Participate in clinical audit
- Participate in quality improvement activities
- Seek opportunities to reflect on and learn from clinical practice

Supervision

- Adapt level of supervision to the learner's performance and confidence
- Commit to developing skills to become an effective supervisor

- Provide effective supervision, for example by being available, offering an orientation, learning opportunities, and by being a role model

Teaching

- Commit to helping other health professionals learn
- Incorporate teaching into clinical work
- Use approaches that are responsive to the learning needs of others

PGY2

By the end of PGY2 the core professional skills identified for PGY1 should be developed and consolidated. In addition, competencies should be extended with the acquisition of new skills including those relevant to future vocational training.

Examples include:

- Exhibit the qualities of a good leader and take the leadership role when required
- New Zealand Triple Aim for quality improvement:
 - Improved quality, safety and experience of care
 - Improved health and equity for all populations
 - Best value for public health system resources
- Participate in formalised educational opportunities in relation to professionalism and ethics
- Participate in quality improvement
- Participate in research

Communication

Doctors should be able to provide safe treatment to patients through effective communication. The following outcome statements apply to all aspects of communication.

PGY1

By the end of PGY1 doctors are able to identify and practise effective communication, while recognising the limits of their personal capabilities. They should be able to recognise complex or uncertain situations and seek advice appropriately.

Patient interaction

Breaking bad news

- Participate in breaking potentially distressing news to patients and carers
- Recognise and manage potentially distressing communications with patients and carers
- Show empathy and compassion

Complaints

- Identify factors likely to lead to complaints and act appropriately to minimise the risk of complaints
- Use local protocols to respond to complaints, including notifying more senior staff

Context

- Arrange an appropriate environment for communication, for example private, no interruptions

- Use effective strategies to deal with difficult situations or vulnerable patients
- Use principles of good communication to ensure effective healthcare relationships

Meetings with families and whānau, or carers

- Ensure relevant family/whānau/carers are included appropriately in meetings and decision-making
- Identify the impact of family dynamics on effective communication
- Respect the role of families/whānau in patient health care

Open disclosure

- Explain and participate in implementing the principles of open disclosure
- Help ensure patients and carers are supported and cared for after an adverse event

Providing information

- Apply the principles of good communication (verbal and non verbal) and communicate with patients and carers in ways they understand
- Involve patients in discussions and decisions about their care
- Use interpreters for non English speaking backgrounds when appropriate

Respect

- Build rapport and demonstrate empathy and compassion
- Demonstrate politeness, courtesy and patience
- Maintain privacy and confidentiality
- Provide clear and honest information to patients and respect their treatment choices
- Treat patients courteously and respectfully, showing awareness and sensitivity to different backgrounds

Working in teams

Communication in healthcare teams

- Communicate effectively with team members in a variety of situations, including acute settings, team meetings, ward rounds, telephone consultations
- Concisely present cases to senior medical staff and other healthcare professionals in a range of contexts
- Engage patients and carers in the team decision-making process where possible
- Perform effective written and verbal handover at different stages of medical care for patient safety and continuity of care (for example team member to team member, service to service, hospital to general practice)

Team structure

- Adopt an appropriate role within a healthcare team
- Identify the purposes and functions of a range of healthcare teams and team members, including teams which extend outside the hospital
- Understand and respect the roles and responsibilities of multidisciplinary team members
- Understand the characteristics of effective teams, leaders and team members

Working in health care teams

- Contribute to teamwork by behaving in ways that maximise the team's effectiveness
- Demonstrate an ability to work with others
- Demonstrate flexibility and ability to adapt to change

- Lead when appropriate
- Seek to prevent or resolve conflicts that may arise

Managing information

Electronic

- Comply with policies regarding information technology for example passwords, e-mail and internet
- Use electronic patient records to optimise patient care where available
- Use electronic resources appropriately in patient care, for example decision support systems, electronic access to results, completion of discharge summaries, and referencing pharmacopoeia

Health records

- Comply with legal/institutional requirements for health records
- Facilitate appropriate coding and classification by accurate documentation

Written

- Accurately document drug prescription and administration
- Comply with organisational policies regarding timely and accurate documentation
- Demonstrate high quality written skills in all clinical communications (writes legible, concise and informative discharge summaries)

PGY2

By the end of PGY2 the core communication skills identified for PGY1 should be developed and consolidated. In addition, competencies should be extended with the acquisition of new skills including those relevant to future vocational training.

Examples include:

- Undertake formalised communication courses that are offered by Medical Colleges

Clinical management

Doctors should be able to provide safe treatment to patients by delivering appropriate clinical management. The following outcome statements apply to all aspects of clinical management.

PGY1

By the end of PGY1 doctors are able to demonstrate the following clinical management skills, while recognising the limits of their personal capabilities. They should be able to recognise complex or uncertain situations and seek advice appropriately.

Safe patient care

Adverse events and near misses

- Document and report adverse events in accordance with local incident reporting systems
- Manage adverse events and near misses
- Recognise harm caused by adverse events and near misses

Infection control

- Practise correct hand-hygiene and aseptic techniques
- Prescribe appropriate antibiotic/antiviral therapy for common conditions
- Use methods to minimise transmission of infection between patients

Medication safety

- Document patient allergies in every case
- Identify the medications most commonly involved in prescribing and administration errors
- Prescribe and administer medications safely
- Provide adverse drug reaction reporting
- Routinely report medication errors and near misses in accordance with local requirements

Public health

- Inform authorities of each case of a 'notifiable disease'
- Know which diseases are notifiable

Radiation safety

- Minimise the risk to patient or self associated with exposure to radiological investigations or procedures
- Request appropriate radiological investigations and procedures

Risk and prevention

- Explain and report potential risks to patients and staff
- Identify the main sources of error and risk in the workplace
- Recognise and act on personal factors which may contribute to patient and staff risk

Systems

- Advocate for the improvement of systems
- Identify and understand concept of system errors
- Participate in continuous quality improvement, for example clinical audit
- Use mechanisms that minimise error, for example checklists, clinical pathways

Patient assessment**Evidence-based practice**

- Critically appraise evidence and information
- Understand the principles of evidence-based practice and hierarchy of evidence
- Use best available evidence in clinical decision-making

History and examination

- Elicit symptoms and signs relevant to the presenting of problems or conditions
- Recognise how patients present with common acute and chronic problems and conditions
- Undertake and can justify clinically relevant patient assessments

Investigations

- Follow up and interpret investigation results appropriately to guide patient management
- Identify and provide relevant and succinct information when ordering investigations
- Negotiate with patients the need for tests and explains results
- Select, request and justify investigations in the course and context of particular patient presentation

Patient identification

- Comply with the organisation's procedures for avoiding patient misidentification
- Follow the stages of a verification process to ensure the correct identification of a patient

Problem formulation

- Establish a possible differential diagnosis relevant to patients presenting problems or conditions
- Regularly re-evaluate the patient problem list as part of the clinical reasoning process
- Synthesise clinical information to generate a ranked problem list containing appropriate provisional diagnoses

Referral and consultation

- Apply the criteria for referral or consultation relevant to a particular problem or condition
- Collaborate with other health professionals in patient assessment
- Identify and provide relevant and succinct information

Emergencies

Advanced Cardiac Life Support

- Complete Advanced Cardiac Life Support (ACLS) Level 7
- Participate in decision-making, and debriefing after cessation of resuscitation

Assessment

- Initiate resuscitation when clinically indicated
- Recognise and effectively assess potentially acutely ill, deteriorating or dying patients
- Recognise the abnormal physiology and clinical manifestations of critical illness

Basic life support

- Effectively use semi-automatic and automatic defibrillators
- Implement basic airway management, ventilatory and circulatory support

Prioritisation

- Describe the principles of triage
- Identify patients requiring immediate resuscitation and when and how to call for help
- Provide clinical care in order of medical priority

Disasters

- Show awareness of role in the organisation's disaster management plan

Patient management

Return to Work, Ambulatory and community care

- Identify and appropriately certify work capacity
- Identify and arrange ambulatory and community care services appropriate for each patient
- Identify patients suitable for aged care, rehabilitation or palliative care programmes
- Show awareness of available community care services

Discharge planning / transfer of care

- Follow organisational guidelines to ensure smooth discharge and transfer

- Liaise with appropriate health professionals, family and other support personnel to ensure proper discharge or transfer of care
- Undertake effective discharge planning

End of life care

- Contribute to effective initiation and coordination of palliative care
- Manage the confirmation and certification of death and complete death certificates under supervision
- Recognise cases that may need to be referred to the Coroner
- Show awareness of the Coroner's procedures

Fluid, electrolyte and blood product management

- Develop, implement, evaluate and maintain an individualised patient management plan for fluid, electrolyte and blood product use
- Identify the indications for and risks of fluid and electrolyte therapy and use of blood products
- Manage blood transfusion reactions
- Recognise and manage the clinical consequences of fluid and electrolyte imbalance in a patient

Management options

- Identify and justify the patient management options for common problems and conditions
- Implement and evaluate the management plan in consultation with the patient
- Recognise complex or uncertain situations and seek advice appropriately

Pain management

- Evaluate the pain management plan to ensure it is clinically relevant
- Prescribe pain therapies to match the patient's analgesia requirements
- Specify and can justify the hierarchy of therapies and options for pain control

Therapeutics

- Evaluate the outcomes of medication therapy
- Involve nurses and pharmacists, and other allied health professionals appropriately in medication management
- When prescribing, take account of the interactions and actions, indications and contraindications, monitoring requirements, and potential adverse effects of each medication used

PGY2

During PGY2 the ability to recognise and demonstrate important aspects of clinical management as provided for in PGY1 should be developed and consolidated. In addition, competencies should be extended, and new clinical management skills acquired, including those relevant to future vocational training.

Examples include:

- Advance care courses
- General audit and research

Clinical problems and conditions

Doctors should be able to adequately identify common or important conditions through history taking, eliciting the relevant signs at examination and investigations. They should then formulate a differential diagnosis and establish and monitor an initial management plan.

PGY1

By the end of PGY1 doctors are able to recognise and manage core clinical problems and conditions, while recognising the limits of their personal capabilities. They should be able to recognise complex or uncertain situations and seek advice appropriately.

General

- Cognitive or physical disability
- Functional decline or impairment
- Recognition of the deteriorating patient

Abnormal investigation results

- Abnormal blood results
 - Abnormal INR and/or coagulation profile
 - Electrolyte abnormalities
 - Red cell abnormalities
 - White cell abnormalities
 - Arterial blood gases
- Abnormal imaging
- Abnormal pathology results

Circulatory

- Cardiac arrhythmias
- Chest pain
- Electrolyte disturbances
- Heart failure
- Hypertension
- Ischaemic heart disease
- Leg ulcers
- Limb ischaemia
- Reduced urinary output
- Shock
- Thromboembolic disease

Critical care/ Emergency

- Child abuse
- Elder abuse
- Family violence
- Injury prevention
- Minor trauma
- Postoperative care
- Shock

Dermatological

- Common skin conditions for example eczema, allergic skin conditions
- Skin malignancies for example basal cell carcinoma (BCC), squamous cell carcinoma (SCC), melanoma

Ear, Nose, Throat

- Epistaxis
- Upper Airway compromise

Endocrine

- Abnormal thyroid functions
- Adrenal disease
- Diabetic ketoacidosis
- General management of diabetes and its complications
- Post operative diabetic management

Eyes (Ophthalmology)

- Foreign body identification
- Red eye
- Refractive difficulties
- Sudden loss of vision

Gastrointestinal

- Abdominal pain
- Common liver disease for example alcoholic liver disease, hepatitis, non-alcoholic fatty liver disease
- Constipation
- Diarrhoea
- Gastrointestinal bleeding
- Jaundice
- Nausea and Vomiting
- Recognition of acute abdomen

Genito Urinary

- Contraception & sexual health
- Dysuria and /or frequent micturition
- Pyelonephritis and UTIs
- Urinary retention

Gynaecological

- Abnormal menstruation
- Urinary Incontinence

Nephrology

- Renal failure

Haemopoietic

- Abnormal bleeding due to platelet and coagulation disorders
- Anaemia
- Bleeding in the anticoagulated patient

- Cytopenia
- Thromboembolic disease

Immunology

- Anaphylaxis
- Drug reactions
- Urticaria

Infectious Diseases

- Local infections
- Meningitis
- Non-specific febrile illness
- Septicaemia
- Sexually Transmitted Infections(STI)

Musculoskeletal

- Acute joint swelling
- Joint disorders
- Sprains and strains

Neurological

- Acute headache
- Delirium
- Falls, especially in the elderly
- Loss of consciousness
- Seizure disorders
- Stroke/TIA
- Subarachnoid haemorrhage
- Syncope

Nutrition / Metabolic

- Weight gain
- Weight loss

Obstetric

- Pain and bleeding in early pregnancy
- Post partum haemorrhage

Oncology

- Oncological emergencies, for example spinal cord compression, raised intracranial pressure, hypercalcaemia, neutropenia

Oral Disease

- Toothache
- Oral Infections

Pharmacology / Toxicology

- Poisoning

Psychiatric / Drug and Alcohol

- Addiction (smoking, alcohol, drug)
- Anxiety
- Deliberate self-harm
- Dementia
- Depression
- Disturbed or aggressive patient
- Psychosis
- Substance abuse
- Suicide risk assessment

Respiratory

- Asthma
- Breathlessness
- Chronic Obstructive Pulmonary Disease
- Cough
- Obstructive sleep apnoea
- Pneumonia / respiratory infection
- Respiratory failure
- Upper airway obstruction

PGY2

Doctors should have acquired greater knowledge and broader clinical skills to manage all of the clinical problems and conditions listed for PGY1. Doctors should also have extended the range of clinical problems and conditions they are able to manage including those relevant to future vocational training.

Procedures and interventions

Doctors should be able to provide safe treatment to patients by competently performing certain procedural and assessment skills. The following outcome statements apply to all procedures and interventions.

Decision-making

- Explain the indications and contraindications for common procedures
- Select appropriate procedures with involvement of senior clinicians and the patient

Informed consent

- Apply the principles of informed consent in day to day clinical practice
- Identify the circumstances that require informed consent to be obtained by a more senior clinician
- Provide a full explanation of a procedure to patients when undertaking that procedure

Preparation

- Arrange appropriate equipment and describe its use
- Prepare and position the patient appropriately
- Recognise the indications for local, regional or general anaesthesia

Procedures

- Arrange appropriate support staff and define their roles
- Provide appropriate analgesia

Post-procedure

- Identify and manage common complications
- Interpret results and evaluate outcomes of treatment
- Monitor the patient and provide appropriate aftercare

Prescribing

Prescribing is an intervention and expected skills required for this are found under the headings of 'medical safety', 'pain management', 'infection control' and 'therapeutics' in the Clinical Management section of the Curriculum Framework.

Examples include:

- Anti coagulants
- Insulin
- Opiates

PGY1

By the end of PGY1 doctors are able to perform the following procedures and interventions, while recognising the limits of their personal capabilities. They should also be able to recognise complex or uncertain situations and seek advice appropriately.

Cardiopulmonary

- 12 lead electrocardiogram recording and interpretation
- Bag and Mask ventilation
- Completed ACLS level 7
- Laryngeal Mask Airway placement
- Oropharyngeal airway
- Oxygen therapy

Diagnostic

- Blood culture
- Blood Glucose Testing
- MSU
- Nasal swab
- Throat swab
- Urethral swab
- Wound swab

Ear, Nose and Throat

- Anterior nasal pack insertion
- Anterior rhinoscopy

Injections

- Intramuscular injections
- Subcutaneous injections

Intravenous / Intravascular

- Arterial and venous blood gas sampling and interpretation
- Blood transfusion
- Intravenous cannulation
- Intravenous electrolyte administration
- Intravenous fluid and drug administration
- Intravenous infusion set-up
- Venepuncture

Mental health

- Alcohol withdrawal scale use
- Mini-mental state examination

Ophthalmic

- Corneal foreign body removal
- Eye bandage application
- Eye drop administration
- Eye irrigation
- Eyelid eversion

Respiratory

- Nebuliser/inhaler therapy
- Peak flow measurement and interpretation
- Spirometry measurement and interpretation

Surgical

- Administration of local anaesthesia
- Scrub, gown and glove
- Simple skin lesion excision
- Surgical knots and simple wound suturing
- Suture removal
- Wound debridement
- Wound dressing

Trauma

- Apply splints and slings
- Cervical collar application
- In-line immobilisation of cervical spine
- Pressure haemostasis

Urogenital

- Bladder catheterisation (Male and Female)

Women's health

- Genital swabs/cervical smear
- Vaginal speculum exam

PGY2

By the end of PGY2 the core procedural skills and interventions identified for PGY1 should be developed and consolidated. In addition, competencies should be extended with the acquisition of new skills including those relevant to future vocational training.

Examples include:

- Advanced prescribing
- Anaesthetic techniques, for example regional anaesthesia
- Basic surgical techniques, for example simple wound closure
- Critical care interventions, for example non invasive ventilation
- Diagnostic ultrasound
- Invasive diagnostic techniques for example joint aspiration, lumbar puncture, biopsies
- Management of trauma, for example reduction of fractures
- Psychological interventions, for example behavioural interventions, counselling skills

Acknowledgements

The Medical Council of New Zealand (Council) would like to acknowledge the Confederation of Postgraduate Medical Education Councils (CPMEC) for allowing us to use the Australian Curriculum Framework for Junior Doctors (ACF) as a basis for the draft *New Zealand Curriculum Framework for Prevocational Medical Training*.

Council would also like to thank the Prevocational Training Working Group members for their time and effort in drafting the *New Zealand Curriculum Framework for Prevocational Medical Training*:

- Prof John Nacey (Chair), MCNZ Education Committee Chair; CPMEC Board member
- Dr Ken Clark, Chair, Chair of National DHB, Chief Medical Officer Group
- Prof Pete Ellis, MCNZ Education Committee member and Deputy Chair of MedSac
- Dr Jonathan Foo, Doctors in Training Council, New Zealand Medical Association
- Dr Alex Lee, MCNZ Education Committee member
- Dr Lyndy Matthews, Chair of Council of Medical Colleges
- Dr Heidi Mayer, RNZCGP
- Prof Phillippa Poole, Chair of Prevocational Training Committee, NORTH
- Dr John Thwaites, Intern Supervisor, Christchurch
- Prof Tim Wilkinson, Associate Dean (Medical Education), University of Otago
- Dr John Adams, Chair of MCNZ
- Mr Philip Pigou, Chief Executive, MCNZ
- Ms Joan Crawford, Strategic Programme Manager, MCNZ

Recertification requirements for doctors registered in a general scope of practice

Council has strengthened recertification requirements for doctors registered in a general scope of practice. These doctors are required to participate in the Council approved recertification programme called *inpractice* administered by bpac^{nz}. The programme is based around a professional development plan developed from the individual doctor's identified learning needs and includes 50 hours of continuing professional development (CPD) per year made up of:

- 20 hours of CME
- 10 hours of peer review
- Audit of medical practice
- Meetings with the nominated Collegial Relationship Provider (six in the first year and four in subsequent years).

In addition to the annual requirements participants must complete:

- The Essentials Test in the first year and then once every three years
- Feedback on their practice, either through Multisource Feedback or Patient Questionnaires once in every three year period
- A Regular Practice Review visit when scheduled (not required for this first three years after gaining a general scope).

Doctors who are participating in a Council accredited vocational training programme are exempt from having to enrol and participate in the bpac^{nz} *inpractice* programme.