SA Health

Prevocational Manager’s Guide

Designed for managing and supporting prevocational trainees

SA ME+
SOUTH AUSTRALIAN
MEDICAL EDUCATION & TRAINING

FOREWORD

The South Australian Medical Education Health Advisory Council in conjunction with the Directors of Clinical Training Committee and Medical Education Officer Subcommittee are pleased to provide this guide as a resource to all staff who contribute and work with prevocational trainees.

Understanding the complexities of the medical workforce can be challenging and I acknowledge and thank all of our hardworking staff in South Australia's health services, who continually care and support our prevocational trainee medical officers.

I trust that staff will be able to use this guide to hone their skills and knowledge. This guide will be amended from time to time and as the roles of those that support trainee medical officers evolves.

Professor Kevin Forsyth
Presiding Member
SA MET Health Advisory Council

Overseeing and supporting prevocational TMOs within SA Health encompasses a broad range of activities. This guide aims to capture the Medical Education Officer's key roles and functions. Outlining every task completed by Medical Education Officer would result in an unwieldy document, thus the activities that are common across SA Health, rather than every activity completed by Medical Education Officers in each a Local Health Network have been included in this guide.

The activities of a Medical Education Officer vary from site to site, with some of the Medical Education Officer activities intertwining with the functions of other roles throughout a Local Health Network. It is vital that, as Medical Educational Officers, we continue to communicate with all units involved with prevocational management to allow for a streamlined experience for our Trainee Medical Officers.

We hope this guide will be an excellent starting point for new Medical Education Officers, assist with understanding the role in detail, while also being useful to anyone who manages prevocational trainee medical officers in any capacity.

Natalie Michael
Chair, Medical Education Officer Subcommittee

ABOUT THIS DOCUMENT

The Prevocational Manager's Guide is intended for staff who manage prevocational trainee medical officers and aims to assist staff in understanding the functions and activities involved in the management of prevocational trainee medical officers. This guide refers to prevocational trainee medical officers, including interns and prevocational doctors who are not part of a vocational training program, as Trainee Medical Officers (TMOs).

This guide is intended to be a tool and reference guide to both Medical Education Officers (MEO) and staff within TMO manager / medical administration roles, as these roles are generally dedicated to providing TMO management, education and training and welfare support. The guide uses the terminology of MEO to describe activities and responsibilities undertaken in managing TMOs. However, it should be noted that both MEO and TMO managers / medical administrator roles are sometimes intertwined and responsibilities will vary from each Local Health Network (LHN) and health service.

Directors of Clinical Training (DCT) and Executive Directors of Medical Services (EDMS) may be able to use this guide to help facilitate their role also and understand the prevocational medical education and training landscape.

The guide will be practically useful to new staff to gain an understanding on the immense range of tasks involved in TMO management. It has a focus on prevocational trainees and also acknowledges that some MEOs are responsible for a much broader cohort of doctors – many of the principles and resources contained within it are also applicable to these other medical staff. Whilst not every section of this guide will be relevant to everyone, it aims to increase understanding of TMO management.

ACKNOWLEDGMENTS

This guide was written by the South Australian Medical Education and Training Health Advisory Council, with significant support and contributions by the Medical Education and Training Subcommittee. We thank the Health Education Training Institute (HETI) from NSW for allowing South Australia to adapt the material from the JMO Manager's Guide.

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DECIPHERING ACRONYMS

ACFJD	Australian Curriculum Framework for Junior Doctors
AMC	Australian Medical Council
AHPRA	Australian Health Practitioner Regulation Agency
CMO	Career Medical Officer / Chief Medical Officer
CPMEC	Confederation of Postgraduate Medical Education Councils
DCT	Director of Clinical Training
EDMS	Executive Director of Medical Services
IMG	International Medical Graduate
LHN	Local Health Network
MBA	Medical Board of Australia
MEO	Medical Education Officer
PGY	Postgraduate year (number denotes years since graduation, assuming engagement in full time clinical practice)
PMC	Postgraduate Medical Councils – bodies across Australia that oversight prevocational medical education and training
PMEU	Postgraduate Medical Education Unit
SA MET	South Australian Medical Education and Training
TMO	Trainee Medical Officer

PART ONE - MEDICAL EDUCATION OFFICERS ROLE

The Medical Education Officer role at a glance

Ask any experienced MEO what they do and they will generally reply "everything". This response reflects both the diversity of the role and responsibilities and the context and location of the facility or Network within which MEOs work.

It also reflects that many MEOs bring to the role a deep commitment to making a difference to the working lives of prevocational trainees. "Everything" in this context might sometimes be translated as "whatever it takes". TMOs recognise and value this commitment and express it in a myriad of ways.

MEOs with this approach are an integral part of the healthcare team – they are after all, looking after the doctors who look after the patients.

Whilst this guide has a focus on prevocational trainees, it also acknowledges that some MEOs are responsible for a much broader cohort of Medical Officers – many of the principles and resources contained within it are also applicable to these other medical staff.

The MEO role can range from managing a small cohort of TMOs in a rural hospital, (often in addition to a number of other responsibilities), through to having responsibility for the entire TMO medical workforce across a large metropolitan Network. The variation in roles and responsibilities may also depend on the other support structures and staffing arrangements within the facility or network. Although not all MEOs will be responsible for all of the following, activities and responsibilities may include:

- Focus on prevocational trainees
- Term allocations aligning with program and prevocational trainee preferences
- Orientation – commencement of year, mid-year and change of rotations
- Organisation of the prevocational trainee education program
- Assessment and progression management
- Identify clinical setting / terms that meet program requirements
- Liaise with clinical supervisor to ensure education and training in clinical settings / terms is optimal
- Preparation and support of accreditation processes (SA MET and Specialty Medical Colleges)
- Leave management including professional development leave
- Advocate on behalf of prevocational trainees
- Managing grievances and complaints involving prevocational trainees
- Liaison with external organisations in relation to prevocational trainees, on behalf of the facility
- Oversight of prevocational trainees workforce in a hospital, facility or network
- Assist with identifying and supporting TMOs with performance concerns
- Assist with the development, monitoring and documentation of TMO performance concerns.

Prevocational training

To the new MEO unfamiliar with the medical training continuum, the structures, requirements and associated terminology can appear very complex and at times, confusing. This section focuses on the prevocational training period. An earlier section provides some information on deciphering all the acronyms.

Prevocational training refers to the two-year period immediately following medical school undertaken prior to a doctor entering specialist (vocational) training. During the first year, postgraduate year one (PGY1) doctors (referred to as 'interns') are provisionally registered with the Medical Board of Australia (MBA) and are only permitted to work in intern accredited training facilities, during which they complete a number of rotations or terms. Accreditation of intern training is carried out by the South Australian Medical Education Training (SA MET) Health Advisory Council.

At the end of the successful completion of 12 months of training, or internship, the prevocational trainee is recommended to the Medical Board of Australia for general registration.

Prevocational trainees in their second postgraduate year (PGY2) are also required to work in terms accredited by SA MET for prevocational training. The general prevocational training (or general training) program is guided by the Australian Curriculum Framework for Junior Doctors (ACFJD) and provides each prevocational trainee with appropriate clinical experience and supervision during which knowledge, skills and professional behaviours fundamental to safe medical practice are consolidated.

Whilst some TMOs enter vocational training programs at the commencement of the PGY2/3 year, others may complete further general training years, undertake academic studies or research prior to entering a vocational training program.

The essential elements of the prevocational training are:

- Patient safety – the program provides a supervised environment in which prevocational trainees are able to make the transition from medical student to medical practice in ways that are safe for patients.
- Learning by doing – the majority of learning during the prevocational training period is by doing. The apprenticeship model is central to this and supplemented by a range of formal educational activities.
- Trainee welfare – the program ensures through appropriate structures that prevocational trainees are safe and supported in their work. MEOs have a central role with regards to this.
- Learning culture – the program promotes the values of self-directed lifelong learning by all of its participants, both supervisors and trainees, thereby promoting and contributing to the learning culture of the health care system.
- Career planning – the program supports TMOs to structure their training to assist in advancing to vocational training, if desired.

The role of the MEO is immense, it is important to collaborate with not only colleagues within your facility or network but MEOs from other sites. The results achieved by working collaboratively can be remarkable while also acting as a valuable support structure.

A YEAR AT A GLANCE

The calendar below represents an example of a typical prevocational training year. Much of the workflow involved in managing prevocational TMOs is governed by important, immovable dates throughout the calendar year. Workload often peaks prior to an important date, such as orientation or producing 'certificates of completion of an accredited internship' for qualifying PGY1 doctors.

Term 1 **Term 2** **Term 3** **Term 4** **Term 5**

JANUARY

S	M	T	W	T	F	S
		ETA	🔴	🔴	🔴	
		●				
		●				

FEBRUARY

S	M	T	W	T	F	S
	○	●		MEO		
		●				
		●	MTA			
		●				

MARCH

S	M	T	W	T	F	S
		●				
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APRIL

S	M	T	W	T	F	S
		ETA ●	TC			
		●				
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MAY

S	M	T	W	T	F	S
	R1	●		MEO		
		●	MTA			
		●				
		●				

JUNE

S	M	T	W	T	F	S
		●				
		●				
ETA	TC	●				
	R2	●				

- ● (grey) Australia & New Zealand Prevocational Medical Education Forum
- ● Intern Formal Education Program
- 🔴 Intern Orientation and commencement of intern clinical year
- ○ PGY2+ orientation and commencement of PGY2+ clinical year

ETA End of term assessment
IC Certificate of completion of an accredited Internship due
MEO SAMET Health Advisory Council MEO subcommittee meeting
MTA Midterm assessment
MTS Medical Training Survey commences
R1 Intern recruitment commences for the following year
R2 Annual PGY2+ Recruitment commences for the following year
TA Term allocation for following year
TC Intern Team Changeover

"One of the best things another MEO told me when I started in this role was to organise my year around these important dates"

Natalie Michael, Medical Education Officer, Women's and Children's Health Network

JULY						
S	M	T	W	T	F	S
		●				
		●				
		●	MTA			
		●				

AUGUST						
S	M	T	W	T	F	S
	MTS	●				
		●		MEO		
		●				
ETA	TC	●				

SEPTEMBER						
S	M	T	W	T	F	S
		●				
		●				
		●				
		●				

OCTOBER						
S	M	T	W	T	F	S
		●	MTA			
		●				
		●				
●	●	●●	●			

NOVEMBER						
S	M	T	W	T	F	S
	TA	●				
ETA	TC	●		MEO		
		●				
		●				

DECEMBER						
S	M	T	W	T	F	S
		●				
	IC	●	MTA			
		●				
		●				

PART TWO - MEDICAL EDUCATION AND TRAINING

Governance arrangements

The governance arrangements involved in medical education and training within Australia can seem quite complex, with multiple organisations and structures involved. This section provides a brief overview, with a focus on the prevocational training period.

Training for medical practice is a lengthy process, commencing with a university based degree of between four and six years. Many medical degree programs are now undertaken on a postgraduate basis, with applicants having completed a basic degree prior to entering a medical program.

Most graduates from Australian medical schools graduate with a M.D. (Doctor of Medicine) previously known as a Bachelor of Medicine (BMed) or Bachelor of Surgery (MBBS). Despite the variation in the name of the actual degree awarded, all medical school programs within Australia must comply with the standards set by the Australian Medical Council (AMC), who are responsible for developing standards for medical education and training in all phases of medical education, including medical schools.

The purpose of the AMC accreditation is to ensure that medical courses produce graduates competent to practice safely and effectively under supervision as interns in Australia and New Zealand, with an appropriate foundation for lifelong learning and for further training in any branch of medicine.

Upon completion of the university-based program, medical graduates are eligible for provisional registration with the Medical Board of Australia. During the year of provisional registration, interns are only permitted to work in terms and facilities accredited through their state based postgraduate medical council. Following the successful completion of the internship, prevocational trainees obtain general registration with the MBA and may complete a further prevocational training. In South Australia, SA MET, as an authorised accrediting body by the AMC, has responsibility for setting the standards and accrediting facilities and posts for both years of the prevocational training period.

Although all prevocational trainees are employed within the public sector (state or territory health departments), and predominantly work within the public hospital system, they may also complete rotations in accredited terms in other settings, including community health and rural general practice.

Interns who do not obtain a vocational training position will generally take on a general training year. It is common for prevocational trainees to complete between two and three years in general rotations before entering a vocational training program. Vocational or specialty training generally takes between three and six years.

Specialty Medical Colleges are responsible for specialty training, both setting the curriculum, training program and examination requirements for candidates, in addition to oversight of continuing professional development of college fellows.

In addition to accrediting university based medical schools, the AMC also has responsibility for accreditation of providers of specialist medical training and their specialty training programs that lead to qualifications for practice in recognised medical specialties.

Training continuum at a glance

The training pathway of a doctor will take nearly a decade after high school and can be extremely rigorous. The image below shows the training continuum, starting with high school and ending with a specialist qualification. It is important to note this image is indicative only and that the training continuum can vary. Some doctors may choose not to specialise or practice in recognised medical specialties.

Training Continuum

High School

Other degree +/- work experience (optional)

Australian Medical Council

Medical School (postgraduate or undergraduate 4-6 years MBBS, BMBS, MD etc)

Training Accreditation Authority	Commence Working as a Doctor		
SA MET	**Internship (Intern)**	• MBA mandated and must be undertaken in accredited intern posts. • Internship is a minimum of 47 weeks FTE currently including mandatory posts in Emergency Medicine, Surgery and Medicine. • These doctors have Provisional registration with MBA.	**Novice**
SA MET - PGY2 Many posts are unaccredited	**Prevocational Trainee Medical Officer (Resident Medical Officers)**	• These doctors may not be enrolled in a speciality program. • SA MET accredits postgraduate year two posts. • Doctors may work as an 'unaccredited registrar'. • Doctors may commence research or further training either out of interest or to get into a speciality training program. • These doctors have General registration with the MBA.	**Advanced Beginner**
Speciality Medical Colleges	**Vocational Trainee Medical Officer (Registrars)**	• These doctors have been accepted into a speciality training program with a Speciality Medical College. • These doctors have General registration with the MBA. **GP** Minimum 3 years **Physician** 3 years basic training + exam & 3 years in one speciality (advanced training) **Surgery** 5-6 years streamed program + exam **Other** Many other colleges, each has their own pathway requirements and exams	**Competent**
Members of a speciality medical college/s	**Fellowship**	• These doctors may spend a further 1-2 years in a sub-speciality or research.	**Proficient**
Members of a speciality medical college/s	**Specialist Consultant**	• These doctors have completed their Speciality Medical College training requirements. • These doctors have specialist registration with MBA. **GP** FRACGP or FACRRM (rural). Can pursue further interests, often commenced whilst a registrar. For example: Women's health, Mental health, Occupational medicine, Environmental medicine **Physician** FRACP. For example: Cardiologist, Endocrinologist, Gastro-enterologist, General physician, Haematology, Infectious diseases, Nephrologist, Neurologist, Oncologist, Respiratory physician, Rheumatologist **Surgery** FRACS. For example: Cardiothoracic surgeon, General surgeon, Neurosurgeon, Orthopaedic surgeon, ENT/head+neck surgeon, Paediatric surgeon, Plastic/reconstructive surgeon, Urologist, Vascular surgeon, Rheumatologist surgeon **Other** FRACMA – Administrators, FRAZCA – Anaesthetist, FACD – Dermatologist, FACEM – Emergency, FACICM – Intensivist, FRANZCO – Ophthalmologist, FRANZCOG - Obstetricians and Gynaecologists, FRCPA – Pathologist, FRANZCP – Psychiatrist, RANZCR – Radiology	**Expert**

Medical Graduates

To obtain a medical degree a university education is required. In South Australia there are two universities students can attend.

The University of Adelaide offers a degree called Bachelor of Medicine and Bachelor of Surgery and is an undergraduate course over a six year period. Students who go from high school to studying medicine typically attend The University of Adelaide.

Flinders University offers a four year postgraduate medical degree, known as a Doctor in Medicine. This provides an alternative to the traditional continuum from secondary school to an undergraduate medical course. The four-year program enables students to graduate with a medical qualification that is comparable to a six-year undergraduate program. Flinders University also provide an undergraduate pathway for students who study a Doctor of Medicine combined with a Bachelor of Clinical Sciences.

Interns

Interns doctors are known as PGY1. The intern year marks the transition from student to medical practitioner. It provides the experience of applying the theory to the treatment of patients as a responsible professional. The Australian Health Practitioner Regulation Agency (AHPRA) issues medical graduates with provisional registration to undertake this period of supervised practice.

MEOs are responsible for managing this cohort and will find a large portion of their work will revolve around intern management.

At the completion of the intern year, the employing hospital is required to certify that the internship has been completed satisfactorily, including details of completed rotations and total number of weeks worked. AHPRA will grant general registration when it receives confirmation that the internship has been satisfactorily completed, along with other requirements.

PGY2 and beyond

After internship (PGY1 year) trainees advance to the next stage known as Postgraduate Year 2 (PGY2). A + symbol is often put on the end of PGY2 to reference trainees who are beyond their second year.

PGY2+ employees are commonly in Prevocational (General) Training, Surgical TMO or Medical TMO positions. These positions will provide trainee doctors with general rotations through medical, surgical, emergency and other units and are suitable if they have not yet decided on a specialist training program or wish to obtain more experience. This is the most common pathway after internship. MEOs are also responsible for these prevocational trainees.

Another option after internship is to enter Vocational or Pre-specialist Training. These positions will provide trainee doctors with experience in specific clinical specialties and are suitable if the doctor knows the specialty career path they wish to follow. These TMO will need to be accepted by the relevant Specialty Medical College.

Registrar: Basic Vocational and Advanced Vocational Training

After TMOs have completed their internship they may wish to apply for admission to a recognised medical specialty training program. This stage is the necessary training to obtain fellowship of one of the recognised Specialist Medical Colleges and allows trainees to practice medicine independently.

Specialty Medical Colleges have clinical, practical and exit exams, in conjunction with other assessments (e.g. workplace based assessment) to assess the full range of skills and behaviours required as a doctor, such as communication and team work. Specialist training programs and examinations are administered by the individual colleges and the length of training varies between three and seven full-time years to complete, depending upon the specialty chosen. Vocational training for most medical specialties is undertaken in a public hospital, however it increasingly includes rotations in private hospitals, regional, rural and community health settings. The exception is general practice, where doctors undertake most of their training in designated private general practices in a community setting. MEOs are not typically responsible for these trainees.

Fellowship

Upon completion of a recognised specialty training program Basic Vocational and Advanced Vocational trainees will be awarded a fellowship of the college and can undertake additional sub-specialty training. These doctors are not managed by MEOs. Up to this point trainees would have almost exclusively undertaken training in the public health system, except for GPs who undertake their training in private practice.

Not all doctors choose to undertake specialist training. Some will leave the medical workforce, others pursue a research career, and continue to work in hospitals as non-vocational doctors, typically known as Career Medical Officers (CMOs).

How doctors learn

MEOs with experience in the public sector will notice some important differences with respect to prevocational trainees, some of which have implications for the way in which they work and are employed.

In the first instance, prevocational trainees are just that – trainees. Medical training during the prevocational period is still largely predicated on the apprenticeship model. TMOs learn by doing. Whilst some of their training will be supplemented by formal educational activities (see later section on the formal education program) much of what a prevocational trainee learns will be on the basis of the clinical exposure they get whilst caring for patients, during their rotations, under the supervision of consultant medical staff and other doctors. Interns in their first year of training must complete core terms as required by the MBA.

Interns are provisionally registered with the MBA and having graduated from medical school, have the basic knowledge and skills to work as doctor. However there is a clear expectation that during the course of the prevocational training period they will develop and consolidate the knowledge, skills and behaviours required, gradually moving toward more independent medical practice.

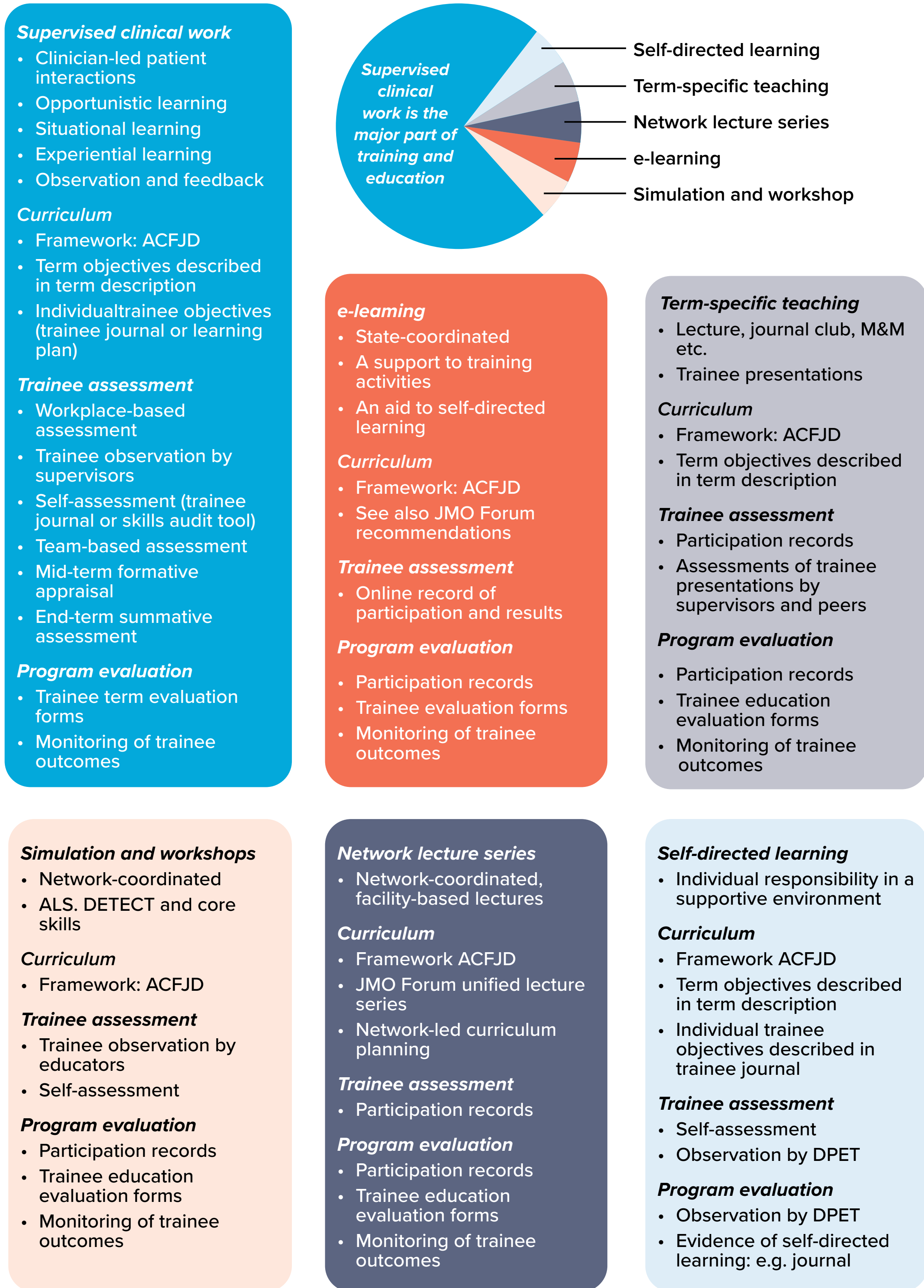
Terms are accredited on the basis of casemix, the skill mix of the medical workforce and levels of supervision available to support prevocational trainees throughout this period. As the year progresses, the prevocational trainee will gain clinical experience and require progressively less direct supervision. It is also understood that it will be many years of medical practice before a doctor is ready to practice completely independently.

TMOs are engaged by the public hospital system on the basis of temporary contracts whilst they complete their prevocational and vocational training. This has implications not just for recruitment but also means that the TMO workforce as a whole can be quite mobile, with large cohorts changing hospitals and locations as they access the various terms required of their training program.

Sometimes the interface between trainee education and employee service commitments can become a point of tension. Experienced MEOs will work with TMOs to create a positive training environment, but one that places the delivery of safe patient care at the centre.

The table on the next page describes a learning model for prevocational medical education and training and demonstrate how prevocational training is delivered.

A learning model for prevocational medical education and training



Source: Health Education and Training Institute. Network principals for prevocational medical training. Sydney: HETI, 2012.

Core term requirements

The AMC is reviewing the National Framework for Medical Internship. Currently, the Medical Board of Australia requires that interns undertake a twelve month period of general clinical experience providing opportunities for the newly qualified medical graduate to apply, consolidate and expand clinical knowledge and skills while taking increasing responsibility for safe

high quality patient care.

The general clinical experience is achieved by completing a series of supervised rotations. Under the terms of the provisional registration with the Medical Board of Australia, interns are required to undertake 47 weeks of satisfactory, supervised clinical experience, which involves:

- A core term of at least 10 weeks in medicine
- A core term of at least 10 weeks in surgery
- A term of at least eight weeks in a core emergency medicine rotation
- Non-core rotations which make up the balance of the intern year.

These clinical settings provide opportunities to explore additional areas of medicine and surgery, psychiatry, rehabilitation medicine, palliative care and more.

All Local Health Networks must have adequate numbers of emergency, surgical and medical terms accredited for interns to cover the actual number of interns allocated to the Local Health Network.

Local Health Networks may establish agreements with one another and interns may rotate between Local Health Networks in order for interns to meet their program requirements.

Supervision

Generally term supervisors are expected to have an initial meeting with their TMO to ensure the TMO is aware of the name and contact details of their supervisor at all times of service. They may also chose to make this meeting part of the broader Unit orientation they provide to the TMO. It is also expected that the term supervisor will work with the TMO to develop mutually agreeable education goals based on the Australian Curriculum Framework for During the first years, term supervisors assess prevocational trainees with regards to performance under three domains of the ACFJD– clinical management, communication and professionalism. MEOs are frequently involved in the administrative processes underpinning assessment of prevocational trainees, in addition to monitoring the wellbeing, performance and progression of trainees.

All TMOs must be allocated a term supervisor for each term.

The term ‘supervision’ encompasses a number of practices important for TMO wellbeing and patient safety. Supervision can refer to:

- Ensuring practices are performed safely for both patients and TMOs (clinical oversight).
- Ensuring TMOs have access to appropriate supports for administrative, human resource, mentorship and counselling functions (administrative and professional supervision).
- Providing TMOs with training, feedback and assessment of clinical procedures and patient care (educational supervision).

Generally term supervisors are expected to have an initial meeting with their TMO to ensure the TMO is aware of the name and contact details of their supervisor at all times of service. They may also choose to make this meeting part of the broader unit orientation they provide to the TMO. It is also expected that the term supervisor will work with the TMO to develop mutually agreeable education goals based on the ACFJD and where possible facilitate training and informal education to meet these goals.

Working with the TMOs with the shared goal of patient safety, making clear process of clinical escalation, planned periods of communication and easy availability with the senior clinician having ultimate responsibility.

Assessment processes

This section provides an overview of prevocational trainee assessment processes. Interns will receive two assessments per term, a mid-term assessment and an end of term assessment. PGY2+ will ideally have a mid-term assessment and an end of term. Ideally there should be no surprises in a formal assessment process for a TMO. TMOs should know via informal and midterm assessments if they are not performing. All underperformance concerns must be documented.

The purposes of assessment are as follows:

- Assessment should provide the prevocational trainees with feedback about their performance that will help their development as doctors. This is the formative assessment purpose and with respect to the mid-term assessment is referred to as appraisal. Appraisal should help prevocational trainees identify their strengths and weaknesses, and give them ideas about how to improve.
- Assessment should provide evidence that prevocational trainees are achieving the competencies required for their future responsibilities as doctors. This is a summative assessment process and provides evidence for certification and registration. A good assessment system should assure the community that doctors are meeting certain standards of practice and competence before advancing to higher levels of responsibility.
- Assessment should identify underperforming prevocational trainees so that appropriate remedial action can be taken early. In some cases this may involve the provision of additional supervision or support activities. In more serious cases of underperformance, the prevocational trainee is prevented from advancing to the next stage of training before remediation. This is the safety purpose, protecting both patients and trainees.

In the case of interns, the satisfactory completion of rotations during internship is the basis on which the hospital provides a recommendation to the MBA for progression from provisional to general registration. Term supervisors should meet with prevocational trainees at the commencement of the rotation to provide an orientation to the term in addition to discussing the appraisal and assessment processes. Term supervisors should meet with their prevocational trainees in about week 5 to discuss the mid-term appraisal and then at the end of term, to complete the end of term assessment.

MEOs who are responsible for the administrative processes supporting the assessment of prevocational trainees will likely have systems in place that ensure that prevocational trainees are provided with the assessment forms in a timely manner in addition to being able to collate and monitor forms as they are returned.

Tips from MEOs on supporting assessment processes

- **Group email to prevocational trainees to remind them about requirements for mid-term assessments and end of term assessments**
- **Group email to term supervisors to remind them about requirements for mid-term assessments and end of term assessments**
- **Remind interns that they need signed forms to be submitted for recommendation for general registration with the Medical Board of Australia**
- **Encourage PGY2s to get forms signed as useful for future recognition for prior learning (RPL).**

Orientation program

All prevocational trainees should receive an appropriate orientation:

(1) To the facility or network within which they work at the commencement of employment

(2) to the specific unit or rotation at the commencement of each term.

These requirements are reinforced through the provisions of the accreditation standards. MEOs are likely to be very involved in both organising and participating in the orientation program for prevocational trainees at the commencement of the clinical year. This also extends to managing rosters and term changeover to optimise attendance.

The intern and PGY2 orientation program, held just prior to the formal commencement of the clinical year, is a major undertaking for any facility or network. Orientation consists of three full days of presentations and two days shadowing. The Intern Orientation program covers a range of topics that are aimed at assisting the prevocational trainees transition to working as a doctor. Most programs cover the following themes:

- General information about the hospital/facility/Network as it relates to all employees. This includes mandatory training, important general policies and procedures, human resource matters, IT systems, and usually a tour of the hospital.
- Specific information related to the role as a prevocational trainee. This might include roles and responsibilities of prevocational trainees, important clinical policies and procedures, multidisciplinary care, diagnostic test ordering, education and training as a prevocational trainee, assessment procedures, and medicolegal matters and so on.
- Clinical and procedural skills training and verification. All orientation programs incorporate some practical training sessions, sometimes with additional skills verification activities, covering topics such as basic and advanced life support, venepuncture, cannulation, scrubbing and safe prescribing.
- Ward attachment with outgoing TMO. Incoming prevocational trainees are attached to the outgoing TMO on the term that they are rotated to for term 1. This provides an opportunity for an effective clinical handover in addition to a more extended term orientation.

The orientation period will provide prevocational trainees with the opportunity to meet TMOs attached to your Network.

The PGY2+ orientation program will also cover off general information and specific information related to the role. This orientation generally occurs approximately one month after the intern orientation and at the commencement of the resident medical officer and registrar clinical year. Orientation consists of one or two days. PGY2+s who have previously worked at the same local health network will only need to attend relevant presentations.

Term orientation

In addition to the main orientation program held at the commencement of the clinical year, facilities also hold a short orientation at the commencement of each term. Term orientation is an important component of the prevocational training program. This orientation program should supplement the main orientation provided to interns and PGY2+s and delivers information specifically about the new unit, highlighting unit specific policies and procedures, access to IT systems, diagnostics (particularly after hours) and clinical services. It should also include a tour of the unit.

It is the responsibility of the term supervisor to provide an orientation to the term for prevocational trainees. Registrars, nursing staff and allied health staff, might deliver some aspects of the orientation. This orientation provides an opportunity for the prevocational trainee to get to know and be inducted by members of the team that they will closely work with for the duration of the term.

Term orientation is an opportunity for the term supervisor to discuss and set expectations and responsibilities with the prevocational trainee. The supervisor may also use orientation as an opportunity to set learning goals with the prevocational trainee, which they will aspirer to achieve throughout the term and the supervisor will assist in creating the learning environment. Goals will be discussed during summative and formative assessments that are carried out during the term.

MEOs, working with the DCTs and others, may be involved in implementing systems and processes that support effective term orientation. These include:

- Ensuring that there is a term description for every prevocational term with current information reviewed by the term supervisor on a regular basis and made available to the prevocational trainee prior to the commencement of term.
- Having systems in place that remind term supervisors and other clinical staff of term changeover dates and the requirement for term orientation.
- Reviewing rosters covering the term changeover period in order to optimise term orientation and effective clinical handover.

Formal education program

Whilst the focus of prevocational training is learning by doing, the formal education program supplements unit-based activities and ensures that all prevocational trainees have an opportunity to cover important clinical topics, pitched at their level.

The development of the formal education program is one of the cornerstones of a prevocational training site. As the MEO you will undoubtedly have a role in providing support to its development and implementation. The topics, underpinned by the ACFJD, are ordered in such a way as to ensure that common clinical problems are dealt with during the first part of the year.

MEOs will also have a critical role in encouraging and supporting attendance. MEOs can use this as an opportunity to make important announcements, provide reminders of significant events and so on. It should be noted though, that this is quarantined time for medical education activities and therefore the time should not be used for non-clinical topics.

Expecting and encouraging prevocational trainees to attend formal education sessions provides an important lesson in exposing them to the discipline of setting aside time in the context of clinical demands for their own professional development and learning – this is a lesson in life-long learning.

Of course, rostering practices and support from term supervisors will underpin this.

In addition to the obvious educational benefits, the formal education program also offers an opportunity for prevocational trainees to come together as a group away from the clinical environment. This can foster an 'esprit de corps' amongst the group.

As well it will provide you with an opportunity to informally catch up with them on a regular basis, even if you are only able to attend for a few minutes at the beginning of the session or during the break.

Sessions are often recorded and available for trainees to access electronically. This also assist trainees who were not able to make the session. MEOs often have access to an online platform where they can publish reading materials so all resources can be easily accessible.

An example of the formal education session topics can be seen on the next page. Topics can vary from year to year with the general theme staying the same. MEOs are encouraged to gain feedback from TMOs after each session to help continually improve these formal education program.

Formal education session topics

TERM 1

- Short Calls
- ACLS
- Chest pain and acute coronary syndrome
- Assessing shortness of breath
- Assessing syncope and loss of consciousness
- Management of diabetes
- Fluid and electrolyte management
- Assessing abdominal pain
- Assessing and managing delirium
- The deteriorating patient
- Management of and blood products

TERM 2

- Analgesia and pain management
- Interpreting chest and abdominal x-rays
- Gastrointestinal bleeding
- ECG interpretation and management of arrhythmias
- Perioperative assessment and management
- Antibiotics and their use
- Pathology tests: ordering and interpretation
- The hard stuff: death certification, breaking bad news, communicating with difficult patients and families

TERM 3

- Pleural and ascitic taps and drains:
- The when, why and how
- Geriatric medicine
- Recognition of a sick child
- Introduction to trauma
- Anticoagulants and their use
- Looking after the JMO
- Psychiatry 101: depression, anxiety and Mental Health Act
- Medicolegal issues: privacy, confidentiality, informed consent and open disclosure.

TERM 4

- Introduction to ENT medicine
- Fundamental orthopaedics
- Intracerebral events
- Psychiatry 102: the psychotic patient, drug overdose and withdrawal syndromes
- Basic anaesthesiology
- O & G emergencies
- Introduction to ophthalmology
- Wounds, dressings and suturing

TERM 5

- Vascular surgery
- Urology
- Introduction to oxygen delivery systems and intensive care medicine
- Oncology and palliative care
- Advanced lines
- Radiology essentials
- Neonatal and paediatric resuscitation

Australian Curriculum Framework for Junior Doctors

The learning outcomes required of prevocational trainees are described in the Australian Curriculum Framework for Junior Doctors (ACFJD). The ACFJD is built around three learning areas: clinical management, communication and professionalism.

These areas are subdivided into categories, each of which is further subdivided into learning topics.

Within each learning topic, the ACFJD describes the workplace performance outcomes that prevocational trainees are expected to acquire. The ACFJD is about more than what doctors actually know, it is about what they actually do at work.

It includes a list of specific skills and procedures that prevocational trainees should learn over the two years of training in addition to a list of common problems and conditions they learn to manage and assess.

The ACFJD is not just about knowledge acquisition, it is also about the application of knowledge, skills and behaviours within the workplace. This is about learning for performance (as opposed to simply demonstrating competence) and then demonstrating that performance consistently within the workplace.

The ACFJD can be used in a number of ways, including the following:

- To provide a guide to appropriate goals for each training term
- To review learning opportunities offered by existing training terms and to identify gaps in training
- To plan development of new training terms
- As a starting point for discussions about innovative approaches to clinical teaching and development
- To structure mid-term appraisal and end-of-term assessment
- Planning the formal education program.

Resources

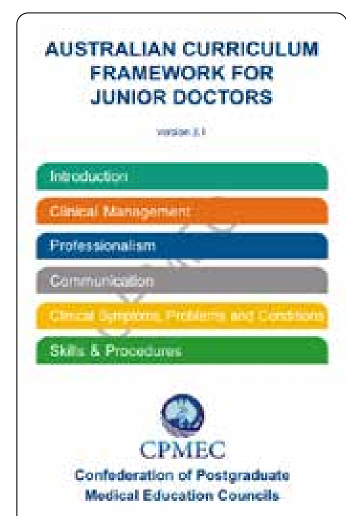
Australian Medical Council
https://www.amc.org.au/

Australian Curriculum Framework for Junior Doctors
http://www.cpmec.org.au/Page/acfjd-project

Internship Standards
http://www.cpmec.org.au/index.cfm?Do=View.Page&PageID=169

Intern Assessment Resources
http://www.cpmec.org.au/index.cfm?Do=View.Page&PageID=203

TMO Supervision Guideline
https://www.samet.org.au/wp-content/uploads/2019/04/TMO-Supervision-Guideline-v1.5.pdf



PART THREE - MANAGING TRAINEE MEDICAL OFFICERS

Working with doctors

As a MEO, many of your professional interactions are likely to be with doctors. Whilst you will obviously have regular contact with TMOs, you will also likely have frequent contact with senior doctors, including the Executive Director Medical Services (EDMS), the Director of Clinical Training (DCT) and term supervisors. Effective MEOs work to establish collaborative relationships when working with doctors and appreciate that sometimes doctors and managers may have different perspectives.

Despite an increasing recognition on the importance of team work within the healthcare setting, doctors continue to have primary responsibility for patient care. Whilst TMOs will be very closely supervised during the prevocational training period, postgraduate medical training, particularly vocational training, is concentrated on doctors taking increasing responsibility for clinical care under gradually decreasing levels of supervision.

Medical training can also be a highly competitive and at times a stressful enterprise. Doctors are on a very steep learning curve, particularly in the immediate postgraduate period. They must adapt to working in increasingly complex healthcare environments whilst frequently changing terms. With every change of term they must adapt to working with a new team (not just their medical supervisors but also with respect to the other healthcare team members – nursing, allied health and ward administrative staff).

Postgraduate medical training is a very significant undertaking involving a high level of commitment, long hours of study, the ability to successfully pass a number of barrier exams, all whilst working (usually) full-time. Terms provide opportunities for TMOs to experience different clinical specialties, get to know the senior doctors in those specialties and make important decisions regarding their future specialty or career pathway. As a result, TMOs, even during the prevocational training period, can be very focused on working toward their particular training goal or specialty. This can sometimes become a point of tension as training needs are from time to time are prioritised over other work obligations.

Effective MEOs who recognise these different perspectives and work to establish cooperative and supportive relationships with prevocational trainees are able to have a significant impact on the way in which doctors interact within the organisation.

"This role allows you to know your Junior staff on all levels, seeing their highs as well as lows. Being able to support them through their journey is an honour."

Natalie Hickman, Medical Education Officer,
Central Adelaide Local Health Network

Welfare and support

The prevocational trainee period represents a significant touchpoint in the medical career, as they make the transition from medical student to medical practitioner. Whilst most prevocational trainees enjoy the challenge, many also report that at times it can be stressful as young doctors can be vulnerable to poor mental health and high levels of stress.

The reasons for this stress can be numerous but include:

- Loss of a structured learning environment coupled with increased demands on knowledge and performance
- Longer hours and shift work
- New responsibilities and confrontations with life and death experiences
- Unprecedented levels of administrative duties that may conflict with the trainee's self-image as a professional clinician
- Frequent changes in work environment, patients, team partners and bosses.

Given the regular contact that they have with prevocational trainees, MEOs are well positioned to provide support to them. This can be a fundamental component to the role and one that many MEOs report as being the source, when done well, of considerable professional satisfaction. Implicit in this is a supportive but firm approach in managing prevocational trainees.

The way in which MEOs work with trainees can have a major impact on the morale of the TMO group. This might range from having an open door policy, promoting a culture of cooperative working relationships, a can do attitude and a positive approach to resolving issues. This approach is highly valued by prevocational trainee.

The fact that the MEO sits somewhat to the side of the medical hierarchy means that many prevocational trainees may be more willing to confide in the MEO (rather than a more senior doctor) about their concerns and anxieties.

MEOs are often very adept at picking up those prevocational trainees who may be struggling and may be involved in managing trainees in difficulty, often with the support and assistance of others (refer to later section for more information). Some resources and references that MEOs may find useful are included at the end of the section.

Performance management

MEOs are often responsible for first line management of performance issues involving prevocational trainees, sometimes in collaboration with clinical unit heads. This can include ensuring that prevocational trainees meet their obligations with respect to public sector employment policies and related human resource matters, such as turning up for work on time, submitting appropriate leave forms, responding to a complaint from a nurse, completing discharge summaries and so on.

MEOs will be involved in developing and supporting systems that provide prevocational trainees with regular feedback, both informal and formal about their performance.

All public health organisations have well-established policies and procedures with regards to the performance management of employees and these should be followed. You will undoubtedly seek assistance when required from the EDMS, DCT, clinical Head of Department, HR and a range of others depending on the context of the specific issue.

Trainee in difficulty

As the MEO you may often be the first to recognise that a prevocational trainee is experiencing difficulties. Management of a trainee in difficulty is a supportive and confidential process and is the joint responsibility of the MEO, DCT EDMS and term supervisor.

Whilst the way in which a prevocational trainee in difficulty may present might vary, all require appropriate support and timely intervention.

Many MEOs report that dealing with trainees who are experiencing difficulties is one of the most challenging aspects of their work. The reasons for this are numerous and include the following:

- The legal and industrial frameworks are complex and there are multiple public sector policies to consider.
- Those involved must negotiate the interface between the roles of the prevocational doctor as both trainee and employee.
- Working with prevocational trainees experiencing difficulties can be demanding, particularly those who have problematic attitudes and behaviours. Effective communication skills are required.

Employers have a legal responsibility to ensure that industrial conditions and legislated requirements pertaining to employment are upheld. This includes responsibility for managing performance and disciplinary matters, and ensuring that performance issues are responded to in a timely, fair and objective way.

Every public health organisation has processes for identifying, investigating, managing and supporting prevocational trainees who are experiencing difficulties. Some situations will additionally require assistance from medical administration or human resources.

Each facility is required to have an Education and Training Program (ETP) Committee. This committee will have in its membership, a range of individuals experienced with management of trainees. Most trainee matters can be discussed in a de-identified way, but remember that if a trainee in difficulty is being rotated to another hospital, that hospital needs to be aware of ongoing issues. Similarly, a new term supervisor needs to be aware. Communication about performance concerns needs to be managed carefully, with the utmost confidentiality.

Deciding when to inform others is always difficult. Wisdom and experience are critical to effective intervention. Seek advice from an experienced DCT in the network or beyond. All Local Health Networks have Clinical Governance Units (or equivalent) responsible for patient care, for minimising risks to consumers, and for continuously monitoring and improving the quality of clinical care throughout the organisation.

Early signs of a trainee in difficulty:

- **The disappearing act**
- **Low work rate**
- **Ward rage**
- **Rigidity**
- **Bypass syndrome**
- **Career problems**
- **Insight failure.**

SA MET has a broad range of skilled personnel who are deeply involved and committed to the education, training and welfare of postgraduate trainees in South Australia. SA MET will often be able to provide or direct DCTs to specific resources and is also able to provide an advocacy service for supervisors and trainees which is confidential.

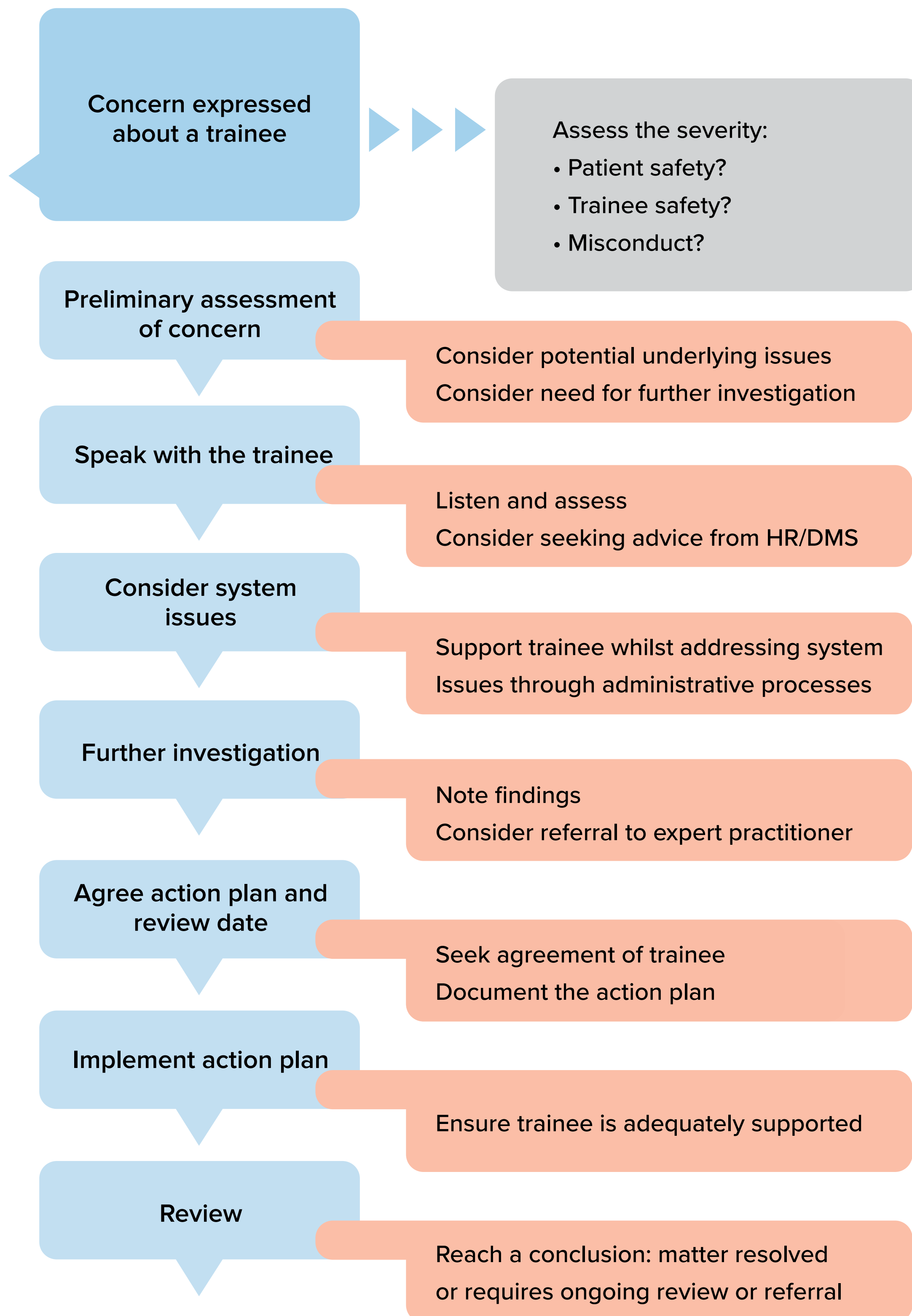
Key Messages:

- Most prevocational trainees in difficulty can be assisted, over time, to become competent doctors. A supportive approach, with common sense intervention, usually leads to a satisfying result for the prevocational trainees and their clinical supervisors.
- "You cannot unknow what you know"– do not accept someone telling you something "off the record."
- Any risks to patient safety, risk to prevocational trainee safety or allegations of criminal conduct require immediate action and referral.
- All prevocational trainees should be encouraged to have their own general practitioner and should seek early advice from their GP in the event of emerging health issues.
- There are other individuals within any healthcare organisation who have particular expertise in dealing with these matters.
- The MEO is often the first to notice that something is amiss. Some prevocational trainees experiencing difficulties may be at risk of self-harm and need timely escalation to expert health practitioners such as a general practitioner or mental health clinician.

3 key principles

1. **Patient safety should always be the primary consideration.**
2. **Prevocational trainees require supervision and support.**
3. **Prevention, early recognition and early intervention are the preferred approach.**

Management outline for trainee in difficulty



The responsibility of managing a trainee in difficulty needs to be within the health unit and may include the MEO, DCT, EDMS and/or term supervisor.

Dealing with grievances and complaints

Given their regular contact with prevocational trainees, it is not surprising that MEOs report that dealing with grievances and complaints can sometimes occupy a significant proportion of their time.

The circumstances and context can vary – from involving an issue of incorrect pay; interpersonal tensions between a prevocational trainee and another doctor or nurse on the team; through to more complex issues, such as an allegation of bullying.

All public health organisations have clearly documented grievance policies. MEOs should be well aware of the relevant organisational grievance policy. The principles and policies expressed in these documents should always be followed.

The vast majority of issues or complaints from prevocational trainees that cross your desk are likely to be able to be resolved without the requirement for escalation or significant interventions by adopting a supportive and fair, but firm approach.

It is worth remembering that responding professionally to situations in the workplace where one might justifiably feel upset, irritated or angry is an important learning point for prevocational trainees. Sometimes just having someone listen to their side of the story or concerns is enough. By giving them the opportunity to debrief and express frustration they will then be able to work constructively towards a resolution.

The obvious exceptions to this are significant grievances or complaints that involve patient or prevocational trainee safety or serious allegations involving other staff. These matters can be very complex to investigate and manage. The MEO should be alert to the requirement for timely referral and escalation to the, medical administration or the human resource department for assistance and support.

Resources

Trainee in Difficulty: a Handbook for Directors of Clinical Training
https://www.samet.org.au/reports-and-resources/resources/trainee-in-difficulty/

PART FOUR - TERM ALLOCATIONS AND ROSTERING

Term allocations

Similar to rostering, that is referred to later in this section, the interface between prevocational trainee and employer is no more keenly felt than when it comes to term allocations. This is reflected in the amount of time that you will spend engaged in trying to meet the needs of both!

On one hand you will have a responsibility to the organisation to ensure that all units and terms (including at nights and on weekends) are adequately covered with prevocational trainees. On the other, you will be trying to juggle everybody's specific training and other requirements. It can sometimes feel like trying to complete a 5000-piece jigsaw puzzle blindfolded – only a lot less fun!

During the first twelve months of training, interns are required to complete a number of rotations (currently five terms of between ten to eleven weeks duration combining to provide a minimum of 47 weeks clinical experience), with core terms in medicine, surgery and emergency medicine. The core requirements were described in an earlier section.

Most facilities or networks have a number of available terms beyond the core requirements. Most prevocational trainees may undertake terms across a range of specialty areas in a variety of settings.

Towards the end of the clinical year, as MEO, you may have the challenging task of assigning prevocational trainees to the terms for the following year. This is usually done immediately following the recruitment period.

In addition to core requirements there are a number of other factors to consider in the allocation of terms. These include: individual trainee preferences; capacity to undertake a term in a rural setting; timing of a particular term in relation to annual leave requests; prerequisite requirements for college training programs; and so on.

Given all of these considerations it is no wonder that term allocations can sometimes be very complex and there is a range of ways to approach this task. Whilst you may be put under pressure by some individual trainees to provide terms to meet Specialty Medical College prerequisites, this must only be done where a fair and equitable term allocation can still be made for all the prevocational trainees. The principles of fairness and equity of access are important here and should underpin whatever approach is taken.

Most MEOs start this process early (particularly in the bigger sites or networks) and seek the assistance of others. Some MEOs form a small subcommittee of TMOs to help. Others send out a term preference list (often along with a leave request form) giving prevocational trainees the opportunity to list their preferences. For the intern year, this is often done as soon as medical graduates are allocated a position in the LHN. For PGY2s this is done toward the end of the intern year. MEOs may need to work with others in the LHN to ensure alignment and coordination of terms.

Once term allocations have been completed, it is useful to maintain two databases (spreadsheets), the first cut by terms (to ensure that there are no vacant terms) and the second by individual prevocational trainee (to ensure that each TMO has an appropriate range of terms).

Why term allocations are important

The prevocational training program (namely internship and general training) provides the foundation for a skilled medical workforce with a broad range of training experiences across specialties and in different contexts, including tertiary, outer metropolitan and rural hospitals, general practice and community settings.

From a medical education and training perspective, term allocations provide the opportunity for prevocational trainees to gain important clinical experience within a clinical specialty. This can provide them with a sense of what the specialty (and the training program for that specialty) might be like, through their work with consultants and vocational trainees. Experience in a particular specialty can have a very significant impact in making career choices, by seeking greater clarity about which specialty they would like to pursue, and just as importantly, which ones they don't.

From a service provision point of view, you as the MEO will be concerned about ensuring that all terms across the LHN or in your facility are adequately staffed with TMOs, with the appropriate seniority and skill mix.

From the prevocational trainee point of view, having the opportunity to complete a particular term can be very important. Put simply, term allocations can have a very significant impact on their choice of career. As the numbers of trainees in the system increases and with it, competition for training places, the decisions around term allocations are likely to become more contentious. MEOs should have transparent systems in place for allocating terms, based on the principles of fairness and equity of access.

Rostering

Rostering of prevocational trainees can be a complex business. MEOs who work in large metropolitan networks or facilities will often have responsibility for coordinating, in consultation with the various clinical departments, numerous rosters involving doctors. Even MEOs responsible for much smaller cohorts of prevocational trainees, will find that they spend a significant amount of their time managing rosters and associated tasks. Rosters can include, but not limited to, night roster, weekend roster, on-call rosters, annual leave roster and professional development leave roster.

At the commencement of their medical careers, prevocational trainees may have had little experience with working on a roster. Working after hours, weekends, evenings and nights can be a new experience. Many doctors report that the work they undertake outside of normal hours, where supervision arrangements and skill mix of staff may differ from that available during business hours can be stressful.

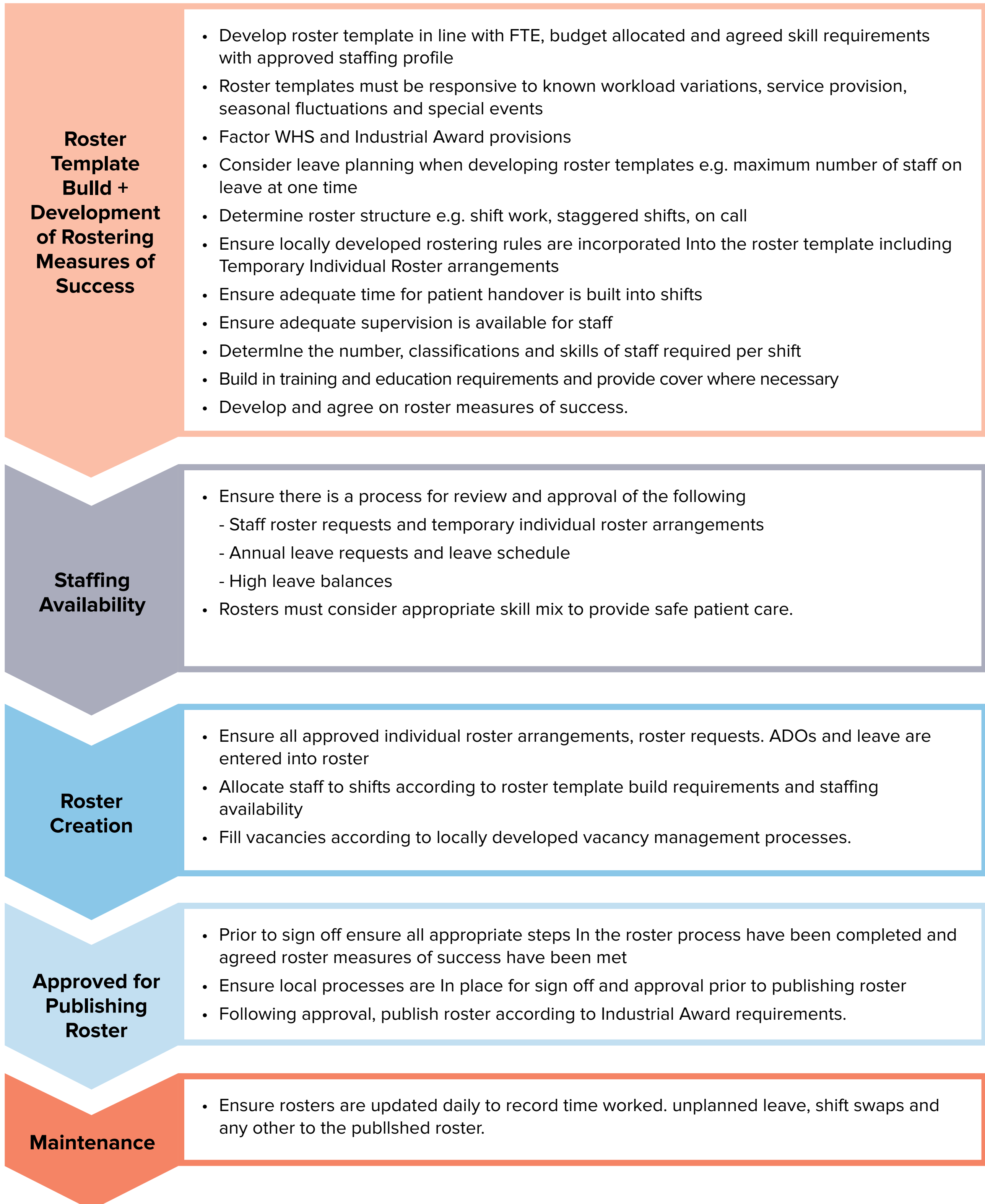
Experienced MEOs will also confirm that as increasing numbers of prevocational trainees are entering the system, rostering templates for this cohort are changing. One of the most significant changes, at least in the large centres is the reduction in rostered overtime hours with a simultaneous increase in the number of ordinary hours worked outside of the traditional business hours for an individual TMO.

Adjusting to working shifts, particularly night shifts, requires support. In recognition of this, the AMA has developed a National Code of Practice: Hours of Work, Shiftwork and Rostering for Hospital Doctors. This Code responds to concerns about working hours and safe practice, providing practical guidance on how to manage fatigue. When developing rosters for prevocational trainees in this context, access to the formal education program and other teaching opportunities (which for medical staff continue to be held predominantly in normal hours) needs to be taken into consideration.

TMOs are entitled to five weeks of annual leave per year. Interns are recommended to take a maximum of four weeks during the training year to comply with AHPRA training requirements of completing 47 weeks of training throughout the training year. This allows an extra week for unforeseen circumstance, such as sick leave. Rostering annual leave can be a long and difficult process as when one is on leave, a reliever TMO is often required.

TMOs are also entitled to five days of leave for professional development. This can involve attending local, interstate or international workshops or conferences to improve their clinical, research or leadership skills.

Rostering Process



Source: NSW Health Rostering Resource Manual - for full version of the rostering process see page 10 of the Manual

Budget and finance management

Many MEOs have responsibility for managing budgets and finances relating to the prevocational workforce. This may extend to managing rosters and medical overtime in ways that are cost effective and within budget. MEOs may undertake this work in collaboration with clinical units, finance and other key individuals within the organisation. As a MEO you should be familiar with the financial reporting systems within your facility.

Many MEOs are also responsible for implementing policies and processes around rosters and overtime, in addition to monitoring the compliance. Central to this is the development of clear communication with prevocational trainees regarding their responsibilities in meeting obligations regarding rosters and overtime, including timesheets and approval processes.

Monitoring prevocational trainee's workload

MEOs frequently have responsibility for setting up systems to monitor prevocational trainee workload. This may range from monitoring rostered and unrostered overtime, call backs, through to patient loads on individual teams. A number of factors may impact upon workload at the level of the individual trainee. These can include the following:

- Rosters (ordinary hours)
- Rostered overtime
- Unrostered overtime
- Patient numbers and clinical complexity
- Senior medical officer rosters (as prevocational trainees are generally assigned to a number of senior medical staff within a given specialty, changes to senior medical staff rosters or senior medical staff leave and cover arrangements can significantly impact on individual workload)
- Numbers and skill mix of other TMOs in the term, including leave arrangements
- Seasonal fluctuations in patient numbers in some terms
- Individual prevocational trainees (particularly at the commencement of the year, trainees may take longer to complete tasks compared with the end of the year).

Systems that monitor workload should be in place and significant issues escalated to the relevant individual. Depending on the organisational context this may be the DCT, EDMS or Clinical Head of Department.

Supporting effective clinical handover

MEOs are well positioned to support effective clinical handover practices in their facilities or Networks. Clinical handover refers to the "transfer of professional responsibility and accountability for some or all aspects of care for a patient, or group of patients, to another person or professional group on a temporary or permanent basis".

Given the nature of their roster and term arrangements, prevocational trainees need to develop and engage in effective clinical handover practices as a critical component of their work, appropriately supervised and supported by more senior medical staff.

At the end of handover, the prevocational trainee, be it at the end of a shift or at the end of the term, should have a clear understanding of:

- Acutely unwell, deteriorating and unstable patients
- Outstanding actions, procedures, test or results to be reviewed
- How to escalate for clinical support and in a timely fashion
- Other important factors that will impact work on the following shift.

MEOs have an important role in developing systems that support effective clinical handover. MEOs who are familiar with the range of tools and resources developed to support effective clinical handover practices for prevocational trainees will be able to actively promote them amongst their prevocational trainee cohort.

MEOs can also assist effective clinical handover in the following ways:

- Development of roster templates that facilitate time for handover – this implies that there is provision for rostered shift overlap and that punctuality with start and end times of shifts with prevocational trainees are reinforced.
- Incorporate requirement and responsibility for clinical handover into prevocational trainee position descriptions and term descriptions.
- With respect to the end of term changeover, coordinate with LHN partners to ensure that rostering practices are aligned to maximise opportunities for incoming and outgoing prevocational trainees to provide clinical handover of patients, (in addition to other considerations such as time to travel, management of fatigue and so on).
- Participate (with other relevant staff) in audit and monitoring of clinical handover practices within your facility.

Resources

AMA National Code of Practice (Safe Hours)
https://ama.com.au/system/tdf/documents/FINAL_NCP_%20Hours_of_work_2016.pdf?file=1&type=node&id=37826

PART FIVE - RECRUITMENT AND SELECTION

Overview

Prevocational and vocational trainees, in addition to non-streamed doctors, are employed within SA Health on temporary contracts, which generally have a start and end date aligned with the clinical year. This means that TMOs must apply for positions at various points in the training continuum and this is managed by a general recruitment period known as the PGY2+ recruitment process. The medical administrator and MEO role are the most significant contributors to this process.

The SA MET Unit has been managing the PGY2+ recruitment process on behalf of SA Health and the LHN and their training programs since 2008. The application and recruitment process has evolved over the years to make improvements for the training programs as well as the applicants. The process has advanced with consultations and each party involved has clear and distinct roles and responsibilities.

Primarily the process streamlines the allocation of PGY2+ positions across South Australia and reduces applicants accepting multiple job offers resulting in vacancies at the beginning of the year. The PGY2+ recruitment process also has benefits for applicants; they are able to apply to multiple positions within the single application.

The process also enables a coordinated approach to shortlisting application. This is also an advantage to applicants and LHNs as it can, for example, reduce the number of interviews an applicant is required to attend, subsequently reducing the impact on the workplace due to timeout.

LHNs involved in this process have agreed to the following:

- Maintaining a centralised PGY2+ application and collection of applicant data to reduce duplication.
- Advertising positions centrally so there is consistent and concise messages about the selection and allocation of positions.
- Streamlining shortlisting and ranking processes, where possible.
- Centralise position offers so applicants do not receive multiple job offers.

The Medical Officer Appointment Working Group has been appointed to provide governance and advice on the overall PGY2+ recruitment process. The Medical Officer Appointment Working Group reports to the EDMS.

The specific dates for the commencement of the clinical year and subsequent term rotation dates are set by the Medical Appointment Working Group and align to nationally agreed time frames as set by Australian Health Ministers.

Many Local Health Networks also run a small medical workforce recruitment process for positions commencing in August. This allows for a consistent number of prevocational trainees, as throughout the year many trainees will gain college positions, take extend leave, locum jobs or move interstate/ overseas.

Experienced MEOs will tell you that the period May through to October represents a very busy five to six months of the year. Some MEOs, particularly at the larger facilities, will deal with thousands of applications during this period. Given the complexity of the task, a systematic approach to the recruitment period, often working in collaboration with others (Clinical Heads of Department, SA MET, medical administration and the human resources department) is required.

Recruitment process

Preparation for the recruitment period begins well ahead, usually several months before the positions are advertised. In the first instance, many MEOs will be responsible for confirming the budgeted FTE (including at what level) and seeking approval for the proposed recruitment action. MEOs should be aware that changes may occur from year to year and the relevant policies should be accessed to ensure up to date procedures are being implemented.

Medical Administrators are more likely responsible for organising formal contracts with successful applicants, and at this point in time should be careful to check what further employment requirements the applicants need to meet - such as registration renewal, police checks, health checks, immunisation, employment visa etc.

Tips from MEOs on preparations for the annual recruitment period

- **Refer to recruitment policies to ensure currency of understanding and compliance**
- **Review recruitment systems and processes within the SA MET Unit**
- **Check budgeted FTE and obtain approvals**
- **Review job packs and position descriptions**
- **Work with Clinical Heads of Department/HR/ Medical Administration and other relevant people as required**
- **Organise selection panels**
- **Book senior medical staff for selection panels early**
- **Allow plenty of time for shortlisting and ranking applicants**
- **Maintain appropriate records for HR employment processes**
- **Prepare onboarding packs (these might include letter templates, contracts forms and information about the Network).**

Medical graduate recruitment

Final year medical graduates are invited to apply for internship positions about 7 months prior to the commencement of the clinical year, through a process that is managed by the SA MET Unit. This usually commences in May each year.

Each LHN EDMS will determine how many intern positions will be required from year to year. MEOs are responsible for preparing valuable information about the intern training year and is an opportunity to try and attract new graduates to your health service.

The SA MET Unit coordinates the advertising and application management of the intern recruitment; with the open and closing dates in line with national standards.

The SA MET Unit reviews all applications and verifies that applicants meet the eligibility criteria for internship. Once eligibility of applicants has been confirmed, they are processed through the optimised preference allocation, with the exception of those placed through the rural pathway. Applicants are then offered a position within a LHN and given an opportunity to accept or decline. At the end of the process, LHNs (usually through the MEO/medical administrator) will be advised of which medical graduates have been allocated to their LHN. Once a LHN is notified by the SA MET Unit of the medical graduates who have accepted positions, the MEO/medical administrator will need to undertake the necessary pre-employment checks, clearances, generation of contracts and associated paper work.

Applicants that are offered an intern position, and have accepted, will also be asked to complete a term preference form and this will be managed by SA MET through the electronic recruitment system. The SA MET Unit will provide these completed electronic forms to MEOs and the term allocations can then be undertaken.

> **"There is an innate pleasure in watching an Intern grow from their first day to a confident Junior doctor by the end of the year."**
>
> Lynne Burn, Medical Education Officer,
> Central Adelaide Local Health Network

Resources

PGY2 Recruitment
https://www.sahealth.sa.gov.au/wps/wcm/connect/public+content/sa+health+internet/careers/career+streams/medical/trainee+medical+officer+recruitment

Medical graduate recruitment
https://www.sahealth.sa.gov.au/wps/wcm/connect/public+content/sa+health+internet/careers/career+streams/medical/intern+recruitment

PART SIX - SA MET ACCREDITATION

Accreditation ensures prevocational trainees receive high quality education, training, assessment and support. The SA MET Health Advisory Council accredits prevocational medical posts in LHNs after assessing the quality of education and training provided.

The accreditation process emphasises working towards goals to develop a quality postgraduate medical education system in South Australia. Through accreditation the SA MET Health Advisory Council is able to advocate for improvement to prevocational training programs.

Overview of accreditation standards

The Medical Board of Australia in granting provisional registration to interns has a requirement that interns can only work in terms or rotations accredited by a postgraduate medical council or equivalent body.

In South Australia, SA MET has the responsibility for accrediting facilities and posts for prevocational year one training posts (from the Medical Board of Australia) and prevocational year two training posts.

The accreditation standards have three primary goals:

- The facility/term ensures prevocational trainees have the appropriate knowledge, skills and supervision to provide quality patient care.
- The facility/term provides a wide range of educational and training opportunities for prevocational trainees to ensure that they are competent and safe.
- The facility/term promotes the welfare and interests of prevocational trainees.

The standards measure performance of the facility or practice in the following areas:

- **Hospital orientation**
- **Term orientation**
- **Supervision**
- **Professional development**
- **Training and service requirements**
- **Formal education program**
- **Clinicians as teachers**
- **Assessment and feedback**
- **Education and information resources**
- **Prevocational trainee management**
- **Prevocational trainees with special needs**
- **Safe practice**
- **Promoting prevocational trainee interests**
- **Supporting prevocational trainees**
- **Physical amenities.**

Accreditation process

The accreditation process is predicated on a peer review system, whereby a team comprising of three to four members including a senior clinician, a prevocational trainee, and often a medical administrator, or MEO who visit the facility to make an assessment of the facility's performance against the standards.

The process commences with a self-assessment conducted by the facility several months prior to the accreditation visit. Staff responsible for prevocational training at the hospital or facility complete the self-assessment component, and collate evidence in support of the submission. This material is submitted to the SA MET Unit who then commences preparation for the site visit. At the accreditation visit, the accreditation team interview key staff involved in prevocational training including but not limited to trainees, term supervisors, MEOs and Hospital Executives. The duration of accreditation visits vary from 0.5 to 2 days dependent on the nature of the visit (full facility, mid-cycle review, assessment of unit).

Following the visit, a report is formulated from the information obtained during the visit collectively with the reviewed documentation provided by the hospital. The data is assessed against the accreditation standards where the team addresses any identified areas of concern and determines provisos which aim to address concerns. The finalised report is forwarded to the SA MET Health Advisory Accreditation Committee where they evaluate the report and make any necessary amendments. In considering the report, the committee makes a recommendation regarding awarding of accreditation status as well as prioritising the provisos, determining required actions and evidence in relation to any high level recommendations. These will be communicated to the hospital or facility and they will be expected to address the provisos and report back to the committee within a given time frame.

Accreditation processes not only ensure that minimum standards regarding prevocational trainee supervision, education, training and welfare are met, the process also encourages quality improvement and strives for excellence with regards to the provision of medical education.

As the MEO you will be very involved in both the preparation and conduct of the accreditation.

Preparing for the accreditation visit

The accreditation process relies on the provision of evidence across all standards – it has a systems focus with attention to what structures and processes are in place that support prevocational training. As the MEO, you may be responsible for ensuring that many of these systems are in place.

You should be familiar with the content and structure of the standards, particularly with respect to the specific requirements, guidelines and evidence requirements. You will note that significant emphasis is placed on monitoring, collecting evidence, evaluation and continuous improvement. Whilst not all of the requirements in the standards, or the evidence needed may necessarily fall to your responsibility, it is very likely that you will be involved in at least assisting the organisation's preparation for the accreditation visit. Experienced MEOs who have been through the process will advise that one of the most helpful things to do is to keep the documentation or evidence that you will need to provide for the accreditation team as you go. It can also be very useful to participate

in an accreditation of another hospital prior to going through your own hospital accreditation process. By being familiar with the standards at an early point in time, you will be guided as to what information to collect.

Collecting information or evidence as you go (particularly in the twelve months prior to accreditation), makes the job of completing the self-assessment report and producing the evidence in the lead-up to the accreditation a whole lot easier.

The self-assessment report is completed a couple of months prior to the visit. It asks for details around how the facility believes it has progressed against the standards and criteria (including the specific requirements and guidelines) in the period since the previous accreditation. It also includes a section to report on previous provisos.

The self-assessment report is often the first contact the accreditation team have with your hospital. Therefore the information contained in the accreditation self-assessment helps form the accreditation team's opinions even before the first day of the visit. In completing the accreditation self-assessment, if that responsibility falls to you, engage the support of others. The self-assessment material is required back at SA MET six weeks prior. As your facility nears the time of the visit, it is likely that you will have increased contact with a accreditation team member from SA MET – they will be a useful resource to assist and support your preparation.

What to expect at the accreditation visit

Generally speaking by the time of the accreditation visit, most of the hard work from your point of view will be complete. The self-assessment report has been finalised and the evidence is ready for the accreditation team.

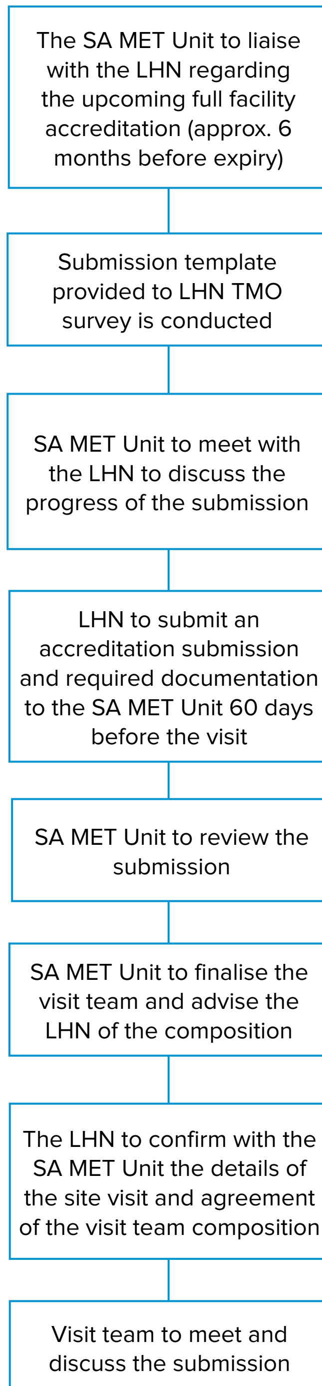
During the visit, the accreditation team will meet with prevocational trainees, term supervisors, the DCT, medical administrators and members of the hospital executive. They will also review all the documentation that has been provided in addition to completing a tour of the hospital.

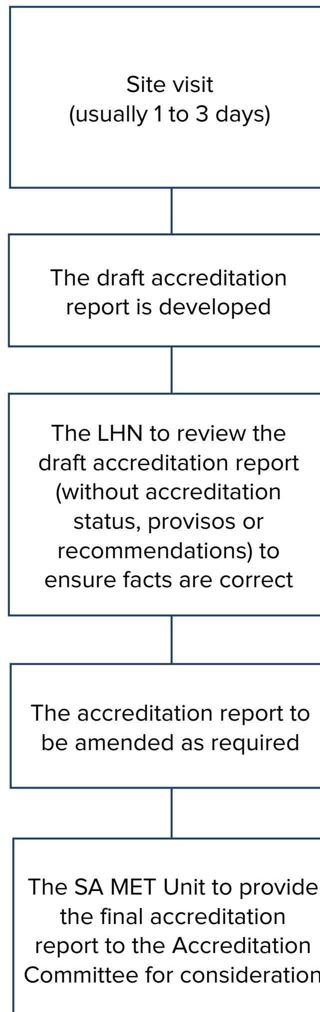
Your Accreditation coordinator will have more information on the actual process and you should speak with them well before the accreditation if required, particularly if this is your first accreditation as a MEO.

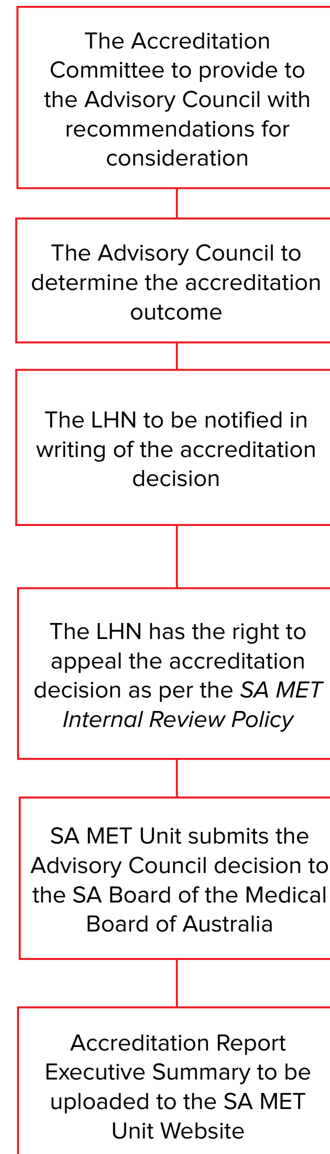
At the conclusion of the visit, the team will meet with the hospital executive team for a formal debrief in order to provide a summary of their main findings. In some instances, depending on the facility, you as the MEO may attend. The debrief provides an opportunity to deliver the findings, check any potential inaccuracies and summarise the main strengths and issues identified at the visit. Whilst it is not the role of the accreditation team to make a recommendation of the accreditation outcome, it is their role to alert the hospital to any major problems. Given that the report is presented to the committee prior to it being forwarded to the hospital, it may be two to three months following the visit before the hospital or facility receives the report. Clearly if there are significant concerns identified the hospital will likely want to address these (or at least start to) prior to receiving the formal report.

The accreditation process is outlined on the next page, showing the accreditation preparation, visit and approval process.

Accreditation Process: Full Facility Accreditation







Post accreditation

As the MEO you will most likely receive a copy of the accreditation report, once it has been finalised through SA MET. It will also be provided to the CEO and EDMS of the LHN. The accreditation report may contain a number of provisos. Provisos will need to be responded to within the timeframe specified in the report. As the MEO you may be involved in responding to the provisos and, with the assistance of the EDMS and DCT.

Term accreditation

Prevocational trainees can only work in terms accredited by the SA MET Health Advisory Accreditation Committee/Advisory Council. The Medical Board of Australia may consider that time worked in non-accredited terms completed by a intern as not counting toward registration.

Whilst all accredited or provisionally accredited terms in a particular site are evaluated during the accreditation visit, facilities wishing to develop new terms (or make significant changes to existing terms) during the intervening period must submit a term description with all the required elements. Refer to the SA MET website for the term description template.

The term description should be signed by the term supervisor and endorsed by the DCT. The term description is then submitted to the Accreditation Committee for provisional accreditation.

Once the SA MET Health Advisory Accreditation Committee/Advisory Council has approved the new term, it will remain provisionally accredited until the next scheduled accreditation visit. Further information about accrediting new terms can be found by following the links included below.

Specialty Medical College accreditation of training posts

Given that most MEOs are responsible for the management of other TMOs, it is very likely that they will also become involved from time to time in Specialty Medical College accreditation processes. The AMC is responsible for accrediting education and training providers of specialist medical training. The MBA delegates this function to the AMC who complete periodic accreditations of Specialty Medical College to ensure that the standard of education and training and requirements for specialist medical training is at a particular level.

Only Fellows of Specialty Medical College accredited by the AMC are eligible to be registered as specialists with the MBA. As part of the requirements set out by the AMC, all Specialty Medical College are required to have processes in place whereby the Specialty Medical College accredits training posts or facilities. There is variation in the way in which Specialty Medical College undertake this. Some accredit posts, others facilities, but generally many of the same themes which are features of the prevocational accreditation standards are present in the Specialty Medical College accreditation. Whilst as a MEO you would not normally be involved in completing the pre-college assessment information, you might well be asked to provide some information.

Other information regarding Specialty Medical College assessment processes can be obtained via the relevant Specialty Medical College website.

Resources

SA MET Accreditation and Accreditation Standards
https://www.samet.org.au/prevocational-accreditation/

Postgraduate Medical Education Unit

The Postgraduate Medical Education Unit (PMEU) provides advice and assistance with teaching, supervision, assessment and evaluation to TMOs. The PMEU is made up of a variety of roles:

Executive Director Medical Services (EDMS)

Responsible for the management of:

- Postgraduate Medical Education Unit
- Clinical Governance including credentialing of medical staff, patient safety and quality improvement
- Clinical information systems development
- Research governance
- Relationships with relevant professional bodies and universities
- Medico Legal and Coroner's matters

Director of Clinical Training (DCT)

The DCT also acts as a TMO advocate to those who experience any problems.

The DCT consults with the EDMS and relevant stakeholders. Other responsibilities of the DCT include:

- Defining the needs of TMOs
- Establishing objectives for TMO Training
- Designing strategies to ensure that those needs and objectives are met
- Evaluating the training program
- Initiating any necessary change
- Welfare and support of TMOs

Medical Education Officer (MEO)

The MEOs primary responsibility is for Intern training and support.

The MEO also provides support for the personal welfare of TMOs and aims to enhance education and training by promoting an environment conducive to learning.

Specifically the MEOs role is:

- Ensure each Intern has a broad based educational experience that meets the requirements to obtain full registration
- Facilitate Intern training by developing support structures and educational and organisational initiatives
- Implement, evaluate and maintain educational programs within the hospital
- Develop, trial and evaluate educational resource material and assessment tools for intern education programs.

Administrative Officer (AO)

The AO assists with distributing and collecting all Intern Assessments and evaluations of Units and will be the person who contacts you if your Assessments are either late or missing. The AO also coordinates various training sessions and other tutorials not administered by individual Divisions and will be the one most able to locate the DCT and MEO should you need them.

Term Supervisors

During each of a TMO rotations (or 'terms') there will be an allocated Term Supervisor. This person is noted in each Term Description which TMOs will receive prior to commencing each term. Term Supervisors, or their delegate, are responsible for orientating TMOs to the unit and collating feedback about their term. It is the TMO responsibility to ensure the Term Assessments are completed. It is important that a term supervisor provides honest feedback.

Medical Education Registrar

Each hospital will have a Medical Education Registrar, the role of the registrar is to assist with the education and training of TMOs. The Medical Education Registrar are a valuable addition to the PMEU and often acts as mentor, providing additional support to TMOs.

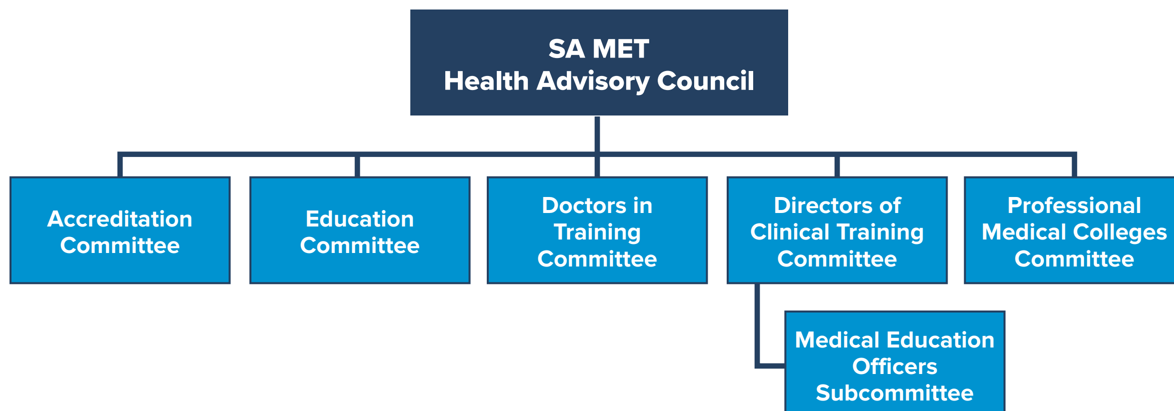
Trainee Medical Officer (TMO) Unit

This unit will generally consist of a manager and support staff. The function of the TMO unit can vary in each hospital. Often this unit will be involved in creating rosters, recruitment, allocating annual leave, professional development claims and credentialing for TMOs. TMOs can often go to the TMO office for any human resource issues. The TMO unit and the PMEU will work closely together in regards to TMO management as many duties of the roles will correlate.

The South Australian Medical Education and Training Health Advisory Council

The South Australian Medical Education and Training Health Advisory Council ("the Advisory Council") was established by the Minister for Health and Wellbeing as an unincorporated health advisory council pursuant to section 15 of the Health Care Act 2008 ("the Act"). The Advisory Council works towards improving the quality of education, training and welfare for trainee medical officers and undertaking the accreditation and monitoring of postgraduate training posts in South Australia. The structure of the Advisory Council gives it integrating operational and advisory responsibilities for postgraduate medical training. It also provides the ability for the Advisory Council to represent all phases of postgraduate medical education including intern and subsequent prevocational and vocational training.

The Advisory Council structure enables rapid and effective integration of on-going developments in education and training, at both local and national levels. In addition, the structure supports a range of objectives and targets from South Australia's Strategic Plan by moving South Australia's health reform agenda forward and being proactive about health workforce needs. The structure can be seen below.



Accreditation Committee

The SA MET Accreditation Committee, through the SA MET Advisory Council, makes recommendations on the accreditation status of Intern positions to the South Australian Board of the Medical Board of Australia, and of other prevocational trainee positions to the Department for Health and Wellbeing and the Minister for Health and Wellbeing.

Education Committee

The Education Committee provides advice to the Advisory Council on appropriate education and training activities for TMOs in South Australia. This includes advice on clinical supervision, education and training. The committee develops partnerships with relevant stakeholders, including Universities and professional colleges, to enhance vertical and horizontal integration of medical education programs.

Education Committee, on behalf of the Advisory Council, developed the clinical enrichment tool, Medical Education and Training Principles, which demonstrates what excellence looks like when a learning culture is actively supported and achieved. The Principles will be one of the enablers to ensure that South Australia has the best-equipped medical workforce possible. Not only must our workforce be well trained, but also supported and challenged in that training using the most up-to-date medical education methods available.

MEOs must work together to support the next generation of professionals to be lifelong learners who possess the knowledge, strength of character and drive, to actively exemplify excellence in the provision of quality healthcare. MEOs are encouraged to model the behaviours, and motivate and support the ongoing development of peers and trainees, ensuring that education and training underpin the delivery of a safe, contemporary and sustainable healthcare system.

Professional Medical Colleges Committee

The Professional Medical Colleges Committee is established to provide advice from the perspective of the Professional Medical Colleges to the Advisory Council. The committee works collaboratively to provide leadership in postgraduate medical education and training in the State and to maintain high quality vocational training.

The Directors of Clinical Training Committee

The Directors of Clinical Training (DCT) Committee provides advice to the Advisory Council on any aspect of the Advisory Council's functions from the perspective of the DCTs. The committee identifies issues and concerns pertaining to prevocational postgraduate training and facilitates solutions. The chair of the Medical Education Officer Subcommittee is a member of this committee to ensure issues and concerns raised by Medical Education Officers are represented and are presented to the Advisory Council.

The Medical Education Officer (MEO) Subcommittee

The Medical Education Officer (MEO) Subcommittee is established as a Subcommittee of the Directors of Clinical Training (DCT) Committee to provide advice to the Health Advisory Council through the Directors of Clinical Training (DCT) Committee on any aspect of the Advisory Council's functions from the perspective of the Medical Education Officers (MEOs) and allow sharing of resources, ideas and knowledge across South Australian hospitals.

The functions of the Medical Education Officers' Subcommittee include:

- Development of common solutions to enhance education and training, the workplace experience and career development of prevocational trainees.
- Sharing of information on education and training programs at each site.
- Provision of information and feedback to stakeholders as required.
- Advocacy for best practice education and training for prevocational trainees.
- Provision of information, feedback and advice regarding centralised resources and resources that may be required for particular groups.
- Communication between SA MET and MEOs on current initiatives and vice versa.
- Advocacy and support for the MEO role.

Membership to the MEO Subcommittee is automatic by appointment to a MEO position or equivalent. The subcommittee meet four times a year, with one meeting combined with the DCT Committee. This enables the two committees a chance to engage with each other on a state-wide level and gives MEOs an opportunity to address concerns that relate to both roles.

MEOs find being a part of this subcommittee as a great advantage to the role. New MEOs will tell you this subcommittee has allowed opportunities to connect with colleagues from other networks and provides a platform to raise any concerns about either the role or prevocational trainee management. Furthermore, this subcommittee is great way to share resources and you will find that what is relevant to one LHN, is often applicable to another. Sharing resources, ideas and knowledge allows for greater continuity within SA Health and enables MEOs to obtain new material.

Resources

SA MET Health Advisory Council and relevant committees
https://www.samet.org.au/about/sa-met-health-advisory-council/

Medical Education and Training Principles
https://www.samet.org.au/reports-and-resources/resources/medical-education-and-training-principles/

PART EIGHT - ENJOYING THE MEO ROLE

> **"The diversity of the MEO role is very rewarding. I too have grown professionally in this role in the short time I have fulfilled it. The community of MEOs supporting each other and sharing knowledge across LHNs, which in turn support the junior doctors."**
>
> Renee Murphy, Medical Education Officer,
> Northern Adelaide Local Health Network

Building and managing your team

Depending on the size and context of the facility, as a MEOs you may be responsible for managing other staff within your team. As the MEO you will rely on the support of your direct reports but will also work collaboratively with many others.

If your position has responsibility for managing a number of staff you will undoubtedly set up systems and processes to facilitate effective working relationships. Fostering collaborative relationships where all staff feel valued, with clear communication and regular team meetings will support this.

Given the nature of the work, many MEOs promote a flexible approach where everyone in the team has an understanding of each other's roles and are therefore able to assist each other during the busy peak times, such as the orientation and recruitment period or provide cover during leave. Some tips from MEOs for building and maintaining a cohesive team are included in the box below.

Tips from experienced MEOs

- **Always keep your sense of humour**
- **Hold regular team meetings, especially during busy times**
- **Maintain clear communication – be on the same page (this also helps to keep any advice or information provided to prevocational trainees consistent)**
- **Consider flexible work arrangements to ensure coverage of unit across required hours**
- **Look for opportunities for staff to develop skills (for example participate in or run projects, attend meetings or represent unit on wider committees)**
- **Consider activities (appropriate to the workplace) that will boost team morale – for example celebration of events with a morning team or lunch get together**
- **Make a point of thanking staff and recognising efforts.**

Career planning (your own!)

MEOs come to the role from a variety of backgrounds and professional experience. No matter what your pathway to the MEO role, it is important that you are able to access professional support during the role and beyond.

Given the varied roles and responsibilities involved in being a MEO (which are dependent on context and location, type of facility) your professional development needs may vary. It can also at times be challenging to make time for professional development activities but these are essential to sustaining enjoyment and further development within the role.

There are lots of professional development activities on offer. You can find out more by speaking with your local DCT, EDMS and HR department.

You should have a performance review each year. This might be used as an opportunity to identify areas that you would like to work on and strategies to assist you in this.

Beyond the MEO role

Many MEOs find that they gain a great deal of knowledge and skills during their term. They find working with, managing and supporting TMOs, particularly those in the very early postgraduate years very professionally satisfying. In addition, the role of MEO often brings with it opportunities to work and collaborate with others across the SA Health system in the medical education and training space. MEOs have the opportunity to be a member on various committees to make a positive difference to prevocational and vocational medical education and training.

Resources

Australian Curriculum Framework for Junior Doctors
http://curriculum.cpmec.org.au

Australian Health Practitioner Regulation Agency
http://www.ahpra.gov.au

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

Confederation of Postgraduate Medical Councils
http://www.cpmec.org.au

South Australian Medical Education and Training Unit
https://www.samet.org.au/

Medical Board of Australia
http://www.medicalboard.gov.au

For more information

www.sahealth.sa.gov.au

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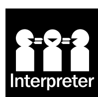

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