



SOUTH AUSTRALIAN
MEDICAL EDUCATION & TRAINING



PREVOCATIONAL MANAGERS GUIDE

SA HEALTH

Designed for managing and
supporting prevocational trainees

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SA Health

Prevocational Managers Guide

Designed for managing and supporting prevocational doctors

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 as the roles of those who support trainee medical officers evolve.

Professor Kevin Forsyth
Presiding Chair
SA MET Health Advisory Council

Supporting and overseeing prevocational TMOs within SA Health involves a wide range of responsibilities. This guide highlights the key aspects of the Medical Education Officer role. Rather than listing every task across every Local Health Network, we've focused on the activities most commonly shared across SA Health.

The role can look a little different from site to site and often overlaps with other teams involved in prevocational training. Clear communication and collaboration across these groups are essential to providing a smooth and supportive experience for our Trainee Medical Officers.

We hope this guide is a helpful starting point, particularly for those who are new to the Medical Education Officer role. Thank you for the work you do to support our prevocational doctors.

Mr Tim Wray
Chair,
Medical Education Officer Subcommittee

About this document

The Prevocational Manager's Guide (the guide) is intended for staff who manage prevocational doctors (PGYs) and international medical graduates (IMGs). It aims to assist staff in understanding the functions and activities involved in the management of prevocational doctors utilising principles from the Australian Medical Council (AMC) Framework. It is noted that even though IMGs do not fall under the remit of the AMC Framework, the management of IMGs will be similar to that of a PGY.

Throughout this document, the phrase 'prevocational doctor' and 'PGY' will be used to refer to all doctors who are managed by Medical Education Units, including IMGs and other early career/trainee medical officers, unless otherwise stated.

This guide is intended to be a tool and reference guide to both Medical Education Officers (MEO) and staff within prevocational doctor management and medical administration roles, as these roles are generally dedicated to providing management, education, training, and welfare support to PGYs and IMGs.

The guide uses MEO to refer to the activities and responsibilities of MEOs, prevocational doctor managers, and medical administration staff in managing PGYs and IMGs, as these roles often overlap, and responsibilities may vary across Local Health Networks (LHNs) and health services.

Directors of Clinical Training (DCTs) and Executive Directors of Medical Services (EDMSs) may also find this guide useful in understanding the broader prevocational medical education and training landscape.

For new staff, the guide provides insight into the diverse responsibilities involved in managing prevocational doctors. While it primarily focuses on prevocational trainees, many of its principles and resources are also relevant to MEOs managing a wider group of doctors. Not every section will apply to everyone, but the guide aims to enhance understanding of prevocational doctor management.

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 health 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 doctors (PGYs). “Everything” in this context might sometimes be translated as “whatever it takes.” Early-career doctors 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.

The MEO role can range from managing a small cohort of PGYs in a rural hospital (often in addition to a number of other responsibilities), through to having responsibility for the entire early career 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 health network. Although not all MEOs will be responsible for all of the following, activities and responsibilities may include:

- Focus on prevocational doctors.
- Term allocations aligning with program and prevocational doctor preferences.
- Orientation – commencement of year, mid-year and change of rotations.
- Organisation of the prevocational doctor education program.
- Assessment and progression management.
- Identify clinical setting / terms that meet program requirements.
- Liaise with clinical supervisors to ensure education and training in clinical settings / terms is optimal.
- Support prevocational doctors in contributing to a culturally safe workforce for Aboriginal and Torres Strait Islander colleagues and patients.
- Preparation and support of accreditation processes (SA MET and specialty medical colleges).
- Leave management, including professional development leave.
- Advocate on behalf of prevocational doctors.
- Managing grievances and complaints involving prevocational doctors.
- Liaison with external organisations in relation to prevocational doctors, on behalf of the facility.
- Oversight of prevocational doctors’ workforce in a hospital, facility, or health network.
- Assist with identifying and supporting prevocational doctors when areas for development have been identified.
- Assist with the development, monitoring, and documentation for prevocational doctors with areas for development.
- Support the DCT with the creation and progression of new term allocations and with changes to existing term allocations.

Prevocational Training

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

To the new MEO unfamiliar with the medical training continuum, the structures, requirements, and associated terminology can appear extraordinarily complex and at times, confusing. This section focuses on the prevocational training period. Appendix A 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. 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.

Interns will complete rotations that meet the criteria outlined in the AMC National Framework for Prevocational (PGY1 and PGY2) Medical Training (AMC National Framework), and on successful completion of the requirements, they will be recommended to the Medical Board for General Registration.

Accreditation of prevocational medical education program terms/rotations is carried out by the South Australian Medical Education Training (SA MET) Health Advisory Council.

Prevocational doctors in their second postgraduate year (PGY2) are also required to work in terms accredited by SA MET for prevocational training. SA MET is guided by the AMC National Framework.

The AMC National Framework for Prevocational Medical Training describes the standards for the first two postgraduate years for prevocational doctors in Australia. These national standards outline requirements for systems, processes, and resources that contribute to quality prevocational training. The complete National Framework components and their relevant documents are:

- Training and assessment – Training and assessment requirements for prevocational (PGY1 and PGY2) training programs
- Training environment – National standards and requirements for prevocational (PGY1 and PGY2) training programs and terms (this document)
- Quality assurance – AMC domains and procedures for assessing and accrediting prevocational (PGY1 and PGY2) training accreditation authorities.

<https://www.amc.org.au/accredited-organisations/prevocational-training/new-national-framework-for-prevocational-pgy1-and-pgy2-medical-training-2024/>

Whilst some prevocational doctors 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 prevocational training are:

- Patient safety – the program provides a supervised environment in which prevocational doctors can make the transition from medical student to medical practice in ways that are safe for patients.
- The training program - providing prevocational doctors with exposure to clinical experiences that support the development of generalist and foundational skills. These experiences should encompass a variety of settings and disciplines with appropriate supervision and structured learning opportunities.
- Prevocational doctor welfare – the program ensures, through appropriate structures, that prevocational doctors are safe and supported in their work. MEOs have a central role with regard to this.
- Learning culture – the program promotes the values of self-directed lifelong learning for all participants, thereby promoting and contributing to the learning culture of the health care system.
- Cultural safety – the program promotes continuous improvement of education to ensure prevocational doctors are contributing to a culturally safe workforce for Aboriginal and Torres Strait Islander colleagues and patients.
- Career planning – the program supports prevocational doctors to access training that will assist their progression into vocational training, if desired.

Rural Generalist Program South Australia

The Rural Generalist Program SA (RGPSA) was introduced to coincide with the commencement of the 2021 training year. The RGPSA coordinates and builds on existing training structures and services for the delivery of medical training across rural and remote SA. The program supports coordinated delivery of training via end-to-end training networks to increase the uptake of rural training positions and to ultimately link them to post-training employment in rural areas. The program enables early career doctors to undertake the full complement of post-graduate training within a region, from internship through to fellowship, with a view to increasing attraction, training, and retention for a skilled and sustainable rural medical workforce.

RGPSA receives funding from the Australian Government and aligns with the National Rural Generalist Pathway. South Australia has a range of variables relevant to the implementation and delivery of our program, such as state early career medical workforce influences, the construct of rural postgraduate medical training programs and the unique geographical and demographical makeup of SA.

With the key objectives of attraction and retention, the RGPSA provides a mechanism for engaging trainees interested in, or committed to, Rural Generalism commencing at the postgraduate stage or beyond (PGY2+), subject to a trainee's successful entry to a GP training program or demonstrated commitment to rural medicine. The RGPSA offers an array of supports to encourage the retention of trainees in rural areas long-term.

Whilst this guide has a focus on prevocational doctors, 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.

Strengthening Cultural Perspectives

Members of the Aboriginal and Torres Strait Islander workforce are most effective when they are in a supportive and culturally safe work environment. As an MEO, providing cultural safety and support for all prevocational doctors is multifaceted and will include:

- following established policies and procedures, including the SA Health cultural leave policy.
- acknowledging and supporting avoidance relationships – these are cultural practices that require formal avoidance between certain individuals, given their relationships to one another.
- supporting employees' cultural obligations to their families and communities.
- being aware of the cultural loading of current Aboriginal and Torres Strait Islander prevocational doctors.
- providing access to culturally appropriate debriefing and emotional support.
- encouraging and supporting members of the Aboriginal and Torres Strait Islander workforce to support each other, such as at regular meetings or attending Aboriginal and Torres Strait Islander forums or conferences (i.e. Australian Indigenous Doctors' Association (<https://aida.org.au/> [PRIDoC], [SA Health Aboriginal Workforce Network \[SHAWN\]](#)).
- being aware of mandatory training requirements in cultural safety for prevocational doctors and keeping yourself up to date. This includes online learning modules as well as face to face level 2 Cultural Safety Training.
- recognising the need for all health employees to contribute to a culturally safe workforce for Aboriginal and Torres Strait Islander colleagues, patients, and communities.
- being familiar with the AMC National Framework for Prevocational (PGY1 and PGY2) Medical Training and their focus on strengthened requirements for Aboriginal and Torres Strait Islander health content to better support Aboriginal and Torres Strait Islander patients and prevocational doctors.
- review the [AMC Guidance resource: Aboriginal and/or Torres Strait Islander health and cultural safety standards](#), to ensure your prevocational training program is aligned with the Aboriginal and/or Torres Strait Islander health-related Prevocational outcomes statements and national standards within the National Framework.

In relation to Indigenous health, medical graduates are expected to understand and describe the factors that contribute to the health and wellbeing of Aboriginal and Torres Strait Islander peoples, including history, spirituality and relationship to land, diversity of cultures and communities, language, epidemiology, social and political determinants of health and health experiences. They are also expected to demonstrate effective and culturally competent communication and care for Aboriginal and Torres Strait Islander peoples.

Prevocational doctors are expected to consolidate and apply knowledge of the culture, spirituality and relationship to land of Aboriginal and Torres Strait Islander peoples to clinical practice and advocacy. Where interactions occur with Indigenous people, prevocational doctors should be encouraged to apply their knowledge to practice in culturally competent ways; for example, to establish whether and how a person identifies as Indigenous. While the prevocational training program may not be able to provide opportunities for an individual prevocational doctor to demonstrate all the elements of caring for Aboriginal and Torres Strait Islander peoples, the prevocational training provider is expected to ensure opportunities are available, such as attending a course, workshops embedded into the formal education program and included within the orientation schedule, to support prevocational doctors to increase their cultural competence.

The outcome statements in the National Framework describe the capabilities prevocational doctors must demonstrate, particularly around cultural safety. The Framework also stipulates that prevocational training providers should provide a supportive learning environment, including the incorporation of cultural safety. There are many resources readily available to assist you as MEO:

- Resources available within LHN, e.g. Aboriginal Health Division, Aboriginal Liaison Officers, Aboriginal Health Practitioners)
- SA Health Policies and Guidelines
- Australian Medical Council Resources
- Australian Commission on Safety and Quality in Health Care: National Safety and Quality Health Service Standards User Guide for Aboriginal and Torres Strait Islander Health

Year at a Glance

The calendar on the following page represents an example of a typical prevocational training year. Much of the workflow involved in managing prevocational doctors is governed by important, immovable dates throughout the calendar year. Workload often peaks prior to an important date, such as orientation or certifying satisfactory completion of PGY1 training for qualifying PGY1 doctors.

“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, previous Medical Education Officer,
Women’s and Children’s Health Network

KEY

ETA	End-of-Term Assessment Due
MTA	Mid-Term Assessment Due
	Term 1 Commences
	Term 2 Commences
	Term 3 Commences
	Term 4 Commences
	Term 5 Commences

PGY1		KEY INFORMATION		PGY2	
PGY1 - ETA					
TERM 1 - PGY1	JAN	PGY1 Orientation	JAN		
PGY1 - MTA	FEB	Accreditation Committee Meeting MEO / DCT Committee Meeting Health Advisory Council Meeting	FEB	PGY2 - ETA	TERM 1 - PGY2
PGY1 - ETA	MAR		MAR	PGY2 - MTA	
TERM 2 - PGY1	APR	Accreditation Committee Meeting	APR	PGY2 - ETA	
PGY1 - MTA	MAY	PGY1 Recruitment Commences MEO Subcommittee Meeting Health Advisory Council Meeting	MAY	TERM 2 - PGY2	
PGY1 - ETA	JUN	Accreditation Committee Meeting Crazy Socks 4 Docs Day (1st Fri June) PGY2 Recruitment Commences	JUN	PGY2 - MTA	
TERM 3 - PGY1	JUL		JUL	PGY2 - ETA	
PGY1 - MTA	AUG	Accreditation Committee Meeting Medical Training Survey Commences	AUG	TERM 3 - PGY2	
PGY1 - ETA	SEPT	Health Advisory Council Meeting	SEPT	PGY2 - MTA	
TERM 4 - PGY1	OCT	MEO Subcommittee Meeting SA Prevocational Medical Education Excellence Awards	OCT	PGY2 - ETA	
PGY1 - MTA	NOV	Accreditation Committee Meeting	NOV	TERM 4 - PGY2	
PGY1 - ETA	DEC	A&NZ Prevocational Medical Education Forum Health Advisory Council Meeting	DEC	PGY2 - MTA	
TERM 5 - PGY1		Accreditation Committee Meeting Certification for satisfactory completion of PGY1 training due			

Resources

AIDA

www.aida.org.au

AMC (Australian Medical Council)

<https://www.amc.org.au/>

AMC Guidance Resource: Aboriginal and/or Torres Strait Islander Health and Cultural Safety Standards
[Implementation-guidance-resource-May-2024-1.pdf](#)

AMC National Framework for Prevocational (PGY1 and PGY2) Medical Training (2024+)

<https://www.amc.org.au/accredited-organisations/prevocational-training/new-national-framework-for-prevocational-pgy1-and-pgy2-medical-training-2024/>

Australian Commission on Safety and Quality in Health Care – NSQHS Standards

User Guide for Aboriginal and Torres Strait Islander Health

<https://www.safetyandquality.gov.au/publications-and-resources/resource-library/nsqhs-standards-user-guide-aboriginal-and-torres-strait-islander-health>

Australian Commission on Safety and Quality in Health Care Standards – Resources for the NSQHS Standards

<https://www.safetyandquality.gov.au/standards/nsqhs-standards/resources-nsqhs-standards/user-guide-aboriginal-and-torres-strait-islander-health>

Rural Generalist Program South Australia

<https://www.ruralgeneralist.sa.gov.au/>

SA Health Aboriginal Workforce Network (SHAWN)

<https://inside.sahealth.sa.gov.au/wps/wcm/connect/1b535475-0699-4ae2-9c48-a30504d43e82/20131+SHAWN+Fact+Sheet+v3.pdf?MOD=AJPERES&CACHEID=ROOTWORKSPACE-1b535475-0699-4ae2-9c48-a30504d43e82-otPmO7s>

SA Health Guideline, Aboriginal Health Program Development

<https://www.sahealth.sa.gov.au/wps/wcm/connect/3a1a9b46-1611-4288-9a26-a96ec58dac93/Aboriginal+Health+Program+Development+Guideline.pdf?MOD=AJPERES&CACHEID=ROOTWORKSPACE-3a1a9b46-1611-4288-9a26-a96ec58dac93-oN7LyN1>

SA Health Policy, Aboriginal and/or Torres Strait Islander Employee Cultural Leave

https://www.sahealth.sa.gov.au/wps/wcm/connect/7fa3588041de04568455bed65487caab/Aboriginal+and_or+Torres+Strait+Islander+Cultural+Leave+Policy+v2+meta.pdf?MOD=AJPERES&CACHEID=ROOTWORKSPACE-7fa3588041de04568455bed65487caab-pFS50ds

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 entry.

Most graduates from Australian medical schools graduate with a M.D. (Doctor of Medicine) Bachelor of Medicine Studies (BMedSt) / MD, or Bachelor of Clinical Sciences (BClinSc) /MD. Despite the variation in the name of the degree, all medical school programs within Australia must comply with the standards set by the Australian Medical Council (AMC). The AMC are responsible for developing standards for medical education and training in all phases of medical education, including medical schools.

The purpose of AMC accreditation is to ensure that medical courses produce graduates competent to practice safely and effectively under supervision as prevocational doctors 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 (MBA). During the year of provisional registration, interns are only permitted to work in terms and facilities accredited through their state based postgraduate medical council (SA Health Advisory Council). Following the successful completion of the internship, prevocational doctors obtain general registration with the MBA and may complete further prevocational training.

In South Australia, SA MET, as an authorised accrediting body of the AMC, has responsibility for accrediting facilities and term allocations for both years of the prevocational training period.

Although all prevocational doctors 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 settings such as community health and rural general practice.

Prevocational doctors who do not secure a vocational training position typically undertake a general training year. Many complete two to three years of general rotations before entering a vocational training program. Vocational or specialty training generally requires an additional three to 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 has responsibility for accreditation of specialist medical training providers and their 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 that 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.

High School											
Other degree +/- work experience (optional)											
Medical Pathway Undergraduate 6 years, BMedSt / MD (Adelaide University) or Postgraduate 4 years, BClinSC / MD (Flinders University)											
Australian Medical Council	Training Accreditation Authority	Commence Working as a Doctor									
	SA MET	Internship (Intern) <ul style="list-style-type: none"> MBA mandated and must be undertaken in accredited intern posts. Internship is a minimum of 47 weeks FTE with exposure to various clinical care categories. These doctors have Provisional registration with the MBA. 	Novice								
Australian Medical Council	SA MET - PGY2 Many posts are unaccredited	Prevocational Trainee Medical Officer (Resident Medical Officers) <ul style="list-style-type: none"> These doctors may or may not be enrolled in a specialty program. PGY2 year is a minimum of 47 weeks FTE with exposure to various clinical care categories. 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 specialty training program. These doctors have General registration with the MBA. 	Advanced Beginner								
	<p align="center">Some Trainees will not enter Vocational Training in PGY3 and will work as Service Registrars/Unaccredited Registrars/Service RMOs</p> <ul style="list-style-type: none"> Not within a formal training program however contribute significantly to clinical service delivery of the unit. These trainees have minimal access to protected teaching time, or career development pathways. 										
Australian Medical Council	Specialty Medical Colleges	Vocational Trainee Medical Officer (Registrars) <ul style="list-style-type: none"> These doctors have been accepted into a specialty training program with a Specialty Medical College. These doctors have General registration with the MBA. <table border="0"> <tr> <td>GP/Rural Generalist</td> <td>Physician</td> <td>Surgery</td> <td>Other</td> </tr> <tr> <td>GP training minimum 3 years Rural Generalist 4 years training + exams</td> <td>3 years basic training + exam & 3 years in one specialty (advanced training)</td> <td>5-6 years streamed program + exam</td> <td>Many other colleges, each has their own pathway requirements and exams</td> </tr> </table>	GP/Rural Generalist	Physician	Surgery	Other	GP training minimum 3 years Rural Generalist 4 years training + exams	3 years basic training + exam & 3 years in one specialty (advanced training)	5-6 years streamed program + exam	Many other colleges, each has their own pathway requirements and exams	Competent
	GP/Rural Generalist	Physician	Surgery	Other							
	GP training minimum 3 years Rural Generalist 4 years training + exams	3 years basic training + exam & 3 years in one specialty (advanced training)	5-6 years streamed program + exam	Many other colleges, each has their own pathway requirements and exams							
Members of a Specialty Medical College/s	Fellowship	<ul style="list-style-type: none"> These doctors may spend a further 1-2 years in a sub-speciality or research. 	Proficient								
Members of a Specialty Medical College/s	Specialist Consultant	<ul style="list-style-type: none"> These doctors have completed their Specialty Medical College training requirements. These doctors have Specialist registration with the MBA. Examples include: <table border="0"> <tr> <td>GP/Rural Generalist</td> <td>Physician</td> <td>Surgery</td> <td>Other</td> </tr> <tr> <td>FRACGP or FACRRM (Rural) Can pursue further interests, often commenced whilst a registrar For example: Anaesthetics Emergency medicine Paediatric medicine Women's health Mental health Occupational medicine Environmental medicine Palliative Care</td> <td>FRACP For example: Cardiologist Endocrinologist Gastro-enterologist General physician Haematology Infectious disease Nephrologist Neurologist Oncologist Paediatrician Respiratory physician Rheumatologist</td> <td>FRACS For example: Cardiothoracic surgeon General surgeon Neurosurgeon Orthopaedic surgeon ENT/head+neck surgeon Oral & Maxillofacial surgeon Paediatric surgeon Plastic/reconstructive surgeon Urologist Vascular surgeon</td> <td>FRACMA – Medical Administrators FRAZCA – Anaesthetist FACD – Dermatologist FACEM – Emergency FACSEP – Sports and Exercise Physicians FACICM – Intensivist FRACDS – Dentistry FRANZCO – Ophthalmologist FRANZCOG – Obstetricians and Gynaecologists FRCPA – Pathologist FRANZCP Psychiatrist RANZCR – Radiology</td> </tr> </table>	GP/Rural Generalist	Physician	Surgery	Other	FRACGP or FACRRM (Rural) Can pursue further interests, often commenced whilst a registrar For example: Anaesthetics Emergency medicine Paediatric medicine Women's health Mental health Occupational medicine Environmental medicine Palliative Care	FRACP For example: Cardiologist Endocrinologist Gastro-enterologist General physician Haematology Infectious disease Nephrologist Neurologist Oncologist Paediatrician Respiratory physician Rheumatologist	FRACS For example: Cardiothoracic surgeon General surgeon Neurosurgeon Orthopaedic surgeon ENT/head+neck surgeon Oral & Maxillofacial surgeon Paediatric surgeon Plastic/reconstructive surgeon Urologist Vascular surgeon	FRACMA – Medical Administrators FRAZCA – Anaesthetist FACD – Dermatologist FACEM – Emergency FACSEP – Sports and Exercise Physicians FACICM – Intensivist FRACDS – Dentistry FRANZCO – Ophthalmologist FRANZCOG – Obstetricians and Gynaecologists FRCPA – Pathologist FRANZCP Psychiatrist RANZCR – Radiology	Expert
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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 offered a degree called Bachelor of Medicine Studies (BMedSt) / MD and Bachelor of Surgery, which 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 of 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.

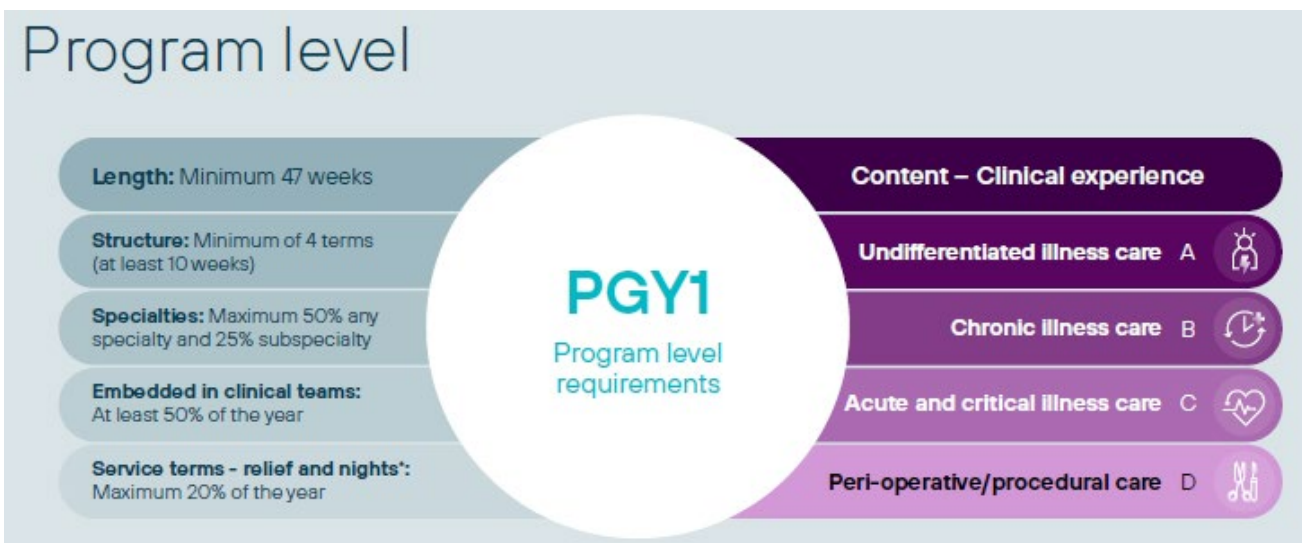
From 2026, the new Adelaide University will offer a six-year integrated curriculum starting with the Bachelor of Medical Studies, followed by the Doctor of Medicine, which is an undergraduate course over a six-year period.

Interns

Intern doctors are known as PGY1 (Post Graduate Year 1). 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 that a large portion of their work will revolve around intern management.

At the completion of the intern year, the employing health network must certify that the requirements for the internship have been met. Once the local health network provides this confirmation, Ahpra will grant general registration.



Source: National Framework for Prevocational (PGY1 AND PGY2) Medical Training- Training Environment (p34)

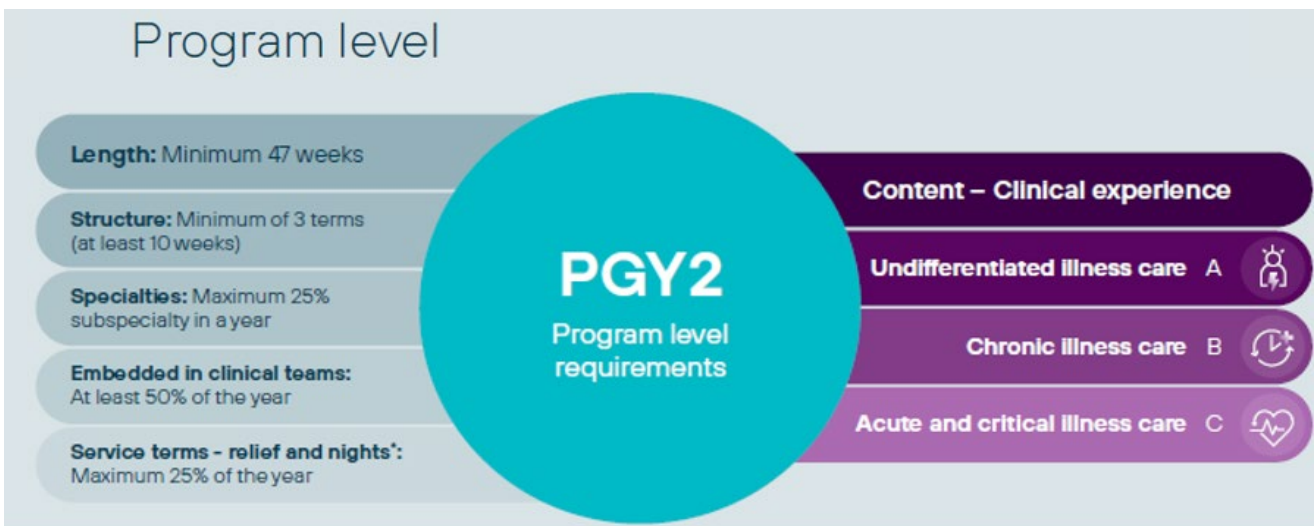
PGY2 and Beyond

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

PGY2 prevocational training programs must follow the AMC National Framework. These programs are suitable for those who have not decided on a specialist training program or just wish to get more experience before specialising. This is the most common pathway after an internship. PGY3+ trainees are not required to follow the AMC National Framework, though LHNs may choose to apply it as a guide.

MEOs are also responsible for these prevocational doctors.

If a doctor has a specific specialty pathway they wish to pursue, they may choose to apply for vocational or pre-specialist training on completion of an internship. These programs provide structured training and clinical experience in specific specialties. Noting that there are some colleges that will require completion of PGY2 under the new AMC Framework as a condition of entry.



Source: National Framework for Prevocational (PGY1 AND PGY2) Medical Training- Training Environment (p34)

CPD Home (Continuous Professional Development)

CPD homes are accredited by the Australian Medical Council (AMC) to deliver high-quality, well-monitored CPD programs that support safe and culturally competent practice. They help doctors tailor learning to their needs, ensure CPD activities meet standards relating to health inequities, professionalism, and ethical practice, and provide systems for tracking and recording CPD hours. Doctors must join a suitable CPD home—college or non-college before beginning their CPD each year, log their activities with that home, and declare their chosen home when renewing registration.

Most practising doctors require a CPD home, but some groups are exempt. Interns and PGY2 doctors in accredited training or supervised clinical roles automatically meet CPD requirements through their programs. Doctors with limited registration for public interest or short-term teaching and research roles (up to four weeks), as well as those with non-practising registration, do not need a CPD home. Specialist trainees and Specialist international medical graduates (SIMGs) on the specialist pathway meet their CPD obligations through the relevant specialist medical college responsible for their training or assessment.

There are 21 AMC-accredited CPD homes available, including all specialist medical colleges and five non-college homes, giving doctors flexibility to choose an organisation aligned with their scope of practice.

CPD Home annual fees vary by provider and can be claimed under a doctor's PD allowance.

Registrar: Basic Vocational and Advanced Vocational Training

After prevocational doctors have completed their internship, they may wish to apply for admission to a recognised medical specialty training program. This stage is necessary to obtain fellowship of one of the recognised Specialist Medical Colleges and allows doctors 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 teamwork. 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 doctors.

Fellowship

Upon completion of a recognised specialty training program, Basic Vocational and Advanced Vocational doctors will be awarded a fellowship of the college and can undertake additional sub-specialty training. Up to this point, doctors would have almost exclusively undertaken training in the public health system, except for GPs who undertake their training in private practice.

These doctors are not managed by MEOs.

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 Service Registrars.

International Medical Graduates

There are different pathways to registration and practice in Australia for internationally qualified medical practitioners (international medical graduates (IMGs)) who have gained their medical qualifications outside Australia or New Zealand. Each pathway involves assessment, and each has different eligibility requirements.

Competent Authority Pathway - The Competent Authority pathway is for IMGs, both non-specialists and international medical specialists, including general practitioners, who have been assessed by a competent authority and who have practised in a competent authority country. This pathway leads to general registration.

Specialist Pathway - The Specialist pathway is for IMGs with an international specialist medical qualification. This pathway leads to specialist registration.

Expedited Specialist Pathway - The Expedited Specialist pathway is for specialist IMGs with an international specialist medical qualification that is on the Board's Expedited Specialist pathway: accepted qualifications list. This pathway leads to specialist registration.

Standard Pathway - The Standard pathway is for IMGs who are not eligible for the Competent Authority or Specialist pathway. This pathway leads to general registration.

Short-term training in a medical specialty pathway - The Short-term training in a medical specialty pathway is for specialist IMGs and specialist IMGs in training, who would like to undertake a short period (usually up to 24 months) of specialist or advanced training in Australia. This pathway does not lead to registration as a specialist or to ongoing registration in Australia.

WBA (Workplace Based Assessment) AMC (Australian Medical Council) framework is an alternative assessment pathway for international medical graduates (IMGs) who have passed the AMC Computer Adaptive Test Multiple Choice Question (CAT MCQ) examination and are seeking general registration in Australia, assessing their clinical skills and professional qualities in a real-world healthcare setting, rather than a traditional clinical exam.

The AMC, through the Prevocational Standards Accreditation Committee, must accredit WBA programs.

Please note the information provided by the AMC's Frequently Asked Questions document on IMGs completing the PGY2 year in the excerpt below.

38. Can an IMG complete the PGY2 year and receive a certificate of completion?

The National Framework does allow for this; however, local arrangements would need to be put in place by your health service and approved by your local Postgraduate Medical Council so you could complete the requirements for PGY2. However, you must still meet the Medical Board of Australia's registration requirements for the pathway you are in.

It is not necessary to complete an accredited PGY2 year to progress your registration.

It is possible that you could be in an accredited position and not be working towards completing the PGY 2 training program.

This is the case for all IMGs, regardless of the Medical Board of Australia registration pathway that you are on.

<https://www.amc.org.au/wp-content/uploads/2023/11/Frequently-Asked-Questions-November-2023.pdf>

How Doctors Learn

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

Medical training during the prevocational period is still largely predicated on the apprenticeship model. While prevocational doctors primarily learn by doing, their training must also be supplemented by formal educational activities (see the later section on the formal education program).

Much of what a prevocational doctor learns will be through the clinical exposure they get whilst caring for patients during their rotations, and under the supervision of consultant medical staff and other doctors. Interns must complete terms that meet the clinical care category requirements of the AMC Framework and complete entrustable professional activity (EPA) assessments.

Interns have the basic knowledge and skills to work as doctors; however, there is a clear expectation that during the course of the prevocational training period they will continue to develop and consolidate the knowledge, skills and behaviours required, gradually moving toward more independent medical practice.

Terms are accredited based on casemix, the skill mix of the medical workforce, education and learning opportunities, and levels of supervision available to support prevocational doctors throughout this period. As the year progresses, the prevocational doctor will gain clinical experience. It is also understood that it will be many years of medical practice before a doctor is ready to practice completely independently.

Prevocational doctors are usually employed by the public hospital system on short-term contracts whilst they complete their prevocational and vocational training. This has implications not just for recruitment but also means that the early career medical workforce can be quite mobile, with trainees changing hospitals and locations as they access the various terms required for their training program.

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

The graphic on the next page describes a learning model for prevocational medical education and training and demonstrates how prevocational training can be delivered.

A Learning Model for Prevocational Medical Education and Training

Supervised Clinical Work

- Clinician-led patient interactions
- Opportunistic learning
- Situational learning
- Experiential learning
- Observation and feedback

Curriculum

- AMC National Framework for Prevocational (PGY1 and PGY2) Medical Training
- Term objectives provided in Term Descriptions
- Individual Trainee objectives (aligned with Prevocational Outcome Statements or learning plan in ePortfolio)

Trainee Assessment

- Entrustable Professional Activities (EPAs 1-4)
- Trainee observation by Supervisors
- Self-assessment in ePortfolio
- Team-based assessment
- Mid-Term assessment
- End of Term assessment

Program Evaluation

- Trainee term evaluation forms
- Monitoring of Trainee outcomes

e-Learning

- State-coordinated.
- A support to training activities
- An aid to self-directed learning

Curriculum

- AMC National Framework for Prevocational (PGY1 and PGY2) Medical Training

Trainee Assessments

- Online record of participation and results via ePortfolio

Program Evaluation

- Participation records
- Trainee evaluation forms
- Monitoring of Trainee outcomes

Term Specific Teaching

- Lectures; Journal clubs; Mortality and Morbidity meetings etc.
- Trainee presentations

Curriculum

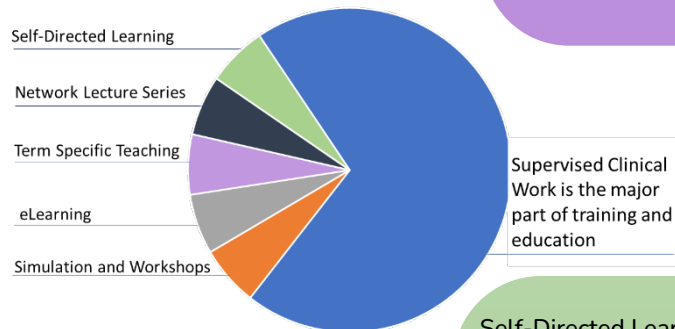
- AMC National Framework for Prevocational (PGY1 and PGY2) Medical Training
- Term objectives provided in Term descriptions.
- Prevocational Outcome Statements

Trainee Assessment

- Participation records
- Assessments of Trainee presentations by peers and supervisors

Program Evaluation

- Participation records
- Trainee evaluation forms
- Monitoring of Trainee outcomes



Simulation and Workshops

- Network coordinated.
- ALS DETECT and core skills.

Curriculum

- AMC National Framework for Prevocational (PGY1 and PGY2) Medical Training

Trainee Assessment

- Trainee observation by educators
- Trainee self-assessments in ePortfolio

Program Evaluation

- Participation records
- Trainee evaluation forms
- Monitoring of Trainee outcomes

Network Lecture Series

- Network coordinated, facility-based lectures.

Curriculum

- AMC National Framework for Prevocational (PGY1 and PGY2) Medical Training
- JMO Forum unified lecture series
- Network-led curriculum planning.

Trainee Assessment

- Participation records

Program Evaluation

- Participation records
- Trainee education evaluation forms
- Monitoring of Trainee outcomes

Self-Directed Learning

- Individual responsibility in a supportive environment

Curriculum

- AMC National Framework for Prevocational (PGY1 and PGY2) Medical Training
- Term objectives provided in Term descriptions.
- Individual trainee objectives described in trainee journal and aligned with Prevocational Outcome Statements

Trainee Assessment

- Trainee observation by DPET
- Trainee self-assessments in ePortfolio

Program Evaluation

- Observations by DPET
- Evidence of self-directed learning: e.g. self-assessment in ePortfolio

Requirements for Programs and Terms

The new AMC National Framework for Prevocational (PGY1 and PGY2) Medical Training requires that PGY1s undertake a minimum of 47 weeks 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.

Requirements for programs and terms for PGY1 and PGY2

Program level

Length: Minimum 47 weeks

Structure: Minimum of 4 terms (at least 10 weeks)

Specialties: Maximum 50% any specialty and 25% subspecialty

Embedded in clinical teams: At least 50% of the year

Service terms - relief and nights*: Maximum 20% of the year

PGY1
Program level requirements

Content – Clinical experience

- Undifferentiated illness care A
- Chronic illness care B
- Acute and critical illness care C
- Peri-operative/procedural care D

Program level

Length: Minimum 47 weeks

Structure: Minimum of 3 terms (at least 10 weeks)

Specialties: Maximum 25% subspecialty in a year

Embedded in clinical teams: At least 50% of the year

Service terms - relief and nights*: Maximum 25% of the year

PGY2
Program level requirements

Content – Clinical experience

- Undifferentiated illness care A
- Chronic illness care B
- Acute and critical illness care C

*Definition of service terms provided in glossary

Term level

Term descriptions must define:

- The term
- the role of the prevocational doctor and
- the team
- the clinical experiences and learning outcomes.

Source: National Framework for Prevocational (PGY1 AND PGY2) Medical Training- Training Environment

Supervision

During the first years, prevocational doctors are expected to understand the training and assessment requirements of the framework, monitor their own progress against those requirements and proactively work with their supervisors to address any areas needing improvement to meet the requirements.

MEOs are frequently involved in the administrative processes underpinning the assessment of prevocational doctors, in addition to monitoring the well-being, performance and progression of doctors.

Term supervisors (or suitable delegates) are expected to have an initial meeting with their prevocational doctors to ensure they know 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 prevocational doctors. It is also expected that the term supervisor will work with the prevocational doctors to develop mutually agreeable education goals based on the AMC National Framework for Prevocational (PGY1 and PGY2) Medical Training.

The outcome statements provide clinical supervisors and training directors with clear criteria for determining progress and completion. Achieving the outcomes is a requirement for general registration at the end of PGY1.

All prevocational doctors must be allocated a term supervisor for each term.

The term 'supervision' encompasses a number of practices important for prevocational doctor wellbeing and patient safety. Supervision can refer to:

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

Working alongside prevocational doctors with the shared goal of patient safety, ensuring clear process for clinical escalation, planned communication, and ready availability of support, with the ultimate responsibility resting with the senior clinician.

Assessment Process

The AMC National standards and requirements for programs and terms document is the basis for the assessment approach. Assessment must be based on prevocational doctors achieving the prevocational outcome statements, and it must be understood by supervisors and prevocational doctors.

In prevocational training, assessments are mainly done in two ways:

- Term assessments
- Assessment of EPAs (Entrustable Professional Activities)

Throughout each term, prevocational doctors will take part in a few key evaluations: a start-of-term discussion, a midterm review, at least two EPA assessments, and a final end-of-term assessment. At the end of the year, an assessment review panel will review the results from the EPA assessments along with the final term assessment to make their overall decision.

It is important to note that there is no set minimum number of EPA or term assessments that must be passed. Instead, the panel decides based on whether the doctor has met the overall prevocational training goals by year's end.

Prevocational doctors should be aware via EPAs, informal and mid-term assessments, if they are not yet meeting the expected standard. The AMC Framework has a strong emphasis on assisting prevocational doctors who are experiencing difficulties to improve performance, with a focus on early identification. All areas of concern must be documented.

The purposes of assessment are as follows:

- Assessments should provide the prevocational doctors with feedback about their performance that will help their development as doctors. Assessment processes should apply equally to all prevocational doctors and occur at appropriate intervals. Formal midterm and end-of-term assessments should be completed using the 'Prevocational training term assessment form.'
- Assessments should provide evidence that prevocational doctors are achieving the competencies required for their current stage of training. 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 expected standards of practice and competence before advancing to higher levels of responsibility.
- Assessments assist in identifying underperforming prevocational doctors 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 doctor is prevented from advancing to the next stage of training before remediation. This has a safety purpose, protecting both patients and prevocational doctors.

In the case of interns, the satisfactory completion of rotations during the internship is the basis on which the health service provides a recommendation to the MBA for progression from provisional to general registration. Term supervisors should meet with prevocational doctors 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 in person with their prevocational doctors (PGY1s and PGY2s) at the mid-term point to discuss the mid-term appraisal and then at the end of the term, to complete the end-of-term assessment.

Term supervisors and primary clinical supervisors can track and monitor training for each PGY1 and PGY2 doctor in Clinical Learning Australia (CLA™) and record start-of-term discussions, mid-term and end-of-term assessments. More information about CLA is in the next section.

Clinical supervisors and health practitioners who conduct EPAs with PGY1 and PGY2 doctors can complete these in CLA™. Supervisors do not need to be registered users in the system and can be invited as 'guest' assessors. Registering as a CLA™ user is convenient for those who regularly conduct EPAs. Medical Education Units can assist with registration.

MEOs who are responsible for the administrative processes supporting the assessment of prevocational doctors will likely have systems in place to ensure that prevocational doctors are reviewing the assessment forms in CLAT™ 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 doctors 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 completed assessments to be submitted for recommendation for general registration with the Medical Board of Australia
- Encourage PGY2s to get completed assessments recorded in their ePortfolio as they can be useful for future recognition for prior learning (RPL).

Clinical Learning Australia™

[Clinical Learning Australia](#) (CLAT™) is an ePortfolio that records the development, training, and assessment of Postgraduate Year 1 (PGY1) and Year 2 (PGY2) doctors across all states and territories in Australia. Delivering a consistent approach to prevocational training and assessment in line with the National Framework for Prevocational Medical Training, which is managed by the Australian Medical Council, governed by the National ePortfolio Project Board.

CLAT™ enables a harmonised approach to recording learning outcomes for prevocational doctors, supporting assessments over the PGY1 and PGY2 years and mobility across jurisdictions. CLAT™:

- is aligned to the National Framework for Prevocational (PGY1 and PGY2) Medical Training.
- provides a consistent experience for prevocational doctors and supervisors.
- supports improved visibility for monitoring and tracking of training progress.
- replaces manual paper-based learning and assessment.
- provides detailed and aggregate data to support continuous improvement in training delivery.
- enables the collection of on-the-job assessment feedback through mobile app-enabled features.

CLAT™ records the progress of prevocational doctors as they complete their first two postgraduate years. Prevocational doctors log training activities that they undertake, and their supervisors can assess their progress in meeting the requirements of the National Framework for Prevocational (PGY1 and PGY2) Medical Training - ensuring a consistent and supportive approach to medical training and supervision.

Assessment Review Panel

The Assessment Review Panel (ARP) provides a systematic process for measuring and providing feedback on a prevocational doctor's progress and/or level of achievement of the prevocational outcome statements. At regular intervals throughout the year and at the end of each year (PGY1 and PGY2), an ARP reviews the outcomes of term assessments and the record of learning and makes a recommendation on progress to the next stage of training.

It is important to understand the role of the ARP in guiding prevocational doctors' progression through prevocational training. [Assessment Review Panels: A guide for prevocational training providers](#) is a document provided by the AMC to align with the National Framework documents.

Understanding the ARP Process

- PGY1: The Medical Board of Australia uses evidence of satisfactory completion from the ARP to decide on granting general registration.
- PGY2: Upon successful completion as determined by the ARP, a certificate will be issued from the AMC.
- Longitudinal Assessment Approach
 - The ARP focuses on performance throughout the year, ensuring standards are met by year's end. The ARP also assists with complex remediation cases.
- Who is on the Panel?
 - The ARP must consist of at least three members, who should have a sound understanding of procedural fairness and prevocational training requirements. Members may include:
 - Director of Clinical Training (DCT)
 - Director of Medical Services (DMS) or Chief Medical Officer (CMO), or delegate
 - Medical Education Officer (MEO)
 - Human Resources expert (to advise on well-being and leave, not performance management)
 - Experienced supervisors and/or a consumer representative
 - *Note:* The ARP is chaired by a senior medical practitioner but not the DCT. An impartial member from another Local Health Network may be included with proper agreements in place. The EDMS can choose not to participate to allow for escalation if required.
- Meeting Schedule
 - The ARP must meet at least annually to make progression recommendations but may also convene as needed to support improving performance processes, especially for doctors in Phase 3 of remediation. Meetings are timed to allow sufficient implementation and review of performance improvement plans.
- What Evidence is Reviewed?
 - The ARP relies on data summarised in Table 2 of the [AMC Training and Assessment Guide](#) (page 58). Evidence includes supervisor assessments and reports captured in the prevocational doctor's e-portfolio record of learning.

Orientation Program

All prevocational doctors 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 involved in both organising and participating in the orientation program for prevocational doctors at the commencement of the clinical year. This can extend to managing rosters and term changeover to optimise attendance.

The intern and PGY2 orientation programs are a major undertaking for any facility or network. Intern orientation runs up to five days and may consist of a combination of presentations, simulation, and clinical skills opportunities to shadowing outgoing interns on their clinical units. The Intern Orientation program covers a range of topics that are aimed at assisting prevocational doctors 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 of a prevocational doctor. This might include roles and responsibilities of prevocational doctors, important clinical policies, and procedures.
- multidisciplinary care, diagnostic test ordering, education, and training as a prevocational doctor, assessment procedures, 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 prevocational doctor. Incoming prevocational doctors are attached to the outgoing prevocational doctor for the term that they are rotated to for term one. This provides an opportunity for an effective clinical handover in addition to a more extended term orientation.

The orientation period will provide the prevocational doctor with the opportunity to meet other prevocational doctors attached to your Network.

The PGY2+ orientation program will also cover general information and specific information related to the role. This orientation generally occurs 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 deliver 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 doctors. Registrars, nursing staff and allied health staff might deliver some aspects of the orientation.

This orientation provides an opportunity for the prevocational doctor to get to know and be inducted by members of the team that they will actively 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 doctor. The supervisor may also use orientation as an opportunity to set learning goals with the prevocational doctor, which they will aspire 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 doctor prior to the commencement of the 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 doctors 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.

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 a quarantined time for medical education activities and therefore the time should not be used for non-clinical topics.

Expecting and encouraging prevocational doctors 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 doctors 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 doctors to access electronically. This also assists doctors who were not able to make the session due to night shift commitments and leave. 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 table over the page. Topics can vary from year to year, with the general theme staying the same. MEOs are encouraged to gain feedback from prevocational doctors after each session to help continually improve these formal education programs.

PGY2 doctors require formal education sessions tailored to their specific learning needs to support their clinical development, bridge knowledge gaps identified during PGY1, and enhance readiness for advanced training, ensuring continued competence, confidence, and progression within their medical careers. This may include specific education sessions to support PGY2 doctors in meeting the training outcomes that may not be available through completion of clinical activities.

PGY1 Formal Education Session Topic Suggestions

TERM 1	<ul style="list-style-type: none"> 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 blood and blood products
TERM 2	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> 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 the Mental Health Act Medicolegal issues: Privacy, confidentiality, informed consent, and open disclosure
TERM 4	<ul style="list-style-type: none"> 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, dressing and suturing
TERM 5	<ul style="list-style-type: none"> Vascular surgery Urology Introduction to oxygen delivery systems and intensive care medicine Oncology and palliative care Advanced lines Radiology essentials Neonatal and paediatric resuscitation Career progression planning

Resources

Assessment Review Panels: A guide for prevocational training providers

<https://www.amc.org.au/wp-content/uploads/2023/09/Guide-to-Assessment-Review-Panels.pdf>

Australian Medical Council

<https://www.amc.org.au/>

Clinical Learning Australia

<https://www.digitalhealth.gov.au/healthcare-providers/initiatives-and-programs/workforce-capability/clinical-learning-australia>

CPD Home

<https://www.medicalboard.gov.au/Professional-Performance-Framework/CPD/About-CPD-homes.aspx>

Guide to Prevocational Training in Australia for Supervisors

<https://www.amc.org.au/wp-content/uploads/2023/07/Guide-to-Prevocational-Training-in-Australia-for-Supervisors.pdf>

International Medical Graduates (IMGs) Assessment Pathways

<https://www.amc.org.au/pathways/#>

International Medical Graduates (IMGs) Workplace Based Assessment

<https://www.amc.org.au/workplace-based-assessment/>

TMO Supervision Guideline

<https://samet.org.au/app/uploads/2025/03/TMO-Supervision-Guideline-v1.5.pdf>

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

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

Part Three - Managing Prevocational Doctors

Working with Doctors

As an MEO, many of your professional interactions are likely to be with doctors. Whilst you will obviously have regular contact with prevocational doctors, 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. Establishing collaborative relationships when working with other members of staff, including doctors, will not only enhance working relationships but also provide a friendly and welcoming work culture that allows prevocational doctors to feel comfortable approaching the Medical Educational Unit (MEU) with their concerns.

Despite an increasing recognition of the importance of teamwork within the healthcare setting, doctors continue to be the primary decision makers for patient care. Whilst prevocational doctors will be very closely supervised, the aim of education and training is that they increasingly take more responsibility for the clinical care of their patients, requiring less supervision as their confidence and knowledge grows.

Prevocational medical training can be a highly competitive and, at times, stressful undertaking, involving a high level of commitment. Prevocational doctors are on a steep learning curve, particularly in the immediate postgraduate period. For some, this may be their first job. They must adapt to working in increasingly complex healthcare environments whilst frequently changing terms and working environments.

With every change of term, they must adapt to working with a different cohort of patients and a new team, including their immediate medical supervisors, colleagues, and other healthcare team members – nursing, allied health, and administrative staff. This challenge occurs every ten to twelve weeks for two years.

Terms provide opportunities for prevocational doctors to experience different clinical specialties, get to know senior doctors in those specialties and make important decisions regarding their future specialty or career pathway. As a result, prevocational doctors can be focused on working toward their particular training goal or specialty. This can sometimes become a point of tension as they may at times prioritise their training needs over other work obligations.

Effective MEOs recognise these challenges and work to establish open communication and supportive relationships with prevocational doctors. The aim is to give prevocational doctors a positive experience and smooth/facilitate their path throughout their prevocational years.

Welfare and Support

The prevocational doctor period is a significant time in a doctor's medical career, as they transition from medical student to qualified medical practitioner. Whilst most prevocational doctors enjoy the challenge, many report times of stress, making them vulnerable to poor mental and physical health.

The reasons for this stress can be numerous, but may include:

A totally new environment - loss of the structured learning environment and differing expectations and demands that include putting theory into practice, learning from experience and more responsibility.

- Longer hours and shift work.
- New responsibilities, including those of patients' welfare, dealing with their families and confrontations with life and death.
- Unprecedented levels of administrative duties. These may conflict with the doctor's self-image as a professional clinician.
- Frequent changes in work environment, patients, team members and supervisors.

Given the regular contact that they have with prevocational doctors, MEOs are well-positioned to provide support to them. This should be a fundamental component to the role, and many MEOs report this as being a source of considerable professional satisfaction. As well as support, a firm approach in managing prevocational doctors is required.

The way in which MEOs work with doctors can have a major impact on their morale. Approaches that have been successful include an open-door policy, promoting a culture of cooperative working relationships, a can-do attitude, and a positive approach to resolving issues. In the past prevocational doctors indicated they have highly valued these approaches.

The fact that the MEO sits somewhat to the side of the medical hierarchy means that many prevocational doctors may be more willing to confide in them (rather than a colleague or senior doctor).

MEOs are often adept at identifying prevocational doctors who may be struggling and will be involved in managing those in difficulty. To do this, they will require the support and assistance of others. Resources and references that MEOs may find useful can be found at the end of the section.

MEOs can also provide information to the prevocational doctor on the Employee Assistance Program (EAP) for your LHN. The EAP is a confidential employer-funded support service available to SA Health employees and their immediate family members experiencing personal, emotional, or research-related concerns. Immediate family includes your spouse, partner, children, or others living in your household. Highly qualified and experienced clinicians understand the unique aspects of working for SA Health, and are familiar with the structure, roles, and operating environment of the organisation.

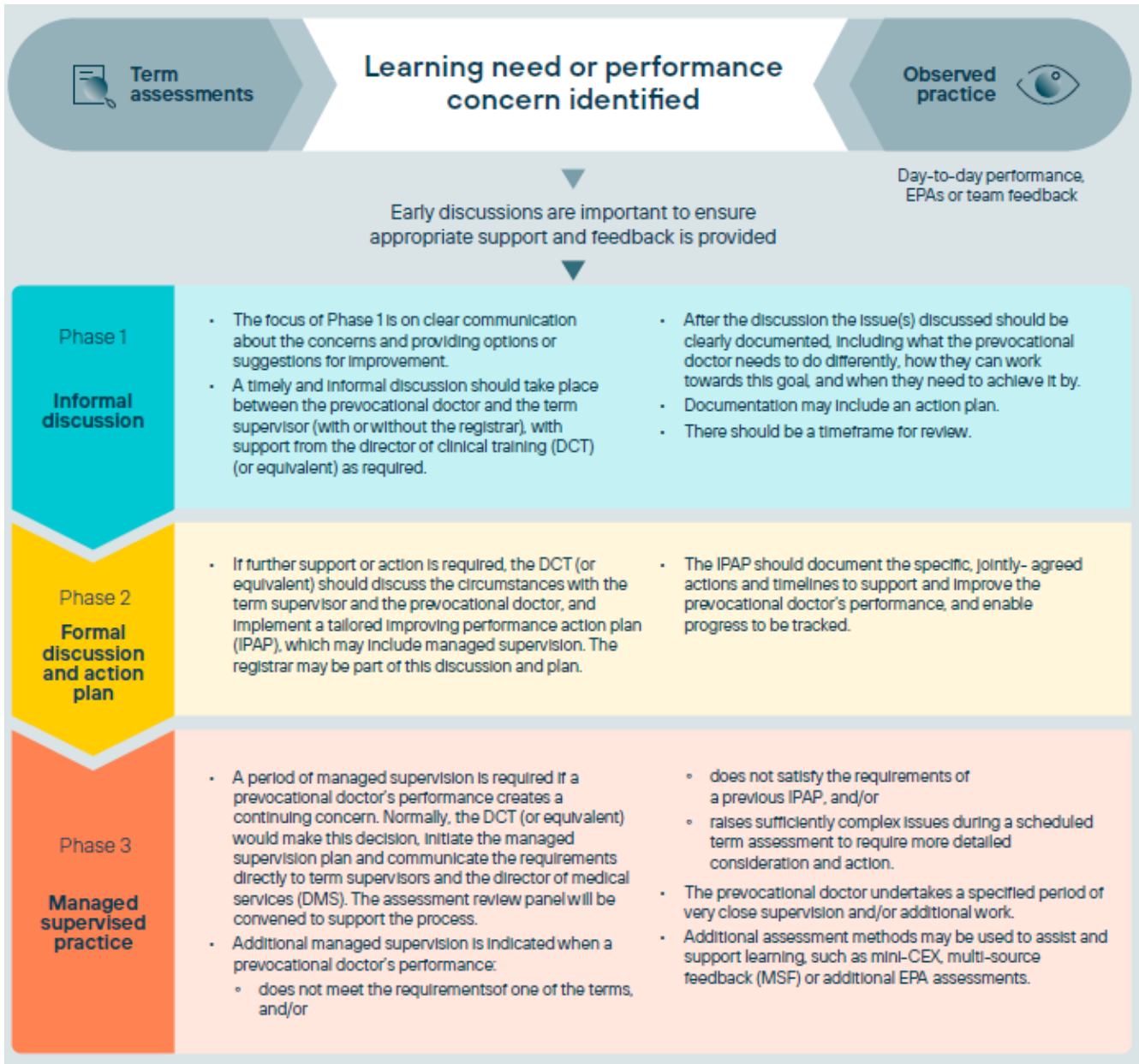
Performance Management

MEOs are often responsible for first-line management of performance concerns involving prevocational doctors, usually in collaboration with clinical unit heads and the DCT. This can include ensuring that prevocational doctors 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 doctors with regular feedback, both informal and formal, about their performance.

All public health organisations have well-established policies and procedures regarding the performance management of employees, and these should be followed. You will need to 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.

Improving Performance Process



Source: National Framework for Prevocational (PGY1 AND PGY2) Medical Training- Training and Assessment Fig. 7

Trainee In Difficulty

As the MEO, you may often be the first to recognise that a prevocational doctor is experiencing difficulties. Management of a doctor 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 doctor in difficulty may present will vary, all require appropriate support and timely intervention.

Many MEOs report that managing prevocational doctors who are experiencing difficulties is one of the most challenging aspects of their work. The reasons for this are numerous and may include:

- The complexity and number of legal and industrial frameworks.
- Navigating the roles of the prevocational doctor as trainee and employee.
- Problematic attitudes and/or behaviours of some prevocational doctors.

Employers have a legal responsibility to ensure that industrial conditions and legislated requirements pertaining to employment are upheld. This includes 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 doctors who are experiencing difficulties. Some situations may require additional 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 the management of prevocational doctors. Most matters can be discussed in a de-identified way, remembering that if a prevocational doctor in difficulty is rotated to another facility, that facility needs to be informed of these issues. Similarly, a new Term Supervisor needs to be aware. Communication concerning performance needs to be managed carefully and with the utmost confidentiality.

Deciding when to inform others is always difficult. Wisdom and experience are critical to effective intervention. Seeking advice from your DCT or other experienced staff in the network or beyond is advised. All Local Health Networks (LHNs) have Clinical Governance Units (or equivalent) responsible for patient care, to minimise risks to consumers, and to continuously monitor and improve the quality of patient care.

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

Early signs of a trainee in difficulty:

- Selective or low engagement
- Experiencing challenges performing at expected level
- Expressing heightened emotional responses
- Others disengaging with or avoiding the trainee
- Difficulty recognising own behaviour or performance gaps
- Limited flexibility in adapting to change or differing perspectives

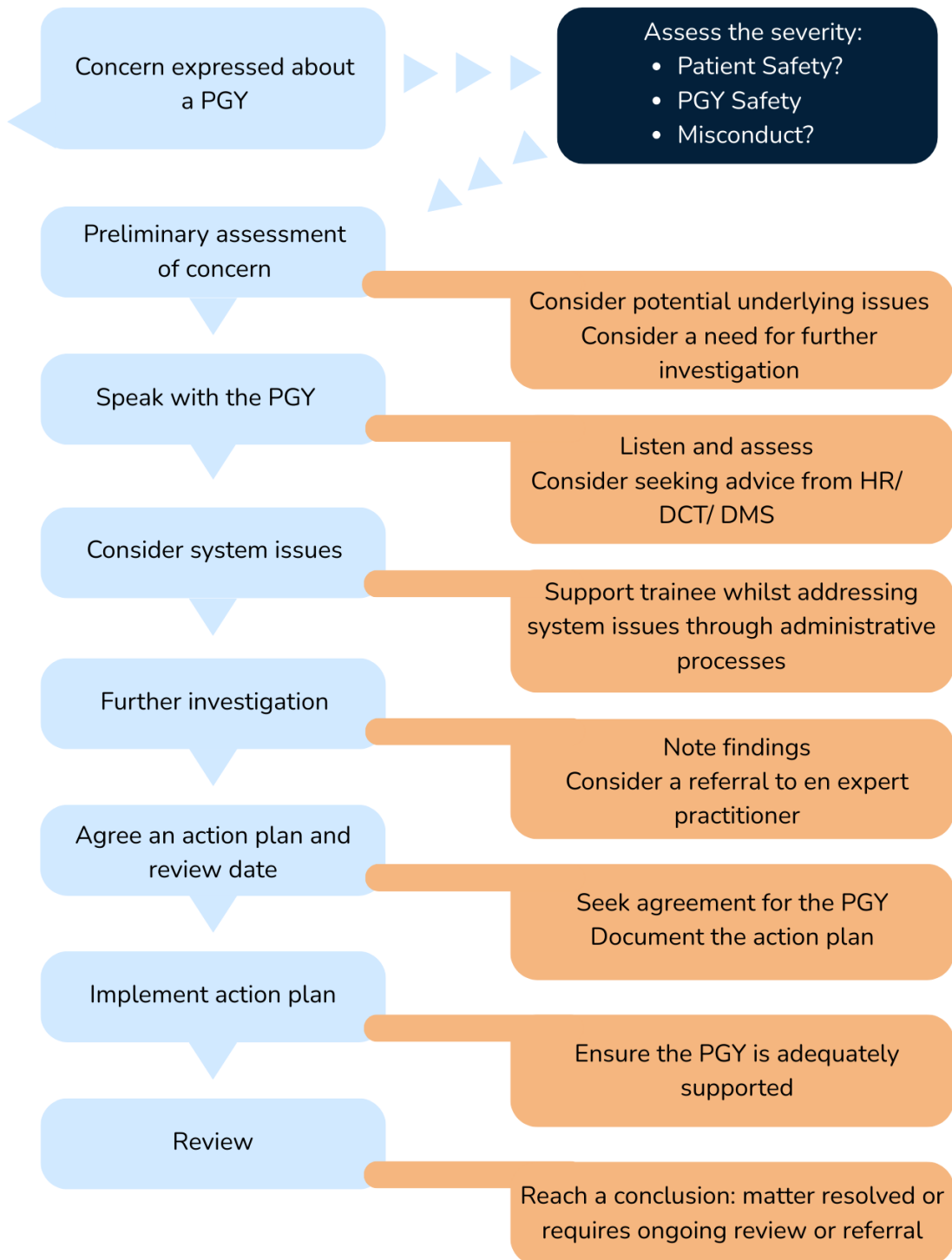
Three key principles

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

Key Messages:

- Most prevocational doctors in difficulty can be assisted to become competent doctors. A supportive and collaborative approach, with common-sense intervention, usually leads to a satisfying result for all involved.
- “You cannot unknow what you know”– do not accept someone telling you something “off the record.”
- Any risks to patient safety, risk to prevocational doctor safety or allegations of criminal conduct require immediate action and referral.
- All prevocational doctors 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 always other individuals within any healthcare organisation who have expertise in dealing with matters that you are unsure of, and yes, you can and should ask for help.
- The MEO is often the first to notice that something is amiss. Some prevocational doctors experiencing difficulties may be at risk of self-harm and need timely intervention from expert health practitioners, such as a GP or mental health clinician.

Management Outline for Prevocational Doctor in Difficulty



The responsibility of managing a prevocational doctor 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 doctors, 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 doctor 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 aware of the relevant policies and follow that process.

The vast majority of issues or complaints from prevocational doctors that cross your desk are likely to be resolved without escalation or significant interventions. All that may be needed is a supportive and fair, but firm approach and open communication.

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 doctors. Sometimes, just having someone listen to their side of the story or concerns is enough. By giving them the opportunity to debrief and express their frustration may enable them to work constructively towards a resolution.

Obvious exceptions to this are significant grievances or complaints that involve patient or prevocational doctor safety or serious allegations involving other staff. These matters can be complex to investigate and manage. The MEO should be aware of when to refer and/or escalate the situation and to whom, e.g. medical administration or the human resource department, to approach for assistance and support. This should be detailed in the organisational policy or refer to the below resource.

Consider [Mental Health First Aid training](#). Training courses focusing on mental health recognition and first aid can be invaluable as an MEO in recognising a trainee in difficulty and ensuring they are identified early to receive the tailored support they may require to be successful.

Resources

Trainee in Difficulty: A Handbook for Directors of Clinical Training
<https://samet.org.au/resources/education/>

Part Four - Term Allocations and Rostering

Term allocations

The prevocational training program (PGY1 and PGY2) 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 doctors to gain important clinical experience within a clinical specialty, and this can provide them with a sense of what the specialty (and the training program for that specialty) might be like. Experience in a particular specialty can influence career decisions. Prevocational doctors are encouraged to explore and gather information about specialties to guide their career pathway.

MEOs may be responsible for ensuring that all units and terms, including nights and weekends, are adequately staffed to meet the organisation's needs. At the same time, MEOs must balance the individual training requirements and other commitments of each prevocational doctor, making it a challenging and complex task.

The relationship between a prevocational doctor and their employer is most evident during term allocations. This is highlighted by the significant time and effort required to balance the needs of both parties.

During the first twelve months of prevocational medical training, PGY1s are required to complete at least 47 weeks of full-time equivalent (FTE) experience as a PGY1 doctor in supervised clinical practice. This must be completed in accredited terms in hospital, general practice or community-based health services and must include a minimum of four terms (of at least 10 weeks each term) in different specialties.

Experience must include direct clinical care of patients in each of the types of patient care below. Up to two types of clinical experience can be counted in each term, which will have been predetermined through the accreditation process:

- A. Undifferentiated illness patient care
- B. Chronic illness patient care
- C. Acute and critical illness patient care, and
- D. Peri-procedural patient care

For the 47 weeks FTE experience, a maximum of 25% in any one subspecialty can be practised and a maximum total of 50% in any one specialty (including its subspecialties). For example, the prevocational doctor may not practise more than 50% in surgical terms or paediatric terms. This is to provide a breadth of exposure across a range of specialties.

The location of training, the program and all terms must be accredited against approved accreditation standards by an organisation accredited by the Australian Medical Council (AMC).

Most facilities or networks have terms that are outside registration requirements. Most prevocational doctors may undertake terms across a range of specialty areas in a variety of settings. These can become important to prevocational doctors and have a significant impact on their career choice.

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

In addition to requirements for registration, there are a number of factors to consider in the allocation of terms. These include:

- Individual prevocational doctors' preferences.
- Other prevocational doctors' needs and 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.
- The needs of the organisation.

Given these considerations, it is unsurprising that term allocations can be extraordinarily complex. There are multiple approaches to managing this process, and while some prevocational doctors may advocate for specific terms to fulfil Specialty Medical College prerequisites, these requests must be carefully balanced with the broader needs of the organisation and other doctors. Ensuring fairness and equitable access is paramount and should serve as the foundation for any allocation strategy.

Most MEOs start this process early (particularly the bigger sites or networks) and seek the assistance of others. Some MEOs form a small subcommittee of prevocational doctors to assist. Others send out a term preference list (often along with a leave request form) giving prevocational doctors the opportunity to list their preferences. For the PGY1 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 the terms.

Once term allocations have been completed, many MEOs have reported it useful to maintain two databases (spreadsheets). The first by terms (to ensure that there are no vacant terms) and the second by individual prevocational doctor (to ensure that each prevocational doctor has an appropriate range of terms). However, the Clinical Learning Australia (CLA) ePortfolio will support this process.

As the numbers of prevocational doctors 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, ensuring these are documented.

Rostering

Rostering of prevocational doctors 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 prevocational doctors. Even MEOs responsible for much smaller cohorts will find that they spend a significant amount of their time managing rosters and associated tasks. Rosters can include, but are 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 doctors may have had little experience working with rosters. Working after hours, weekends, evenings and nights can be a new experience. Many prevocational doctors report that the work they undertake outside of normal hours, where

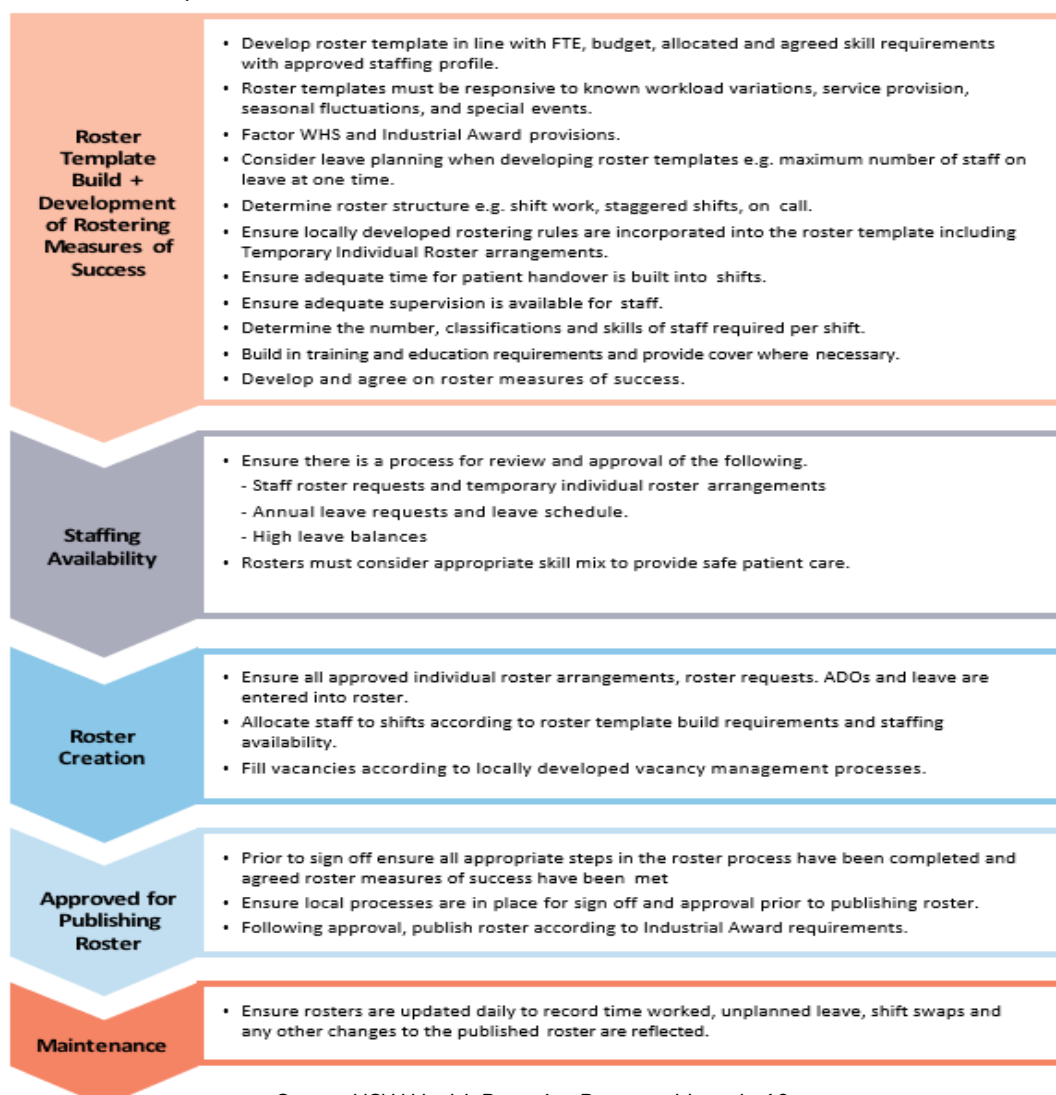
supervision arrangements and skill mix of staff may differ from that available during business hours, can be stressful.

Experienced MEOs have said that increasing numbers of prevocational doctors are entering the system, necessitating changing rostering templates. 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.

Adjusting to working shifts, particularly night shifts, may require some 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 doctors, the fact that formal education programs and other teaching opportunities for medical staff continue to be held predominantly in business hours needs to be taken into consideration.

Prevocational doctors are entitled to five weeks of annual leave per year. To comply with Ahpra training requirements to complete 47 weeks of training throughout the training year, interns are advised to take a minimum of four weeks during the training year. This allows an extra week for unforeseen circumstances, such as sick leave. Rostering annual leave can be a long and difficult process, as when one is on leave, a reliever prevocational doctor is often required.

Prevocational doctors 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.



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 an MEO, you should be familiar with the financial reporting systems within your facility. The local business unit manager can also provide guidance and advice when needed.

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

Monitoring Prevocational Doctors' Workload

Many MEOs are responsible for setting up systems to monitor prevocational doctors' 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 prevocational doctors' workload. These can include:

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

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

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 doctors 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 doctor, 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, tests, 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 doctors will be able to actively promote them amongst their prevocational doctor 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 doctors is reinforced.
- Incorporate requirement and responsibility for clinical handover into prevocational doctor 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 doctors 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/sites/default/files/documents/FINAL_NCP_Hours_of_work_2016.pdf

National Safety and Quality Health Service (NSQHS) Standards – Communicating for Safety

<https://www.safetyandquality.gov.au/standards/nsqhs-standards/communicating-safety-standard>

Part Five – Recruitment Process

Overview

Prevocational (PGY1) and vocational doctors, in addition to non-streamed doctors (PGY2+), are employed within SA Health on temporary contracts. Interns will generally have a contract start and end date aligned with the clinical year. PGY2+ doctors can have contracts of up to 3 years. This means that prevocational doctors must apply for positions at various points in the training continuum. This is managed by the intern application and allocation process and the general recruitment period known as the PGY2+ recruitment process. The medical administrator and MEO roles are the most significant contributors to these recruitment processes.

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 within their LHN. 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.

Intern 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, providing an opportunity to try to attract new graduates to your health service. This information can be shared at information sessions hosted by SA MET.

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 the internship. Once verified, applicants are sorted into their category groups per the [Internship Guideline](#) and then allocated a randomised number. Positions are offered in order of category, then by number order. SA MET then sends provisional offers to the applicants, who are given 48 hours to accept or decline, which is standard practice for the national recruitment campaigns.

Applicants who have preferenced a rural LHN as their first preference are eligible for the rural intern pathway. Their details will be provided to the rural LHNs who have the opportunity to interview the

applicants. Rural LHNs then provide a rank list to SA MET, who will only match ranked applicants to the LHN.

As applicants accept their positions, SA MET will add them to the LHNs requisition on PageUp. The MEO/medical administrators who have access to the requisition (determined by the LHNS) will be able to see and download all applicants who have accepted. SA MET will also upload the PDFs of matched applicants (including referee reports) to the Microsoft Teams group created for the LHN.

Applicants who are offered an intern position and have accepted will then be sent a term preference form. This can be managed by the LHN or by SA MET if the LHN chooses. The MEO/medical administrator will need to undertake the necessary pre-employment checks, clearances, generation of contracts and associated paperwork.

The specific dates for the commencement of the clinical year and subsequent term rotation dates align with 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 doctors, as throughout the year, many doctors will gain college positions, take extended leave, locum jobs or move interstate/overseas.

Experienced MEOs will tell you that the period May through to October represents a 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.

Rural Intern Pathway

Rural intern positions provide broad opportunities in unique settings and are best suited for medical graduates with a history of living or working in a rural area or a desire to commence a career in the country. In 2018, the Rural Intern Pathway was introduced in South Australia as an avenue to select applicants who are suitable for and have a preference to work in a rural location.

The Rural Intern Pathway includes a strength-based selection process for applicants who are interested in undertaking their internship and subsequent years in a rural health network in South Australia.

Once the rural intern pathway applications have been verified by the SA MET Unit, they will be reviewed by the rural LHN selection panel comprising representatives from appropriate rural LHNs. When the application period closes, SA MET will provide the rural LHNs with a list of applicants who preferenced them, along with the applicants' details in a PDF. The LHN selection panel will have the opportunity to interview these applicants and is then required to rank the applicants in order of preference.

The rural LHNs will undertake their shortlisting and interviewing processes in accordance with their LHN employment policies and will directly invite shortlisted applicants to attend an interview. Interviews provide applicants with the opportunity to present their skills and knowledge in a verbal format. SA MET will match the ranked applicants to the positions, with the applicants' preferences in mind if multiple LHNs have preferenced the same person.

Interviews can be held in person or virtually (e.g. Microsoft Teams or Zoom meeting). The rural LHNs will create a ranked applicant list in order of merit and provide this to SA Health for allocation purposes.

Further information is available within the Internship South Australia Application Guideline.

PGY2+ Recruitment

The SA MET Unit has been managing the PGY2+ recruitment process on behalf of SA Health, the LHNs, 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.

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 information packs and role descriptions
- 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).

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 a single application.

The process also enables a coordinated approach to shortlisting applications. This is 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.

Each LHN may have multiple programs included in the centralised recruitment process; it is important that each individual program advises SA MET of the correct contact for their program.

LHNs and programs involved in this process have agreed to the following:

- Maintaining centralised PGY2+ applicant data to reduce duplication.
- Advertising positions centrally so there are consistent and concise messages about the selection and allocation of positions.
- Streamlining of the shortlisting and ranking processes where possible.
- Centralise position offers so that applicants do not receive multiple job offers.
- Reviewing information packs and role descriptions and providing them to SA MET for publishing prior to commencement of the annual recruitment campaign.

When required, governance and advice on the PGY2+ recruitment process are provided by the Executive Director of Medical Services (EDMS) through the EDMS Leadership Council or the Director of Clinical Training (DCT) through the SA MET Health Advisory Council DCT Committee, depending on the subject matter.

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

Experienced MEOs will tell you that the period May through to October represents a 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.

Resources

Medical Intern Recruitment | SA Health

<https://www.sahealth.sa.gov.au/wps/wcm/connect/public+content/sa+health+internet/careers/i+am+a/m+edical+professional/medical+professional>

Postgraduate Year 2 and Beyond positions | SA Health

<https://www.sahealth.sa.gov.au/wps/wcm/connect/public+content/sa+health+internet/careers/i+am+a/m+edical+professional/medical+professional>

Roles & Responsibilities Document (Please contact SA MET Unit to access this document)

“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

Part Six - SA MET Accreditation

The SA MET Health Advisory Council (the Advisory Council) is the prevocational doctors Accreditation Authority for South Australia. The Minister for Health and Wellbeing established the Advisory Council pursuant to section 15 of the Health Care Act 2008 to make recommendations for the accreditation of prevocational doctors' positions in health services.

The Australian Medical Council (AMC), on behalf of the Board of the Medical Board of Australia (MBA) has accredited the Advisory Council to undertake the accreditation of prevocational doctor positions in South Australia. The Advisory Council receive recommendations for approval regarding accreditation of prevocational doctor positions from the Accreditation Committee.

The Accreditation Committee is responsible for delivering effective accreditation processes that consider jurisdictional requirements, national program developments and the training needs of prevocational doctors.

The Advisory Council receives operational support from the SA MET Unit within the Department for Health and Wellbeing. The SA MET Unit is committed to supporting health services through the [AMC National Framework for Prevocational \(PGY1 and PGY2\) Medical Training \(2024+\)](#) to ensure high-quality education and training and prevocational doctor wellbeing, which contributes to the delivery of safe patient care.

The overriding goal of the accreditation process is to develop a quality postgraduate medical education system in South Australia. Through accreditation, the Advisory Council is able to advocate for continuous improvement to prevocational training programs.

- Overview of accreditation standards. The national standards and requirements are part of the National Framework for Prevocational (PGY1 and PGY2) Medical Training, which describes how doctors are trained and assessed in their first two years after medical school and sets the standards that contribute to good quality training. The complete National Framework components and their relevant documents are Training and assessment – Training and assessment requirements for prevocational (PGY1 and PGY2) programs.
- Training environment – National standards and requirements for prevocational (PGY1 and PGY2) training programs and terms.
- Quality assurance – AMC domains and procedures for assessing and accrediting prevocational (PGY1 and PGY2) training accreditation authorities.

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 doctor management
- Prevocational doctors with special needs
- Safe practice
- Promoting prevocational doctors' interests
- Supporting prevocational doctors
- Physical amenities

Accreditation Process

Accreditation is the evaluation process used to assess the quality of prevocational training programs against established National Standards. It includes compliance and quality improvement elements that support both service delivery and training. The process ensures health services offer appropriate education and training for prevocational doctors and promote best practice.

An accreditation survey team using the National Standards will formally assess the health services that employ prevocational doctors.

An assessment visit date is agreed upon in collaboration with the SA MET Unit and the health service's Medical Education Unit. The assessment visit date is then formally communicated to the Chief Executive Officer, and the SA MET Unit can proceed to coordinate an accreditation survey team.

Before an assessment visit, the health service must complete and submit an accreditation submission with supporting evidence. The National Standards consist of five standards and seventy-four criteria.

- This documentation must demonstrate compliance with the National Standards for prevocational training programs and terms.
- The health service must provide a self-assessment rating using the Accreditation Rating Scale and Matrix

The submission should include:

- Details on how each criterion has been met.
- Any challenges faced in meeting the criteria.

Health services are encouraged to use the Suggested Evidence Guideline (Appendix 2) to help gather and attach the required self-assessment evidence.

The completed submission is to be returned to the SA MET Unit 60 days prior to the assessment visit. The submission and evidence documentation will be available to all surveyors for review, but otherwise kept confidential.

The SA MET Unit will coordinate evaluation survey data from prevocational doctors who have undertaken a term at the health service to gain feedback on their experiences, to assist with guiding the visit to focus on areas of concern.

The accreditation survey team will visit the health service and conduct a comprehensive review of the supervision, education, training, and wellbeing received by prevocational doctors against the National Standards.

Key staff involved in prevocational training will be interviewed, including but not limited to prevocational doctors, term supervisors, MEOs, medical administration and local health network Executives.

The duration of accreditation visits varies from 0.5 to 3 days dependent on the nature of the visit (full facility or new unit) and the size of the facility.

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 national standards and requirements for prevocational (PGY1 and PGY2) training programs and terms, where the accreditation survey team addresses any identified areas of concern and determines conditions to address these concerns. The finalised report is forwarded to the SA MET Health Advisory Accreditation Committee, through the Accreditation Committee, where they evaluate the report and make any necessary amendments. In considering the report, the Advisory Committee makes a recommendation regarding awarding of accreditation status, including the number of years accreditation is for (up to four), as well as prioritising the conditions, determining required actions and evidence required to address the conditions. These will be communicated to the hospital or facility, which will be expected to address the conditions and report back to the committee within a given time frame.

Accreditation processes ensure that minimum standards regarding prevocational doctor supervision, education, training, and welfare are met, also encourage quality improvement, and strive for excellence with regard to the provision of medical education.

As the MEO, you will be incredibly involved in both the preparation and oversight of the accreditation.

Preparing for the Accreditation Visit

The accreditation process relies on the provision of evidence across all the national 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 national 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 national standards, or the evidence needed, may necessarily fall to your responsibility, it is highly 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 particularly useful to participate in an accreditation of another facility prior to your own accreditation process. Being familiar with the standards early will help guide you 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 60 days 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 conditions.

The self-assessment report is often the first contact the accreditation survey 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 60 days prior to your assessment date.

It is also your responsibility to provide a program for the visit. To do this, you will need to liaise with all key staff to be interviewed and organise times they are available, working in with all the others. Traditionally, the facility's executives and medical administration are first, then the MEO unit, then the Term Supervisors, and last the prevocational doctors, but this is only a guideline. Your SA MET accreditation team member can help you with this.

As your facility nears the time of the visit, it is likely that you will have increased contact with an accreditation team member from SA MET – they will be a useful resource to assist and support your preparation.

South Australian Trainee Medical Officer Survey (SATMOS)

The South Australian Trainee Medical Officers Survey (SATMOS) was developed as a confidential, statewide tool to gather meaningful feedback from Trainee Medical Officers (TMOs)/prevocational doctors. Its objective is to enhance education, training, supervision, and well-being by standardising evaluation and reducing survey fatigue. SATMOS was developed through broad collaboration, including TMOs, MEOs, DCTs, and national counterparts.

The survey supports TMOs in delivering candid feedback without fear of repercussions and enables Medical Education Units to track progress, identify strengths and concerns, and create improvement plans. LHNs can use SATMOS data for local quality improvement and accreditation.

Focus areas of the SATMOS are the Training Term, Monitoring, Evaluation & Continuous Improvement, Education, Training & Clinical Experience, Supervision, Assessment, and Prevocational Doctor Welfare.

SurveyMonkey is the chosen platform for SATMOS. A single user account on Survey Monkey provided to each LHN will enable the Medical Education Unit to view, edit, send, and evaluate data responses. The LHN and the SA MET Unit will both have access to the response data collected.

It would be expected that the LHN use this data to evaluate training settings and respond to any identified concerns.

SA MET will only access data from the LHN surveys when the LHN has granted permission.

The SA MET Unit will utilise accessed data to support the LHN accreditation process as evidence and will become a part of the final accreditation report that is briefed to the SA MET Health Advisory Council Accreditation Committee and Health Advisory Council.

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 survey team will meet with prevocational doctors, 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 SA MET Accreditation team member 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 an MEO. They are only too happy to help you.

At the conclusion of the visit, the accreditation survey 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 survey 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 facility will likely want to address these (or at least start to) before 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

Accreditation Preparation

The SA MET unit to liaise with the LHN regarding the upcoming full facility accreditation (approx. 6-months before expiry)

Submission template to be provided to the LHN

SA MET Unit to meet with the LHN to discuss the progress of the Submission

LHN to submit an accreditation submission and required documentation to the SA MET Unit 60 days before the visit

SA MET Unit to review the submission

SA MET Unit to finalise the visit team and advise the LHN of the composition

The LHN to confirm with the SA MET Unit the details of the site visit and agreement of the visit team composition

Visit team to meet and discuss the submission

Accreditation Visit

Site visit (usually 1 to 3 days)

The draft accreditation report is developed

The LHN to review the draft accreditation report (without accreditation status, commendations or conditions) to ensure it is factually correct

The accreditation report to be amended as required

The SA MET Unit to provide the final accreditation report to the Accreditation Committee for consideration

Accreditation Approval

The Accreditation Committee to provide to the Advisory Council with recommendations for consideration

The Advisory Council to determine the accreditation outcome

The LHN to be notified in writing of the accreditation decision

The LHN has the right to appeal the accreditation decision as per the SA MET Internal Review Policy

SA MET Unit submits the Advisory Council decision to the SA Board of the Medical Board of Australia

Accreditation Report Executive Summary to be uploaded to the SA MET Unit Website



Post Accreditation

As the MEO, you will receive a draft copy of the accreditation report, asking you to “fact check” the contents. The SA MET accreditation team request you read the draft and using track changes, add comments and alter the content, as it was part of the visit. Your protocols or guidelines may differ from the content, but prevocational doctors may not have had that experience. Once it has been finalised through the Advisory Council, a copy will be sent to you, the CEO and EDMS of the LHN. The accreditation report may contain a number of conditions. Conditions will need to be responded to within the timeframe specified in the report. As the MEO, you may be involved in responding to the conditions with the assistance of the EDMS and DCT. Please contact the SA MET accreditation team for any assistance.

Term Accreditation

Prevocational doctors 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 an intern does not count 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) between accreditation visits 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 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

An MEO will likely 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 Colleges to ensure that the quality of education and training, and requirements for specialist medical training is at a particular standard.

Only Fellows of Specialty Medical Colleges 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 Colleges 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 Colleges undertake this.

Some accredited posts, other facilities, but in general, many of the same themes that are features of the prevocational accreditation standards are present in the Specialty Medical College accreditation. Whilst as an 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.

The Virtual Accreditation Manager (VAM) System

The Virtual Accreditation Manager (VAM) system is an electronic system that has been developed to assist with the coordination of the prevocational accreditation processes. The SA MET Unit accreditation processes involve a range of activities, which include the tracking of accreditation conditions, term allocation information and submission of application forms from the Local Health Networks (LHN).

VAM is housed within SA Health's Safety Learning System.

Your access to VAM will be managed by SA MET, who will also provide training and support in navigating the system.

Resources

SA MET Accreditation and Accreditation Standards

<https://www.samet.org.au/prevocational-accreditation/>

SA Trainee Medical Officer Survey

<https://samet.org.au/satmos/>

Virtual Accreditation Manager (VAM) System

<https://www.samet.org.au/prevocational-accreditation/virtual-accreditation-management-vam-system/>

Part Seven - Support Structure and SA MET Health Advisory Council

Postgraduate Medical Education Unit

The Postgraduate Medical Education Unit (PMEU) provides advice and assistance with teaching, supervision, assessment, and evaluation to prevocational doctors. 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 prevocational doctor 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 prevocational doctors
- Establishing objectives for prevocational doctor training
- Designing strategies to ensure that those needs and objectives are met
- Evaluating the training program
- Initiating any necessary change
- Welfare and support of prevocational doctors

Medical Education Officer (MEO)

The MEO's primary responsibility is for prevocational early career doctors (PGY1 and PGY2) training and support.

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

Specifically, the MEO's role is:

- Ensure all Interns receive a comprehensive and broad-based educational experience that satisfies the requirements for full medical registration.
- Ensure all PGY2 doctors receive a diverse and structured educational experience that meets the criteria for the award of a PGY2 certificate.
- Support the training and development of early career doctors through the creation and implementation of educational, organisational, and support initiatives.

- Design, implement, evaluate, and maintain high-quality educational programs within the hospital setting.
- Develop, pilot, and assess educational resources and assessment tools tailored to PGY1 and PGY2 education programs.
- Assist in the remediation of early career doctors by contributing to the development and execution of targeted performance improvement plans.
- Advocate for the professional and educational needs of prevocational doctors.
- Collaborate with Directors of Clinical Training (DCTs), Term Supervisors, Heads of Units, and other stakeholders to enhance trainee experiences and welfare, including the development and ongoing review of Term Descriptions.
- Engage with local governance structures to ensure compliance with mandatory training requirements and the National Safety and Quality Health Service (NSQHS) Standards.
- Act as the primary liaison between the health service and the South Australian Medical Education and Training (SA MET) unit, ensuring adherence to Australian Medical Council (AMC) accreditation standards and national training requirements.
- Assist in the coordination, planning, and oversight of PGY1 and PGY2 term allocations.

Administrative Officer (AO)

The AO provides general secretariat support to the Medical Education Unit, including calendar oversight and scheduling of meetings for the DCT and MEO, general handling of email and phone correspondence, and record keeping. The AO may also assist with distributing and collecting Term Assessments and feedback evaluations. The duties of this role will vary between LHNs.

Term Supervisors

During each of a prevocational doctor's rotation (or 'terms'), there will be an allocated Term Supervisor. This person is noted in each Term Description, which prevocational doctors will receive prior to commencing each term. Term

Supervisors, or their delegate, are responsible for orienting prevocational doctors to the unit and collating feedback about their term. It is the prevocational doctor's 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 prevocational doctors. The Medical Education Registrar are a valuable addition to the PMEU and often acts as a mentor, providing additional support to prevocational doctors.

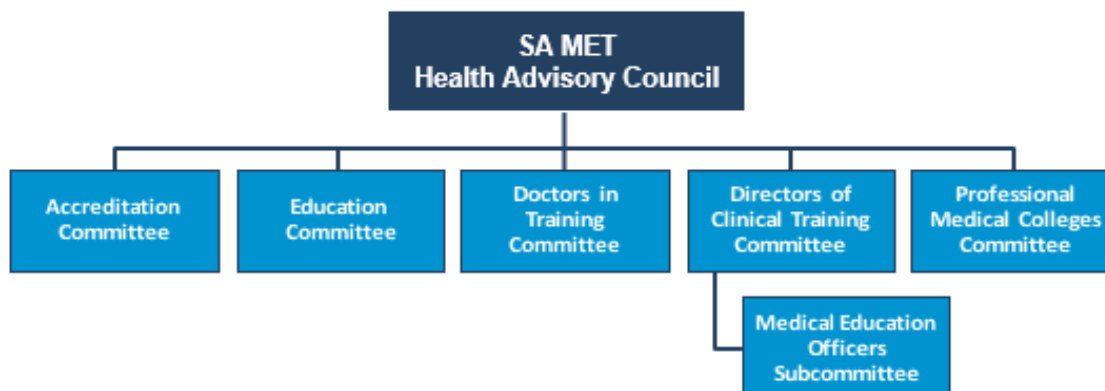
Trainee Medical Officer (TMO) Unit

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 prevocational doctors. prevocational doctors can often go to the TMO office for any human resource issues. The TMO unit and the PMEU will work closely together in regard 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 prevocational doctors as well as 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 ongoing 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 Health Advisory Council (the Advisory Council) is accountable for improving the quality of education, training, and welfare for trainee medical officers within the State and making recommendations for the accreditation of prevocational trainees in health services.

The Accreditation Committee is established as a committee of the Advisory Council to provide advice on accreditation processes for the postgraduate training of prevocational medical officers.

The functions of the Accreditation Committee are to:

1. Provide expert advice to the Advisory Council on accreditation processes for the postgraduate training of prevocational medical officers.
2. Undertake accreditation and monitoring of prevocational trainee medical officer posts, clinical units, facilities, and networks that support these posts using the current Australian Medical Council's National Framework for Prevocational (PGY1 and PGY2) Medical Training and any additional SA MET accreditation standards.
3. Conduct accreditation with a particular focus on developing the trainee medical officer as a practitioner, professional and leader, health advocate and scientist and scholar; whilst ensuring the provision of a supportive environment, with adequate supervision and appropriate welfare support; and assurance of appropriate measures to ensure patient safety.

4. Review matters relating to accreditation processes for the postgraduate training of prevocational medical officers and make recommendations for endorsement by the Advisory Council.
5. Work collaboratively with specialty medical colleges to support and achieve high-quality vocational training within the State.
6. Monitor and review the accreditation standards and processes, ensuring relevance and effectiveness.
7. Oversee the recruitment and training of accreditation visit team members and leaders.
8. Develop links and agreements with other accreditation agencies and education providers to:
 - a) promote a continuum of learning
 - b) foster sharing of expertise and information
 - c) minimise duplication of workload on health services associated with multiple accreditation agency processes.
9. Work collaboratively with other Advisory Council Committees.
10. Establish, maintain, and promote partnerships with relevant national and jurisdictional organisations.

It will be your responsibility as an MEO to submit any Change of Circumstance, New Unit requests, Survey information, mid-cycle reviews and Proviso/ Condition responses to the Accreditation Committee, through the SA MET unit.

The committee meets six times per year, and your SA MET representative will advise you of the meeting and cut-off dates for submissions.

Education Committee

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

The Education Committee, on behalf of the Advisory Council, developed the Medical Education and Training Principles ([the 'Principles'](#)), which demonstrate what excellence looks like when a learning culture is actively supported and achieved. The 'Principles' are 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.

The Education Committee has also been instrumental in the development of the [Transfer of Information Guideline](#), which provides medical students with the opportunity to optimise the transition into internship. This voluntary and confidential process is available for medical students to share information with the employing LHN.

Other initiatives from the Education Committee are the [South Australian Medical Education Interest Group \(SAMEIG\)](#) and the [South Australian Prevocational Medical Education Excellence Awards](#).

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 doctors, 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.

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 doctors.
- 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 doctor.
- 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 two meetings 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 doctor 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

Health Advisory Council

<https://samet.org.au/about-us-sa-met/health-advisory-council-sa-met/>

SA MET Health Advisory Council and relevant committees

<https://samet.org.au/about-us-sa-met/health-advisory-council-sa-met/sa-met-committees/>

Transfer of Information Guide

<https://samet.org.au/resources/doctors-in-training/>

Part Eight - Enjoying the MEO Role

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 understands 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 tea or lunch get together.
- Make a point of genuinely thanking staff and recognising efforts.

Consider [Mental Health First Aid training](#). Training courses focussing on mental health recognition and first aid can be invaluable as an MEO in recognising a trainee in difficulty and ensuring they are identified early to receive the tailored support they may require to be successful.

Career Planning (Your Own!)

MEOs come to the role from a variety of backgrounds and professional experiences. 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 be available 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 twice a year. This might be used as an opportunity to identify your strengths, recognise your accomplishments, reflect on areas that you would like to work on and develop strategies to assist you in this. Come prepared and bring your ideas on what you want to achieve as well.

Many MEOs find that they gain a great deal of knowledge and skills during their term. They find working with, managing, and supporting prevocational doctors, particularly those in the 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.

Caring for the MEO Role

Looking after yourself is important in the MEO role because you can't support others well if you're running on empty. Setting clear boundaries, managing your workload, and taking time to reflect can help prevent burnout and keep your motivation up. Making space for rest, checking in with your colleagues, and knowing your own limits helps you stay patient, supportive, and approachable.

Physical exercise, meditation, good nutrition and connecting with loved ones is as important for the MEO as it is for the prevocational doctor. By practicing good self-care you're not only protecting your own wellbeing but also showing trainees the value of balance and resilience early in their careers.

The challenges of being an MEO are as varied as the role itself. Remember you are part of a team, and you should rely on your team for support when you need it as well. Network with MEOs from your own LHN but connection with MEOs from other LHNs can also be a huge source of information and support.

“The diversity of the MEO role is very rewarding. I too have grown professionally in this role 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

Resources

Australian Health Practitioner Regulation Agency

<http://www.ahpra.gov.au>

Australian Medical Council

<https://www.amc.org.au/>

Confederation of Postgraduate Medical Education Councils

<http://www.cpmecc.org.au>

Employee Assistance Program

<https://samet.org.au/resources/useful-links/>

Medical Board of Australia

<http://www.medicalboard.gov.au>

Mental Health Education Hub SA

<https://www.sahealth.sa.gov.au/wps/wcm/connect/public+content/sa+health+internet/clinical+resources/clinical+programs+and+practice+guidelines/mental+health/mental+health+training/mental+health+education+hub+sa>

South Australian Medical Education and Training Unit

<https://www.samet.org.au/>

sahealth.sa.gov.au
samet.org.au



Government of South Australia
SA Health