PREVOCATIONAL MEDICAL TRAINING FOR DOCTORS IN NEW ZEALAND

Accreditation standards for training providers

Introduction

Prevocational medical training (the intern training programme) spans the two years following graduation from medical school and includes both postgraduate year 1 (PGY1) and postgraduate year 2 (PGY2). Doctors undertaking this training are referred to as interns. The intern training programme applies to all graduates of New Zealand and Australian accredited medical schools and doctors who have sat and passed NZREX.

The aim of the intern training programme is to ensure that interns further develop their clinical and professional skills gained at medical school through substantively attaining the learning outcomes in the *New Zealand Curriculum Framework for Prevocational Medical Training* (NZCF). The intern training programme is based on adult learning principles and has at its core a personally developed Professional Development Plan (PDP).

The Council will accredit training providers for the purpose of providing prevocational medical education through the delivery of an intern training programme to those who have:

- structures and systems in place to ensure interns have sufficient opportunity to substantively attain the learning outcomes of the NZCF
- an integrated system of education, support and supervision for interns
- individual clinical attachments that provide a high quality learning experience.

The standards for accreditation of training providers identify the basic elements that must exist in all accredited intern training programmes while allowing flexibility in the ways in which the training provider can demonstrate they meets the standards.

1 STRATEGIC PRIORITIES

1.1 High standards of medical practice, education, and training are key strategic priorities for training providers.

1.2 The training provider is committed to ensuring high quality training for interns.

1.3 The training provider has a strategic plan for ongoing development and support of a sustainable medical training and education programme.

1.4 The training provider has clinical governance and quality assurance processes that ensure clear lines of responsibility and accountability for intern training in the overall context of quality medical practice.

1.5 The training provider ensures intern representation in the governance of the intern training programme.

1.6 The training provider will engage in the regular accreditation cycle of the Council which will occur at least every three years.

1 – Notes – Strategic priorities

(i) These standards recognise that interns can complete their internship in a variety of accredited clinical attachments in various healthcare settings, including hospitals and in community based and outpatient settings.

(ii) Evidence of medical education and training as key strategic priorities may be demonstrated in documents such as the annual plan or the Medical Education Committee Terms of Reference.

(iii) Teaching, training, appraising and assessing doctors are critical functions for the care of current patients and the development of a highly skilled workforce to care for patients in the future. Recognition and appropriate resourcing of such education is essential to quality patient care.

(iv) The training provider will have its own governance and administrative group responsible for the development, review and ratification of policies and processes.

(v) Intern representation at the governance level should be specific to the intern training programme.

2 ORGANISATIONAL AND OPERATIONAL STRUCTURES

2.1 The context of intern training

2.1.1 The training provider can demonstrate that it has the responsibility, authority, and appropriate resources and mechanisms to plan, develop, implement and review the intern training programme.

2.1.2 The Chief Medical Officer (CMO) or their delegate (for example a Clinical Director of Training) has executive accountability for meeting prevocational education and training standards and for the quality of training and education.

2.1.3 There are effective organisational and operational structures to manage interns.

2.1.4 There are clear procedures to address immediately any concerns about intern performance that may impact on patient safety.

2.1.5 Clear procedures are documented to notify Council of changes in a health service or the intern training programme that may have a significant effect on intern training.

2.1 – Notes – The context of intern training

(i) The organisational structure should include appropriately qualified staff, sufficient to meet the objectives of the programme. This normally includes access to educational support personnel to plan develop, implement and review the intern training programme.

(ii) Prevocational educational supervisors should be the first point of contact when concerns of underperformance or patient safety issues have been identified about an intern. It is recommended that prevocational educational supervisors liaise closely with the RMO unit or its equivalent, the CMO (or delegate), human resource management and other prevocational educational supervisors (both locally and nationally) for the management of the underperforming intern. Please refer to the *Guide for Prevocational Educational Supervisors* for further information.

2.2 Educational expertise

2.2.1 The training provider can demonstrate that the intern training programme is underpinned by sound medical educational principles.

2.2.2 The training provider has appropriate medical educational expertise to deliver the intern training programme.

2.2 – Notes – Educational expertise

(i) The education principles underpinning the intern training programme are required to include an understanding of the teaching, learning practices, and assessment methods in medical education and educational supervision.

2.3 Relationships to support medical education

2.3.1 There are effective working relationships with external organisations involved in training and education.

2.3.2 The training provider coordinates the local delivery of the intern training programme, or collaborates in such coordination when it is part of a network programme.

2.3 – Notes – Relationships to support medical education

(i) Regional Training Hubs and Training Networks may play a key role in coordinating the intern training programme. Engagement with other organisations and networks may include Council, Health Workforce New Zealand (HWNZ), medical schools, medical colleges, primary health organisations and other providers of healthcare in the community.

3 THE INTERN TRAINING PROGRAMME

3.1 Professional development plan (PDP) and e-portfolio

3.1.1 There is a system to ensure that each intern maintains a PDP as part of their e-portfolio that identifies the intern's goals and learning objectives, informed by the NZCF, mid and end of clinical attachment assessments, personal interests and vocational aspirations.

3.1.2 There is a system to ensure that each intern maintains their e-portfolio, to ensure an adequate record of their learning and training experiences from their clinical attachments, CPD activities with reference to the NZCF.

3.1.3 There are mechanisms to ensure that the clinical supervisor and the prevocational educational supervisor regularly review and contribute to the intern's PDP.

3.1 – Notes – PDP and e-portfolio

(i) The PDP should include goals informed by:

- the learning outcomes of the NZCF
- the learning opportunities available on the particular clinical attachment
- mid-attachment feedback
- areas that the intern should focus on for improvement that have been identified in the End of clinical attachment assessment
- additional personal objectives related to vocational aspirations and other professional interests.

(ii) The e-portfolio is central to discussions between an intern, their clinical supervisor and their prevocational educational supervisor. It forms a record of the intern's progress and performance during clinical attachments. The e-portfolio contains the intern's:

- PDP
- skills log
- *End of clinical attachment assessments* (demonstrating their strengths and areas for improvement in subsequent clinical attachments)
- a record of CPD (including the teaching sessions attended as part of the formal education programme, and other appropriate learning opportunities)
- outcomes from multisource feedback (to be implemented November 2015).

(iii) CPD may include a wide range of activities for example attendance at intern teaching sessions, morbidity and mortality meetings, grand rounds, participation of simulation exercises and completion of learning modules.

3.2 Programme components

3.2.1 The intern training programme overall, and the individual clinical attachments, are structured to support interns to achieve the goals in their PDP and substantively attain the learning outcomes in the NZCF.

3.2.2 The intern training programme for each PGY1 consists of four 13-week accredited clinical attachments which, in aggregate, provide a broad based experience of medical practice.

3.2.3 The training provider has a system to ensure that interns' preferences for clinical attachments are considered, mindful of the overall learning objectives of the NZCF and their individual PDP goals in the context of available positions.

3.2.4 The training provider selects suitable clinical attachments for training on the basis of the experiences that interns can expect to achieve, including the:
- workload for the intern and the clinical unit
- complexity of the given clinical setting
- mix of training experiences across the selected clinical attachments and how these, in aggregate, support achievement of the goals of the intern training programme.

3.2.5 The training provider, in discussion with the intern and the prevocational educational supervisor shall ensure that over the course of the two intern years each intern spends at least one clinical attachment in a community setting. This requirement will be implemented over a five year period commencing November 2015 with all interns meeting this requirement by November 2020.

3.2.6 Interns are not rostered on night duties during the first six weeks of their PGY1 intern year.

3.2.7 The training provider ensures there are mechanisms in place for appropriate structured handovers between clinical teams and between shifts to promote continuity of quality care.

3.2.8 The training provider ensures adherence to the Council's policy on obtaining informed consent.

3.2 – Notes – Programme components

(i) One of the requirements for registration in a general scope of practice is that an intern must satisfactorily complete at least 10 weeks in each clinical attachment. Full time is equivalent to a minimum of 40 hours per week.

(ii) Clinical experience in the intern year involves supervised clinical attachments that offer interns a breadth of experience, and opportunity to achieve the learning outcomes in the NZCF. At the end of the year, interns will have demonstrated a high level of clinical, professional and communication competencies that will prepare them for registration in a general scope of practice, and allow further development of skills and competencies in subsequent training.

(iii) Training can take place in a variety of health care settings, including hospitals, outpatient and community-based services, all of which provide a good learning experience for the intern. In each case the quality of the experience depends on the support provided by the service.

(iv) Interns should be encouraged to spend time in an out-patient clinic, ambulatory care facility, or emergency department, as a component of clinical attachments. This is in addition and separate to development of complete clinical attachments in a community based setting.

(v) Community based attachments:
Every intern is required to complete one clinical attachment in a community based setting over the course of the two intern years (PGY1 and PGY2 and doctors who have passed NZREX). Council approved a staged transition, with a goal of 10% of interns completing a community based clinical attachment in the year commencing November 2015 and working towards 100% compliance by November 2020. Training providers will need to demonstrate progress over this period.

A community based attachment is defined as an educational experience in a Council accredited clinical attachment led by a specialist (vocationally registered doctor) in a community focused service in which the intern is engaged in caring for the patient and managing their illness in the context of their family and community.

Features of the community attachment would usually include:
- the community management of medical illness and mental health, including early detection of disease, population health surveillance, acute and chronic care management; and
- the role of the vocational scope of general practice within the wider health care network.

Clinical attachments in a community setting should provide opportunity for direct contact with

patients.

Completing a clinical attachment in a community setting will familiarise interns with the delivery of health care outside the hospital setting. This will assist interns to understand the interface between primary and secondary care. Although it is anticipated that the vast majority of attachments will have a strong focus on general practice, general practice will not be a compulsory component of the community attachment. The attachments will not usually include a hospital-based attachment, with the exception of rural hospitals that have been accredited for rural hospital vocational training that are run predominantly by doctors registered in the vocational scope of general practice or the vocational scope of rural hospital medicine.

(vi) This framework allows for attachments in general practice as well as a variety of other community based settings, including integrated care or outreach attachments undertaken by some hospital based specialists and services, which have a focus on the community.

(vii) Appropriate handover is essential for training in safe and quality clinical care.

(viii) Interns may not be rostered on nights during the first six weeks of PGY1.

(ix) Council provides the following guidance regarding night cover to be considered following the interns first six weeks:

- Interns may be rostered on nights within the first six months of registration if a doctor registered in a vocational scope is available for assistance.

(x) For interns working on night cover, training providers should:

- provide effective backup and support
- ensure appropriate orientation and induction are provided before the intern starts providing night cover to ensure the intern has all the necessary skills
- provide written guidelines on when it is appropriate to contact specialists (with the understanding that specialists would rather be called unnecessarily than not at all)
- ensure the intern knows how to get help and can adequately document for an immediate clinical supervisor any approach used during the shift
- ensure the supervising specialists are available and supportive.

(xi) Where onsite supervision is not maintained, training providers should:

- ensure a doctor registered in a vocational scope is available for assistance
- establish clear protocols that define the circumstances in which a senior doctor will be called
- submit these protocols as part of the application for accreditation for the training provider
- ensure the prevocational educational supervisor submits an annual report to Council on how well the protocols have been implemented.

3.3 Formal education programme

3.3.1 The intern training programme includes a formal education programme that supports interns to achieve those NCZF learning outcomes that are not generally available through the completion of clinical attachments.

3.3.2 The intern training programme is structured so that interns can attend at least two thirds of formal educational sessions, and ensures support from senior medical and nursing staff for such attendance.

3.3.3 The training provider provides opportunities for additional work-based teaching and training.

3.3.4 The training provider ensures the formal education programme provides opportunity for interns to develop skills in self-care and peer support, including time management, and identifying and managing stress and burn-out.

3.3 – Notes – Formal education programme

(i) The work-based teaching and training opportunities for the formal education programme includes:
- Teaching sessions with consultants and other health professionals.
- Team based activities, such as:
  - morbidity and mortality audits and other quality assurance activities
  - case presentations and seminars
  - journal clubs
  - radiology and pathology meetings
  - multidisciplinary meetings.
- Opportunities to develop and practice clinical skills within a simulated environment.
- Speciality specific or hospital wide grand rounds.

(ii) Council's statements and publications, for example *Good Medical Practice*.

3.4 Orientation

3.4.1 An orientation programme is provided for interns commencing employment, to ensure familiarity with the training provider and service policies and processes relevant to their practice and the intern training programme.

3.4 – Notes - Orientation

(i) Orientation for interns is essential both when they commence employment and on transfer within that employment to a significantly different site, whenever this occurs during the year. This is to ensure the intern is ready to commence safe, supervised practice. Orientation at the start of each clinical attachment is equally important and is supported with a written description.

(ii) While many interns will commence at the same time, specific orientation for those joining services during the year, for example NZREX doctors or a doctor returning from a break in training, is equally as important.

3.5 Flexible training

3.5.1 Procedures are in place and followed, to guide and support supervisors and interns in the implementation and review of flexible training arrangements.

3.5 – Notes – Flexible training

(i) If an intern has a flexible working arrangement less than what Council considers as full time the duration of the clinical attachment would need to be extended. Full time is equivalent to a minimum of 40 hours per week.

4 ASSESSMENT AND SUPERVISION

4.1 Process and systems

4.1.1 There are processes to ensure assessment of all aspects of an intern's training and their progress towards satisfying the requirements for registration in a general scope of practice, that are understood by interns, prevocational educational supervisors, clinical supervisors and, as appropriate, others involved in the intern training programme.

4.1 – Notes – Process and systems

(i) The multiple sources of information that inform the intern's PDP include the skills log, *End of Clinical Attachment Assessment*, outcomes from multisource feedback, and CPD activities, all of which are recorded in the intern's e-portfolio.

4.2 Supervision

4.2.1 The training provider has an appropriate ratio of prevocational educational supervisors in place to oversee the training and education of interns in both PGY1 and PGY2.

4.2.2 Mechanisms are in place to ensure clinical supervision is provided by qualified medical staff with the appropriate competencies, skills, knowledge, authority, time and resources.

4.2.3 Interns are clinically supervised at a level appropriate to their experience and responsibilities at all times.

4.2.4 Administrative support is available to prevocational educational supervisors so they can carry out their roles effectively.

4.2 – Notes - Supervision

(i) Supervision is a condition of registration for all new doctors in New Zealand. It enables the doctor's performance to be assessed to ensure the health and safety of the public while the doctor becomes familiar with the New Zealand health system and required standard of practice. All those who teach, supervise, counsel, employ or work with interns are responsible for patient safety. Accountable supervision contributes to patient safety.

(ii) Supervisors should assist an intern's professional development and support interns in achieving their learning objectives. Supervision includes direct and indirect monitoring of an intern's progress and performance, and providing constructive feedback.

(iii) Clinical supervisors must be vocationally registered in a relevant vocational scope to the attachment and the work of the intern. Supervision on a day-to-day basis may be delegated to a representative, for example a registrar.

(iv) The prevocational educational supervisor to intern ratio is one prevocational educational supervisor for up to ten interns, 0.1 FTE protected time.

(v) It is recognised that the level of day to day supervision required for PGY2 will decrease, as the intern moves to more independent practice. Accredited clinical attachments will ensure an ongoing quality learning environment and an appropriate level of support.

4.3 Training for clinical supervisors and prevocational educational supervisors

4.3.1 Clinical supervisors undertake relevant training in supervision and assessment within three years of commencing this role.

4.3.2 Prevocational educational supervisors attend an annual prevocational educational supervisor training workshop conducted by Council.

4.3.3 All staff involved in intern training have access to professional development activities to support improvement in the quality of the intern training programme.

4.3 – Notes – Training for clinical supervisors and prevocational educational supervisors

(i) Relevant supervision training is preferably Council led training for supervisors of prevocational training, but can include training for supervisors provided by medical colleges for their vocational training programmes, or training provided by medical schools for supervision of medical students in clinical settings.

4.4 Feedback to interns

4.4.1 Systems are in place to ensure that regular, formal, informal and documented feedback is provided to interns on their performance within each clinical attachment and in relation to their progress in completing the goals in their PDP, and substantively attaining the learning outcomes in the NZCF. This is recorded in the intern's e-portfolio.

4.4.2 Mechanisms exist to identify at an early stage interns who are not performing at the required standard of competence; to ensure that the clinical supervisor discusses these concerns with the intern, the prevocational educational supervisor (and CMO or delegate when appropriate); and that a remediation plan is developed and implemented with a focus on patient safety.

4.4 – Notes – Feedback to interns

(i) Formal feedback will include review of the intern's e-portfolio by the clinical supervisor and the intern at the beginning, middle and end of each clinical attachment, and by the prevocational educational supervisor at the beginning of PGY1 and PGY2, and at the end of each clinical attachment. These discussions will be summarised in the e-portfolio. Revision of the intern's PDP goals will be based on these comments, outstanding NZCF learning outcomes, areas for improvement identified in the *End of Clinical Attachment Assessments*, and evolving personal objectives related to vocational aspirations and professional interests.

(ii) There should be a documented process for managing poor performance that will ensure patient safety and intern welfare.

(iii) If an intern has been assessed as *marginal* or *unsatisfactory* in an *End of Clinical Attachment Assessment* the prevocational educational supervisor, clinical supervisor and intern will meet to identify goals addressing the competency deficiencies identified in section 1 in the PDP.

(iv) If an intern is assessed as *marginal* they will need to demonstrate improvement on their next clinical attachment in order for the assessment to be considered satisfactory. Clinical supervisors need to utilise all of the information available to them through the e-portfolio in order to inform their global assessment of the intern's performance.

(v) Clinical supervisors are encouraged to seek advice from the prevocational educational supervisor and where necessary the CMO or delegate where there is uncertainty about an intern's performance.

(vi) The prevocational educational supervisor will provide Council with copies of all assessments related to interns whose progress has been deemed unsatisfactory.

(vii) The CMO or their delegate should be informed about concerns about the performance of a doctor.

(viii) If there is a risk, or potential risk to patient safety, training providers need procedures to take action to protect public health and safety. This process should include notifying the prevocational educational supervisor and the CMO (or their delegate) and they will need to advise Council.

4.5 Advisory panel to recommend registration in a general scope of practice

4.5.1 The training provider has an established advisory panel to consider progress of each intern during and at the end of the PGY1 year.

4.5.2 The advisory panel will comprise:

- a CMO or delegate (who will Chair the panel)
- the intern's prevocational educational supervisor
- a second prevocational educational supervisor
- a lay person.

4.5.3 The panel follows Council's *Guide for Advisory Panels*.

4.5.4 There is a process for the advisory panel to recommend to Council whether a PGY1 has satisfactorily completed requirements for a general scope of practice or should be required to undertake further intern training.

4.5.5 There is a process to inform Council of interns who are identified as not performing at the required standard of competence.

4.5.6 The advisory panel bases its recommendation for registration in a general scope of practice on whether the intern has:

- satisfactorily completed four accredited clinical attachments
- substantively attained the learning outcomes outlined in the NZCF
- completed a minimum of 10 weeks (full time equivalent) in each clinical attachment

- developed an acceptable PDP for PGY2, to be completed during PGY2
- advanced cardiac life support (ACLS) certification at the standard of New Zealand Resuscitation Council CORE Advanced less than 12 months old.

4.5 – Notes – Advisory panel to recommend registration in a general scope of practice

(i) In smaller intern training programmes the second prevocational education supervisor may be from another training provider. The membership of the advisory panel ensures that recommendations consider educational, workforce and public accountability aspects of the decisions.

(ii) The lay person must not be a registered health professional, nor should they be an employee of the DHB.

(iii) An important part of the recommendation to Council is the intern's competence and fitness to practice.

(iv) The advisory panel, a collective body of experts who have experience in understanding the standard required, will use all relevant information about an intern's learning stored in the e-portfolio to inform their recommendation. Information could include:
- *End of Clinical Attachment Assessment* forms
- progression in substantively attaining the learning outcomes in the NZCF
- a summary of areas for improvement that have been identified throughout the year and have not been achieved
- a summary of PDP goals and status
- multisource feedback report
- evidence of ongoing learning and responding to feedback
- a summary of CPD and learning modules completed
- advanced cardiac life support (ACLS) certification at the standard of New Zealand Resuscitation Council CORE Advanced less than 12 months old[1]
- the proposed PDP for PGY2.

(v) The advisory panel provides Council with a recommendation about whether the intern should be registered in a general scope of practice, Council is the final decision maker.

(vi) The recommendation of the advisory panel will take account of the following factors:
- The intern is actively engaged in ongoing learning and is responding to feedback.
- The intern has addressed sufficiently all issues arising from the 'areas for improvement' sections *of End of Clinical Attachment Assessment*, particularly those that have any implications on safety to practice.
- The intern has met a substantive proportion of the learning outcomes in the NZCF.
- The intern is making progress to meet all the learning outcomes in the NZCF.

(vii) It is expected that for the vast majority of interns this process will go smoothly and on the receipt of a recommendation from the advisory panel, a general scope of practice application will be processed.

(viii) In the majority of cases where the advisory panel recommends that the intern has not met the requirements for a general scope of practice, the advisory panel will recommend that the intern completes another clinical attachment in order to attain the requirements.

If the advisory panel recommends that the intern has not met the requirements for a general scope of practice, Council would propose to decline the application based on the fact it is not satisfied that the

[1] ACLS CORE Level 7 less than 12 months old will also be accepted until 31 December 2017.

intern is competent to practise in a general scope of practice. The intern would be advised of Council's proposal, the reasons and all information that Council has relied on would be provided to the intern in writing. The intern would be provided with a reasonable opportunity to respond in writing and be heard, either personally or by his or her representative prior to Council's final decision. Council will be responsible for ensuring the consistency and adequacy of recommendations made by the advisory panels. The training provider will be responsible for ensuring their advisory panel follow good process.

(ix) Full time is equivalent to a minimum of 40 hours per week.

(x) Training providers will need to have processes in place to ensure meetings of the advisory panel are organised in a way which ensures interns can move from provisional general registration to general registration in a timely manner. Any process will allow for annual leave of panel members.

(xi) The training provider must keep accurate records of the administration of the advisory panel.

4.6 Signoff for completion of PGY2

4.6.1 There is a process for the prevocational educational supervisor to review progress of each intern at the end of PGY2, and to recommend to Council whether a PGY2 has satisfactorily achieved the goals in the PDP.

4.6 – Notes – PGY2

(i) Council encourages training providers to continue to use the *End of clinical attachment assessment* for PGY2, however it is not a regulatory requirement.

5 MONITORING AND EVALUATION OF THE INTERN TRAINING PROGRAMME

5.1 Processes and mechanisms are in place to ensure the currency of accredited clinical attachments.

5.2 Processes and systems are in place to monitor the intern training programme with input from interns and supervisors.

5.3 There are mechanisms that allow feedback from interns and supervisors to be incorporated into any quality improvement strategies for the intern training programme.

5.4 There is a process to address any matters raised by Council in relation to training, including those arising from accreditation visits.

5 – Notes – Monitoring and evaluation of the intern training programme

(i) The training provider should have in place a process which enables interns to be able to provide anonymous feedback on clinical attachments and the intern training programme.

6 IMPLEMENTING THE EDUCATION AND TRAINING FRAMEWORK

6.1 Establishing and allocating accredited clinical attachments

6.1.1 The training provider has processes for applying for accreditation of clinical attachments.

6.1.2 The process of allocation of interns to clinical attachments is transparent and fair.

6.1.3 The training provider must maintain a list of who the clinical supervisors are for each clinical attachment.

6.1 – Notes – Establishing and allocating accredited clinical attachments

(i) The processes for selecting interns for employment purposes are outside the scope of these standards.

6.2 Welfare and support

6.2.1 The duties, rostering, working hours and supervision of interns are consistent with the delivery of high quality training and safe patient care within a safe working environment, including freedom from harassment.

6.2.2 Interns have access to personal counselling, and career advice. These services are publicised to

interns and their supervisors.

6.2.3 The procedure for accessing appropriate professional development leave is published, fair and practical.

6.2.4 The training provider actively encourages interns to maintain their own health and welfare and to register with a general practitioner.

6.2.5 Applications for annual leave are dealt with properly and transparently.

6.2 – Notes – Welfare and support

(i) Training providers may encourage interns to maintain their own health and welfare by:

- providing a list to the interns of general practitioners willing to take on new patients
- emphasising the importance of having their own doctor who will treat them as a patient
- advising interns that self-prescribing breaches Council's statement *Providing care to yourself and to those close to you*.
- advising interns that prescribing for friends and family is in breach of Council's statement.

6.3 Communication with interns

6.3.1 Clear and easily accessible information about the intern training programme is provided to interns.

6.4 Resolution of training problems and disputes

6.4.1 There are processes to support interns to address problems with training supervision and training requirements that maintain appropriate confidentiality.

6.4.2 There are clear impartial pathways for timely resolution of training-related disputes.

6.4 - Notes – Resolution of training problems and disputes

(i) Smaller DHBs may need to outsource assistance for resolution of disputes.

7 COMMUNICATION WITH COUNCIL

7.1 There are processes in place so that prevocational educational supervisors inform Council in a timely manner of interns whom they identify as not performing at the required standard of competence.

7.1 – Notes – Communication with Council

(i) Council requires prevocational educational supervisors to supply a copy of any unsatisfactory *End of Clinical Attachment Assessments.*

8 FACILITIES

8.1 Interns have access to appropriate educational resources, facilities and infrastructure to support their training.

8.2 The training provider provides a safe working and learning environment.

8 – Notes - Facilities

(i) Educational resources may include but are not limited to:

- Council's prescribed educational resources
- e-learning modules
- Council's statements on standards for doctors
- continuing medical education sessions.

(ii) Facilities and infrastructure includes, but are not limited to:

- computer facilities
- access to internet and intranet services
- library services

- appropriate meeting or training venue/s for continuing medical education sessions
- skills lab or an appropriate venue for simulation training
- common room for interns.

Glossary

New term	Old term	Explanation
Clinical attachment	Run	A Council accredited 13 week rotation worked by an intern.
Clinical attachment – community setting		An educational experience in a Council accredited attachment led by a community focused specialist which involves the learner in caring for the patient and their illness in the context of the community and their family.
Clinical supervisor	Run supervisor	A vocationally registered senior medical officer supervising an intern on a clinical attachment.
Continuing professional development (CPD)	Continuing professional development (CPD)	CPD is involvement in clinical audit, peer review and continuing medical education, aimed at ensuring a doctor is competent to practise medicine.
e-portfolio		An electronic record of learning for each intern to record and track skills and knowledge acquired.
Formal education programme		Compulsory teaching sessions.
Intern	Intern House Surgeon RMO House Officer	Refers to a graduate of an accredited New Zealand or Australian medical school or a doctor who has passed the NZREX Clinical, who is in their first and second year of registration. An intern is usually employed as a House Officer and is often referred to as: • an intern • a house surgeon • a house officer.
Intern training programme		The training provider's training and education programme for PGY1 and PGY2 doctors that has been accredited by Council.
Multisource feedback (MSF)	Multisource feedback (MSF)	Feedback collected from the intern's colleagues, multidisciplinary team and patients about the intern's

		communication and professionalism using a set questionnaire.
New Zealand Curriculum Framework for Prevocational Medical Training (NZCF)		The learning outcomes to be substantively attained by an intern during PGY1 and PGY2.
Post graduate year 1 (PGY1)	PGY1	For New Zealand and Australian graduates, the year following graduation from medical school and for doctors who have passed NZREX Clinical, the provisional general year. PGY1 is a minimum of 12 months however it may take longer as it is the time it takes to satisfactorily complete the requirements for registration in a general scope of practice.
Post graduate year 2 (PGY2)	PGY2	For New Zealand and Australian graduates and NZREX doctors the year after first gaining registration in a general scope of practice. PGY2 is a minimum of 12 months however it may take longer as it is the time it takes to satisfactorily complete the requirements for PGY2.
Prevocational educational supervisor	Intern supervisor	A Council appointed vocationally registered doctor who has oversight of the overall educational experience of a group of PGY1 and/or PGY2 doctors as part of the intern training programme.

New term	Old term	Explanation
Prevocational medical training		The two years* following graduation from an Australian or New Zealand medical school or for doctors that have passed NZREX Clinical, the first two years* of registration in New Zealand. *This may be longer as it is the time it takes to meet the requirements. For

		the majority of people this will be two years.
Professional development plan (PDP)		A live electronic document stored in the e-portfolio outlining the intern’s high level goals and how they will be achieved.
Skills log		A record of the learning outcomes from the NZCF that an intern has attained. Stored in the e-portfolio.
Teaching sessions	Teaching sessions	The regular formal teaching sessions organised by the training provider and attended by interns.
Trainee intern (TI)	Trainee intern (TI)	A medical student in the final year of medical school.
Training provider		The organisation accredited by the Council to deliver an intern training programme for PGY1 and PGY2 doctors.