



Guide for Prevocational Educational Supervisors

Contents

Key responsibilities of the prevocational educational supervisor	4
Introduction	6
Prevocational educational supervisor appointment process	7
The role of the prevocational educational supervisor	8
General attributes	8
Key responsibilities	8
Time and resource allocation	9
Mentoring for prevocational educational supervisors	10
Prevocational educational supervisor meetings	10
Formal education programme	10
Applications for clinical attachment accreditation	11
Clinical attachment evaluation	12
Prevocational medical training	13
Intern training programme	13
Requirements for PGY1 and gaining the General scope of practice	13
Recording learning	14
Supervision	14
Requirements to gain registration in the General scope of practice	14
New Zealand Curriculum Framework (NZCF)	15
Prevocational educational supervisors and clinical supervisors	16
Clinical supervisor role	17
Professional development plan (PDP)	18
Creation of the PDP	18
Role of the clinical supervisor in reviewing and updating the PDP	19
End of clinical attachment assessment	19
Development and endorsement of the PDP for PGY2	20
Advisory panel to recommend registration in a general scope of practice	20
PGY2 – interns registered in a general scope of practice	21
Requirements for PGY2	21
Flexibility in meeting the PGY2 requirements	21
Working overseas in PGY2	21
Vocational training in PGY2	22
Locum work in PGY2	22
End of PGY2 – removal of endorsement	22

Additional information	24
Community-based attachments	24
Informed consent	24
Night cover	25
Handover	25
Taking time out of practice	25
Developing the intern	26
Clinical attachment specific induction	27
Meetings with interns	27
Providing feedback	27
Skills training	28
Stream-lining training provider systems to help the intern	28
Stress and time management of interns	28
Professional support	29
Dealing with complaints about interns	29
Detecting and helping the underperforming intern	30
Symptoms of the intern in difficulty	30
Who detects underperforming interns?	30
Role of the prevocational educational supervisor in addressing poor performance	30
Factors leading to underperformance	31
Managing the underperforming intern	31
Medical Council requirements	32
The informal meeting	32
The formal meeting	33
Competence referrals to Council	34
Intern health	35
Promotion of mental health and wellbeing	35
Early detection and intervention	36
Management and intervention	36
External sources of support for interns	37
The Medical Council's role	37
Council accreditation of training providers	39
NZREX interns	40
Glossary	42

Key responsibilities of the prevocational educational supervisor

Council recommends reading the complete *Guide for Prevocational Educational Supervisors* to gain comprehensive understanding of the role and responsibilities of the prevocational education supervisor. The following summary highlights what the Council views as being the key responsibilities of the prevocational educational supervisor throughout PGY1 and PGY2. Please refer to the guide for further information.

Beginning of PGY1

The prevocational educational supervisor should meet with the intern to discuss:

- the intern's ePort, specifically the NZCF log
- the intern's upcoming clinical attachments
- the learning outcomes in the NZCF including those attained through prior learning, those that can be attained through the mix of clinical attachments and those which will need to be met through the training providers teaching session and learning modules
- how to set goals in the PDP.

After each clinical attachment

The prevocational educational supervisor should:

- meet to discuss the intern's performance on the clinical attachment
- record comments in the end of clinical attachment assessment
- review and discuss the progress of interns goals related to the clinical attachment and offer support and guidance
- where there are performance issues work with the intern and clinical supervisor to develop a PDP to be addressed on the next clinical attachment.

Towards the end of PGY1

The prevocational educational supervisor should meet to assist the intern in developing an appropriate PDP for PGY2. The goals in the PDP for PGY2 should be targeted around the following:

- outstanding learning outcomes from the NZCF for PGY1
- learning outcomes from the NZCF for PGY2
- areas for consolidation identified on previous clinical attachments
- completion of a community based attachment
- vocational aspirations.

Prevocational educational supervisor's role in the advisory panel

The advisory panel is a collective body of experts including the prevocational educational supervisor. The advisory panel will have experience in understanding the standard required and will use all available relevant evidence from ePort which could include:

- End of clinical attachment assessments.
- Progression in substantively¹ attaining the learning outcomes in the NZCF.
- A summary of areas to focus on for further development that have been identified throughout the year and have not been achieved.
- The setting and completion of goals in the interns PDP.
- Evidence of ongoing learning and responding to feedback.
- A summary of learning activities completed.
- Advanced cardiac life support (ACLS) certification at the standard of New Zealand Resuscitation Council CORE Advanced less than 12 months old.
- the proposed PDP and intentions for PGY2.

¹ Each intern is expected to make progress in attaining the learning outcomes in the NZCF. To be considered sufficient, interns should record the attainment of at least 75% (279) of the learning outcomes by the end of PGY1.

Factors to be considered by the advisory panel

- The intern is actively engaged in ongoing learning and is responding to feedback.
- The intern has addressed sufficiently all issues arising from the 'areas to focus on for further development' 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.

After each clinical attachment in PGY2

Meet to discuss the intern's performance on the clinical attachment, offer support, review and update the PDP.

End of PGY2

- At the end of PGY2, interns must demonstrate through the information in their ePort that they have met the prevocational training requirements for PGY2 in order to have the endorsement removed.
- The prevocational educational supervisor must assess whether the intern has met the requirements and recommend to Council that the endorsement be removed.

Ongoing responsibilities

- The prevocational educational supervisor to intern ratio is one1 prevocational educational supervisor for up to ten interns, 0.1 FTE.
- Following up with the clinical supervisors to ensure mid clinical attachment meetings are taking place and end of clinical attachment assessments are completed. It is vital that the prevocational educational supervisor ensures that these key processes take place to ensure the intern meets the requirements for registration in a general scope at the end of PGY1.

Introduction

The role of the prevocational educational supervisor can be one of the more challenging but also one of the more rewarding roles in a medical career. Helping new doctors with their education, professional development and assisting them in their medical careers is of critical importance.

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. Prevocational medical training is undertaken by all graduates of New Zealand and Australian accredited medical schools and doctors who have sat and passed the New Zealand Registration Examination (NZREX Clinical).

Interns are required to complete a minimum of 12 months in each postgraduate year, however an intern remains a PGY1 or PGY2 until the requirements for the relevant postgraduate year are completed. If an intern takes time out during their internship they must complete additional clinical attachments to ensure they have satisfactorily completed four clinical attachments in each year of the two-year programme².

Interns must complete their internship in an intern training programme provided by an accredited training provider. Interns complete a variety of accredited clinical attachments and these take place in a mix of both hospital and community settings.³ Clinical attachments may only be accredited if they form part of the intern training programme provided by an accredited training provider⁴.

An intern who commences PGY1 (registration in the Provisional General scope of practice) must complete the requirements for PGY1 in New Zealand in order to gain registration in the General scope of practice.

The aim of prevocational medical training is to ensure that interns further develop their clinical and professional skills gained at medical school. This is achieved by interns satisfactorily completing four accredited clinical attachments in each of the two prevocational years, setting and completing goals in their professional development plan (PDP) and recording the attainment of the learning outcomes in the New Zealand Curriculum Framework for Prevocational Medical Training (NZCF).

This guide has been written to assist prevocational educational supervisors in fulfilling their role efficiently, effectively and hopefully enjoyably. In addition to the information from the Medical Council of New Zealand (Council), helpful hints drawn from the experiences of prevocational educational supervisors from around the country are included.

² Interns (PGY1 and PGY2) with flexible working arrangements (undertaking part-time work) need to work at least 0.5 FTE for it to count towards meeting the prevocational requirements. Where an intern is working part-time they will be required to complete additional time (if the intern is working 0.5 FTE they will need to complete a further attachment of 0.5 FTE for it to count towards the prevocational requirements).

³ Doctors who have passed NZREX Clinical prior to 30 November 2014 and who meet the specified criteria, are eligible to complete all of their PGY1 requirements in a primary care setting. Please refer to our *Policy on Prevocational Medical Training*.

⁴ Doctors who have passed NZREX Clinical prior to 30 November 2014 and who meet the specified criteria, are eligible to complete all of their PGY1 requirements in a primary care setting. Please refer to Council's [Policy on prevocational medical training for more information](#).

Prevocational educational supervisor appointment process

Prevocational educational supervisors are nominated by the chief medical officer (CMO). Normally, the position is advertised internally and applicants are interviewed. The CMO sends the nomination to Council for consideration in accordance with Council's protocol for appointing prevocational educational supervisors. The term is five years initially, with the opportunity for renewal at the end of each term.

The prevocational educational supervisors act as a Council agent and sign a contract with Council. Variations to the contract are subject to an agreement being reached between all parties. Two months notice, in writing, of variations or cancellation must be given and a copy must be provided to the Chair of Council's Education Committee (the Committee) and the CMO of the District Health Board (DHB) at which the prevocational educational supervisor is employed.

The contract may be cancelled by either party by giving the other party notice in writing. The contract may also be cancelled immediately by either party giving the other party notice if a serious breach of the contract has occurred. Any notice of cancellation must state the reason for cancellation and give the party in breach 20 working days to remedy the breach, if the breach is capable of being remedied.

IMPORTANT NOTE: The contract relates only to the statutory functions of the supervisor that concern the fulfilment of their **education, training and supervision** roles under the Health Practitioners Competence Assurance Act 2003 (HPCAA).

Under the prevocational educational supervisor contract (which is signed by the CMO of the DHB or training provider) the training providers are expected to:

- continue to pay prevocational educational supervisors for the range of services they provide to the training provider related to the service arrangements for interns, and
- make provision in the individual employment contracts of prevocational educational supervisors for this additional contractual arrangement required by the Council, and
- ensure resources funded by the Investment Relationships and Purchasing arm of Health Workforce New Zealand (previously the Clinical Training Agency) for the education of interns are known and accessible to prevocational educational supervisors.

The role of the prevocational educational supervisor

General attributes

Prevocational educational supervisors should:

- be known by, approachable and easily accessible to the interns
- be an advocate for interns to the training provider management
- not be too involved in training provider management, which can interfere with the advocacy role, particularly where there is a potential conflict of interest
- be able to influence decisions on the clinical attachment choices for interns
- be interested in education
- be able to form a good working relationship with human resources personnel dealing with interns
- be able to deal effectively and assertively with other supervising specialists when the Council's requirements are not being met.

Key responsibilities

Prevocational educational supervisors are required to:

- be good role models, and display good professionalism and knowledge of and interest in education
- display good skills in clinical medicine and management, and in interpersonal relations
- make sure they are known to all the interns at the beginning of the year, or when any new interns commences employment
- have an active involvement in orientation and teaching programmes to ensure quality training and learning for interns
- provide pastoral care to interns and take an active interest in ensuring the health and wellbeing of interns
- make sure their interns are aware of the prevocational educational supervisor's role, availability for advice and the assessment procedures
- meet with their interns (individually and as a group) regularly to provide support, review the overall programme and address any concerns
- ensure the clinical supervisors discuss all end of clinical attachment assessments with interns and provide timely feedback to any interns experiencing difficulties in the clinical attachment
- ensure the clinical supervisors are accessing the intern's ePort and having discussions with the intern about their personalised professional development plan (PDP)
- make sure the interns' clinical experience and clinical attachment mix provide a broad based experience of medical practice participate as a member on the advisory panel who consider each intern's progress and make recommendations to Council regarding the intern's appropriateness for general registration at the end of PGY1
- liaise closely with the Chief Executive (CE), CMOs and Clinical Directors at the training provider on the education, training and supervision of interns
- highlight to the CMO (or delegate) and any clinical supervisors who are not completing the assessment process for interns adequately
- highlight to the CMO (or delegate) and to Council any intern who has received an unsatisfactory end of clinical attachment assessment
- monitor the formal education programme and facilities available for interns
- offer counselling if necessary, particularly to those having problems in clinical work or integration into the New Zealand workforce
- report to Council quarterly on the number of interns being supervised, and on any corrections necessary to Council's education clinical attachment database
- attend meetings or seminars arranged by Council and, if required, participate in training provider accreditation visits as part of Council's accreditation team

- have an active involvement in the accreditation process for your training provider, and an understanding of the [Accreditation standards for training providers](#) and [Accreditation standards for clinical attachments](#)
- have an active involvement in the accreditation process for new clinical attachments being offered by the training provider.

Time and resource allocation

The prevocational educational supervisor's role requires protected time allocated each week. This allows time to deal with issues as they arise and allow accessibility for interns to meet with their prevocational educational supervisor. Attempting the role without protected time will result in dissatisfaction on both sides. Council's current Memorandum of Understanding with all DHBs outlines the requirements for intern learning. This includes the requirement that each prevocational educational supervisor is allocated 0.10 FTE protected time for up to 10 interns to carry out the functions of the role.

The prevocational educational supervisor whenever possible should be the same person for the entire year. If an intern moves to a different training provider they must have a prevocational educational supervisor at that provider. However interns in the Wellington or Auckland region may have a prevocational educational supervisor located in one of the other training provider's within the same region. In these cases, the following conditions apply:

- Quarterly meetings must occur between prevocational educational supervisors and interns (at the beginning of the intern year and at the end of each clinical attachment) and must be held in person (as opposed to via telephone or email). Council resolved that this condition is specific to the Auckland metropolitan DHBs (acknowledging that this is not relevant to the Wellington-region DHBs at this point in time).
- If the intern has been identified as needing additional support, then ideally a prevocational educational supervisor should be appointed who is at the same site as the intern. Alternatively a shared care system including support from a local onsite prevocational educational supervisor should be put in place. The role of the local onsite prevocational educational supervisor is to provide immediate support to the intern and assistance with communication with clinical supervisors if needed. If an additional local onsite prevocational educational supervisor is used, then they should also be involved in review of the intern's progress with the Advisory Panel at the end of PGY1 and at the end of PGY2.

If an intern has more than one prevocational educational supervisor over the course of the year:

- A verbal handover should occur between the prevocational educational supervisors to discuss the intern's progress and any concerns.
- A meeting should be held between the intern and new prevocational educational supervisor as soon as the change occurs to form the supervisory relationship.

Adequate secretarial and administrative support is essential. Secretarial support can assist with appointments for interns to meet with the prevocational educational supervisor, send reminders in ePort, assist with correspondence to Council, and many other duties.

Having systems and processes in place for regular meetings with interns, completing registration requirements, maintaining records of meetings, and completing Council forms. These are just some of the necessary processes required to make the role more efficient and effective. Making contact with senior management and outlining requirements and expectations of support is also very important.

Developing a close relationship with the organisation's information technology department is also useful for a whole range of educational objectives such as assisting with training and assessment plans to be placed on the intranet and development of websites for interns.

Mentoring for prevocational educational supervisors

To assist with some of the difficulties encountered in performing the prevocational educational supervisor role, a mentoring system was introduced by Council for prevocational educational supervisors. Generally, more experienced prevocational educational supervisors (past or current) are partnered with those who are new to the role and might like to form a collegial and mentoring relationship. This allows contact with a colleague with whom one can discuss difficult issues, and obtain advice and support accordingly. Discussing concerns with a colleague is recommended whenever doubt exists over the best way to manage a difficult situation. For larger training providers this collegial relationship can be established with an existing prevocational educational supervisor.

Prevocational educational supervisor meetings

Prevocational educational supervisors are required to attend an annual meeting. This meeting provides a forum for prevocational educational supervisors from around the country to come together to discuss topical issues. In addition to formal sessions which are designed to cover relevant topics, there is usually a workshop covering important aspects of intern supervision. These meetings are a great opportunity to network with other supervisors from around the country and share ideas. It is also an opportunity to share educational and training resources. One of the most reassuring aspects of these meetings is that many of the problems experienced by prevocational educational supervisors are common to other training providers. By sharing these concerns, this can in turn help Council to formulate strategies to deal with issues at a national level. Prevocational educational supervisors have generally found these meetings very valuable.

Formal education programme

A structured formal education programme should enhance the apprenticeship learning model. It is important to ensure the teaching session delivered as part of the educational programme covers any of the NZCF learning outcomes that are not generally available on the clinical attachments. The prevocational educational supervisor is responsible for ensuring that the formal education programme is in place, and that interns attend at least two thirds of the teaching sessions. There may be others at the training provider who are also responsible for providing the training. In many training providers the educational programme is managed by RMO or medical education unit staff.

Holding the teaching sessions at a regular time and place, as well as offering refreshments as an incentive, is a good way to improve attendance. Interns also need to know their CMO, clinical supervisors and registrars support their attendance. Ideally interns will have input on the topics and enthusiastic teachers will be found to deliver them. If possible a prevocational educational supervisor or a nurse or experienced secretary of the RMO unit should hold all pagers and take messages during sessions. Secretaries can help by booking rooms and sending reminders. Attendance at these sessions by the prevocational educational supervisor can be a useful way to monitor the programme and provide an opportunity to catch up with interns.

Structured learning activities include:

- educational sessions with other health professionals, specialists and support services
- training provider-wide sessions arranged by the prevocational educational supervisor
- team-based activities, for example, mortality and morbidity audits, quality assurance, formal discussions about ethics and cultural issues in medicine
- self-directed learner sessions supported by prevocational educational supervisor.

Interns must be aware of the teaching sessions on their clinical attachment and training provider wide, and be able to demonstrate they have taken part - a minimum of two hours per week is expected. Attendance at about two thirds is considered realistic due to problems of service/ward commitments, annual leave and night rosters. Self-reporting attendance is recommended. Interns are expected to do self-directed learning, including reading the more general medical and surgical journals. Alongside teaching on clinical topics, there is also a place for stress management and encouraging collegial support within the intern group.

Discussion groups might focus on the 'art and practice' of medicine, rather than the clinical science aspect. A balance is recommended between formal teaching, and general discussion on current issues of interest or concern.

Topics likely to arise in discussion include:

- difficult clinical cases
- conflicts with staff members
- the pressure of time and clinical demands when on call
- medico-legal and ethical dilemmas
- the interns' relationships with their clinical supervisor
- general workload and rostering problems.

Topics for the formal teaching (maybe every second or third week) include:

- stress management, including discussion of common health problems of doctors (especially depression and substance abuse), relaxation techniques and how to maintain health, wellbeing and lifestyle balance (see Council presentation on health issues provided)
- time management
- assertiveness and conflict management
- financial planning and budgeting
- medical career advice
- communication skills, especially dealing with terminally ill patients and their relatives
- professional and sexual boundary issues.

Applications for clinical attachment accreditation

The accreditation of clinical attachments is designed to allow training providers to develop clinical attachments that provide quality feedback and assessment and supervision and to provide interns a breadth of experience with opportunity to achieve the learning outcomes in the NZCF.

Interns must work in accredited clinical attachments provided by their training provider. Each clinical attachment is 13 weeks duration. Clinical attachments are accredited against Council's [Accreditation standards for clinical attachments](#).

Applications for the accreditation of clinical attachments must be submitted by the training provider via ePort. The clinical attachment application form is based on the *Accreditation standards for clinical attachments*. Resident Medical Officer (RMO) unit coordinators, prevocational educational supervisors, clinical directors of training and Chief Medical Officers have the functionality to create and complete the clinical attachment application. A prevocational educational supervisor must review the content of the clinical attachment before submitting the application to Council⁵.

The application for accreditation of clinical attachments does not ask for evidence of how the training provider meets the standards, however, as part of the training provider accreditation process, the accreditation team may review a random selection of accredited clinical attachments to test the information provided in the application for accreditation. The accreditation team may do this by:

- speaking with the named clinical supervisors
- speaking with interns who have completed the attachment
- reviewing collated end of clinical attachment feedback, and the training provider's response
- reviewing the information about the clinical attachment in ePort.

Council's Medical Adviser and Committee Chair review the application for accreditation. If the application is approved, the clinical attachment is allocated a unique number. If the application is declined, a notification

⁵ If the 'creator' is a prevocational educational supervisor, there is no need for an additional prevocational educational supervisor to review the application.

is sent to the 'creator' and prevocational educational supervisor who reviewed the application, advising why the application has been declined.

An intern may not be allocated to a clinical attachment, nor commence work within a clinical attachment, until the attachment has been accredited.

Relief clinical attachments

When considering an application for accreditation of a relief clinical attachment it is important to note that there are specific standards relating to relief clinical attachments in both the [Accreditation standards for training provider](#) and the [Accreditation standards for clinical attachments](#). They are:

- The training provider maintains a small group of clinical supervisors for relief clinical attachments.
- There are mechanisms in place to ensure clinical supervisors of relief clinical attachments seek feedback from those who have worked with the intern over the course of the attachment in order to provide feedback and complete the clinical attachment meetings and end of clinical attachment assessment in ePort.
- Clinical supervisors of relief clinical attachments should seek feedback from the wider team, including consultants, registrars and nurses. The clinical supervisor of relief attachments will require additional support to ensure that they understand the different nature of their role and how to be effective when providing support to interns they are not directly working with.

Clinical attachment evaluation

The Accreditation standards for training providers requires that there are mechanisms in place that enable interns to provide anonymous feedback about their educational experience on each clinical attachment. Interns should be able to provide feedback anonymously without fear of prejudice.

One option that is available to training providers for collecting feedback from interns about a clinical attachment is the Postgraduate Hospital Educational Environmental Measure (PHEEM) tool. However training providers can use their own tool for collecting feedback. The training provider must collate the results of the feedback from interns collected at the end of each clinical attachment. A report demonstrating annual data that provides longitudinal perspective should be included in the self-assessment documentation, as well as a report demonstrating what changes, if any, the training provider has made as a result of the feedback.

Prevocational medical training

Interns and their supervisors are required to use ePort to record learning and progress. Interns use ePort to record attainment of learning outcomes and goals in their PDPs. Supervisors use ePort to monitor and record feedback on the intern's overall progress, as well as progress in each clinical attachment. ePort is accessed through www.ePort.nz.

Intern training programme

The Council will accredit training providers to provide prevocational medical education and training through the delivery of an intern training programme who have:

- structures and systems in place to ensure interns have sufficient opportunity:
 - to attain the learning outcomes of the *New Zealand Curriculum Framework for Prevocational Medical Training* (NZCF), and
 - to satisfactorily complete the requirements for prevocational medical training over the course of PGY1 and PGY2
- an integrated system of education, support and supervision for interns
- individual clinical attachments that meet Council's accreditation standards and provide a breadth of clinical experience and high quality education and learning.

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

For further details please go to the [accreditation page](#) on our website.

The aim of the intern training programme is to ensure that interns further develop their clinical and professional skills gained at medical school. This is achieved by interns satisfactorily completing four clinical attachments in each of the two prevocational years, setting and completing goals in their professional development plan (PDP) and 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).

Interns are required to complete a minimum of 12 months in each postgraduate year, however an intern remains a PGY1 or PGY2 until the requirements for each year are completed. If an intern takes time out during their internship they must complete additional clinical attachments to ensure they have satisfactorily completed four clinical attachments in each year of the two year programme. Interns (PGY1 and PGY2) with flexible working arrangements (undertaking part-time work) need to work at least 0.5 FTE for it to count towards meeting the prevocational requirements. Where an intern is working part-time they will be required to complete additional time.⁶

Requirements for PGY1 and gaining the General scope of practice

Doctors entering the prevocational training programme (PGY1s) are required to demonstrate their progress towards gaining the necessary skills, knowledge and experience to gain the General scope of practice.

Interns in PGY1 are registered in the Provisional General scope of practice until they meet the requirements for registration in the General scope of practice.

⁶ If the intern is working 0.5 FTE they will need to complete a further attachment of 0.5 FTE for it to count towards the prevocational requirements.

Recording learning

Interns record their learning in an online electronic portfolio (ePort):

- Interns set goals and record their progress with completion of these in a professional development plan (PDP).
- Interns record the learning outcomes attained from the New Zealand Curriculum Framework for Prevocational Medical Training (NZCF).
- Clinical supervisors record beginning and mid-attachment meetings and end of clinical attachment assessments.

Interns and prevocational educational supervisors comment on the end of clinical attachment assessment and confirm completion of the clinical attachment.

Clinical attachments

Each clinical attachment is 13 weeks (or 14 weeks maximum) duration. Clinical attachments are accredited against the Medical Council of New Zealand's (Council) prevocational medical training for doctors in New Zealand *Accreditation standards for clinical attachments*.

Supervision

Interns meet with their prevocational educational supervisor at the beginning of the year and after each clinical attachment. Interns meet with their clinical supervisor (Council-approved supervisor of the individual clinical attachment) at the beginning, mid-way through and at the end of each attachment. Clinical supervisors provide feedback to interns about their performance and discuss the intern's goals for the clinical attachment.

Requirements to gain registration in the General scope of practice

To be eligible to apply for registration within the General scope of practice at the end of PGY1, an intern **must meet all** of the following requirements:

- The (satisfactory) completion of four accredited clinical attachments.
- The substantive⁷ attainment of the learning outcomes outlined in the NZCF (prior learning from the final year at medical school will be taken into account).
- Completion of a minimum of 10* weeks full-time equivalent in each clinical attachment. Full time is equivalent to a minimum of 40 hours per week.
- Advanced cardiac life support (ACLS) certification at the standard of New Zealand Resuscitation Council CORE Advanced less than 12 months old.
- A recommendation for registration in a general scope of practice by a Council approved advisory panel.

In addition, interns are required to establish an acceptable PDP for PGY2, to be completed during PGY2. Interns must create goals for PGY2 ahead of the advisory panel meeting. Interns wishing to join a vocational training programme or to practise overseas must add information about these intentions as goals in the PDP.

* Prevocational educational supervisors have some discretion to consider approving less than 10 weeks in limited or extreme circumstances. You may consider it appropriate to mark the intern as having met the time requirements for an attachment if:

- the intern has completed less than 10 weeks due to factors outside their control, for example due to injury, **and**
- the intern has performed satisfactorily on the attachment.

Alternatively, the attachment could be marked as 'conditional' with a note in the 'areas to focus on for further development' that the intern must meet the time requirements on the following attachment.

⁷ Each intern is expected to make progress in attaining the learning outcomes in the NZCF. To be considered sufficient, interns should record the attainment of at least 75% (279) of the learning outcomes by the end of PGY1.

Then, if the intern satisfactorily completes the following attachment, the 'conditional' attachment would then be counted as satisfactory too. This would need to be done in discussion with both the clinical supervisor (who marks the attachment) and the intern.

Anything less than 8 weeks is unlikely to be counted as satisfactory and will need to be considered at the end of the year by the advisory panel, who will take into account the performance across all the other attachments. Any ongoing issues about not meeting the time requirements on more than one attachment would be of concern.

The 10 week minimum allows for three weeks leave to be taken, so this should not be a regular occurrence.

If you have any queries or concerns regarding this, please discuss with the advisory panel Chair or talk to Council office staff.

New Zealand Curriculum Framework (NZCF)

Each intern is expected to reflect on their progress and record the attainment of the learning outcomes in the NZCF. Interns must record at least 75% (279) of the learning outcomes by the end of PGY1 and 95% (354) by the end of PGY2. Interns record attainment of the learning outcomes in the 'NZCF log' in ePort.

The learning outcomes can be attained through clinical attachments, the formal education programme and individual learning. Interns may record the learning outcomes as complete in any of the following circumstances:

- The intern has demonstrated competence in the learning outcome.
- The intern has participated in the learning outcome.
- The intern has knowledge of the learning outcome (either through self-directed learning or through formal or informal teaching).
- Covered during the final year at medical school (prior learning).

Any mix of these options will be satisfactory, as long as progression through the intern years is demonstrated.

Recording of attainment of learning outcomes is based on a high level of trust. While evidence of attaining each learning outcome is not required the conversations between the intern and their clinical and prevocational educational supervisors should cover the NZCF Log. The conversations should reassure the supervisors that the intern has attained the required skills.

Purpose

The NZCF aims to:

- build on undergraduate education by guiding recently graduated doctors to develop and consolidate the attributes needed for professionalism, communication and patient care
- guide generic training that ensures PGY1 and PGY2 doctors develop and demonstrate a range of essential interpersonal and clinical skills for managing patients with both acute and long-term conditions, regardless of the specialty
- guide the seeking of opportunities to develop leadership, team working and supervisory skills in order to deliver care in the setting of a contemporary multidisciplinary team and to begin to make independent clinical decisions with appropriate support
- guide decisions on career choice.

Learning outcomes

The NZCF should be used to guide an intern's continuum of learning from medical school through PGY1 and PGY2. It outlines the desired learning outcomes, however, it is recognised that proficiency in achievement of the capabilities will occur at different stages in training.

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

When commencing new clinical attachments, the NZCF provides an essential guide for discussing and identifying the learning opportunities that are available from a given clinical attachment. It will help to identify particular opportunities that may be taken during the clinical attachment in order to assist learning.

The learning outcomes in the NZCF are underpinned by two central concepts:

1. Patient safety

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

2. Personal development

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

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

Prevocational educational supervisors and clinical supervisors

Prevocational educational supervisors are encouraged to have regular contact with each intern's clinical supervisors. If a clinical supervisor identifies that one of your interns is not performing at the required standard of competence, they should engage the prevocational educational supervisor at the earliest stage to ensure that the intern receives appropriate support. Where the outcome of an end of clinical attachment assessment is 'conditional' or 'unsatisfactory' performance, the clinical supervisor must provide the intern with areas to focus on for further development. The clinical supervisor should also engage with the prevocational educational supervisor. The areas to focus on for further development must be recorded in ePort to allow the clinical supervisor on the next attachment to see where the intern may need further development or assistance.

Prevocational educational supervisors will work closely with clinical supervisor to ensure all sections of the end of clinical attachment assessments are completed and discussed with each intern before the last day of the clinical attachment. This includes providing timely feedback to those who are experiencing difficulties in the clinical attachment. They are also there to ensure that the clinical supervisor is:

- reviewing each intern's ePort
- having discussions with each intern about their personalised professional development plan (PDP)
- reviewing interns progress with attaining the learning outcomes from the NZCF.

Clinical supervisor role

The clinical supervisor is nominated by the training provider and considered by Council as part of the application for accreditation of clinical attachments. Clinical supervisors must be vocationally registered in the relevant scope of practice and in good standing with Council⁸. A doctor who has a current complaint or concern being investigated by Council or the Health and Disability Commissioner is not eligible to act as a Council agent (and therefore be appointed as a clinical supervisor) until the outcome of the investigation is known.

Clinical supervisors provide day to day supervision of interns on each of the clinical attachments and meet with each intern to discuss the intern's progress and goals in their PDP at the:

- Beginning of the clinical attachment to discuss expectations and the intern's goals.
- Mid-point of the clinical attachment. Any areas for improvement that will impact on the end of clinical attachment assessment must be fed back to the intern at this time.
- End of the clinical attachment to provide feedback and complete the End of clinical attachment assessment in the intern's ePort.

Clinical supervisors need to seek feedback from those who have worked with the intern over the course of the clinical attachment including consultants, registrars and nurses amongst others.

Training for clinical supervisors

Clinical supervisors undertake relevant training in supervision and assessment as soon as practicable after commencing their supervisory role. This must be within 12 months of appointment as a clinical supervisor.

An online supervision skills course (level 1) for clinical supervisors of interns is now available to all clinical supervisors and prevocational educational supervisors from the ePort platform. This is an introductory or refresher course, to supplement training for clinical supervisors provided by DHBs and medical colleges.

The online course includes:

1. A series of three short interactive videos presented by Connect Communications, that each include self-reflective exercises:
 - Supervision styles.
 - How to give feedback.
 - The challenge of low insight and debriefing a critical incident.
2. A demonstration on how to give feedback.
3. A web-based tutorial on ePort functionality (presented by Council staff).

In addition to the level 1 online course, Connect Communications are offering DHBs and medical colleges the opportunity to provide a level 2 course. It is encouraged that clinical supervisors liaise with their DHB to find out what supervision training is available to them.

Training for supervisors can be provided by medical colleges for their vocational training programmes, or training provided by medical schools for supervision of medical students in clinical settings. Training providers are responsible for monitoring and ensuring all clinical supervisors have had appropriate training (please refer to the [Accreditation standards for training providers](#)).

⁸ In assessing good standing, Council staff check for: any fitness to practise issues; a current complaint or concern being investigated (an appointment will not be made until the outcome is known); or any adverse decisions in the Health Practitioners Disciplinary Tribunal. Council recognises that there are situations where the only suitable doctor may not meet the criteria for appointment. In rare cases, Council's Registrar might consider an appointment notwithstanding such a concern or Tribunal finding. In these instances the Registrar will take into consideration whether the:

- situation was an isolated lapse in a usually competent standard
- doctor's name was removed from the register, or had conditions put on his or her practice
- the extent to which the circumstances are relevant to the position the doctor is being considered for.

Refer to the [Guide for clinical supervisors](#) for further information about the clinical supervisor's role and responsibilities.

Professional development plan (PDP)

Interns must record goals in the PDP section of ePort over the course of PGY1 and PGY2. The PDP is a short planning document that the intern in collaboration with their prevocational educational supervisor, with input from each of the clinical supervisors.

The goals in the PDP will focus on what the intern needs to learn, needs to consolidate and wants to learn on clinical attachments and through the formal education programme. It helps structure and focus learning, strengthen existing skills, and develop new ones.

Each intern should set at least three, and up to a maximum of eight, goals for each clinical attachment. The goals set should cover more than one domain⁹ from the NZCF. The goals should be focused on the current clinical attachment, however some may be longer term.

Interns must create goals based on the 'areas to focus on for further development' if these have been identified on a previous clinical attachment as needing attention. If an intern receives an end of clinical attachment assessment rated 'conditional', then all of the 'areas for further development' that have been identified by the clinical supervisor will need to be addressed on the clinical attachment immediately following. Once satisfied, the goals need to be marked as complete by the intern, and the prevocational educational supervisor must sign these off.

The training provider must facilitate training for PGY1s on goal setting in the PDP within the first month of the intern training programme. Refer to the Intern requirements for Prevocational Medical Training for further information.

Creation of the PDP

At the start of PGY1, the prevocational educational supervisor will need to meet with each intern they are supervising to assist them in developing overarching goals in their PDP. The PDP should be developed taking into account the intern's prior learning and their mix of clinical attachments. For New Zealand and Australian graduates this prior learning will relate to their experience during medical school, particularly their final year at medical school. For NZREX doctors prior learning may include discussions about their previous medical experience overseas.

The PDP will focus on what the intern needs to learn, what they need to consolidate, and what they want to learn which may relate to future vocational aspirations. Throughout the year (after each clinical attachment), the prevocational educational supervisor will review each intern's PDP to monitor their progress and address any issues if concerns are raised. Exemplars of goals are available in ePort.

⁹ The NZCF is split into five domains:

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

Role of the clinical supervisor in reviewing and updating the PDP

Beginning of clinical attachment

At the beginning of each clinical attachment the clinical supervisor and the intern will meet to review the intern's ePort including the PDP. To assist the intern develop and record goals in their PDP specific to the clinical attachment, they should discuss:

- the learning opportunities available on the clinical attachment
- NZCF learning outcomes which can generally be attained on the attachment
- any prior learning.

Mid-attachment

Midway through the clinical attachment, the intern will meet with their clinical supervisor to gain formal feedback on their progress and performance and review and update the PDP. This meeting is extremely important and the clinical supervisor should identify areas for the intern to focus on for improvement for the remainder of the attachment. These areas for improvement should be recorded as goals in the PDP and the clinical supervisor will record comments in the intern's PDP.

End of clinical attachment assessment

At the end of the clinical attachment the clinical supervisor and intern will meet to:

- discuss the intern's overall performance on the clinical attachment
- review and update the PDP
- complete the end of clinical attachment assessment.

Ideally, there should be 'no surprises' as any ongoing areas for further development for this attachment should have been discussed at the mid-attachment meeting or during the remainder of the attachment. Prior to the meeting the clinical supervisor should consult with members of the healthcare team for feedback on the intern's performance. As part of the end of clinical attachment assessment form the clinical supervisor must identify three strengths and three areas to focus on for further development. The intern can record comments and sign off the assessment which then goes to the prevocational educational supervisor for comments and sign off.

The new model of assessment works under the assumption that everyone can improve and is therefore based around identification of 'areas to focus on for further development'. These areas to focus on inform the PDP that has strong parallels with many CPD programmes for vocationally registered doctors. It has a more natural fit with workplace learning and preparation for lifelong CPD. It also moves towards assessment for learning, rather than assessment of learning.

The clinical supervisor must make an overall summative assessment of the intern's performance using all the information available to them. A guidance document – *Guide for Clinical Supervisors – Deciding outcomes of clinical attachments* is available in ePort.

If the outcome of the assessment is 'conditional' or 'unsatisfactory' the intern's clinical supervisor must discuss with the intern the 'areas to focus on for further development' and record these in the assessment. This should also be discussed with you.

Clinical supervisors are encouraged to complete this section for all interns. Where they have given a 'conditional' or 'unsatisfactory' outcome 'areas to focus on for further development' must be identified and recorded.

The intern will need to evaluate and refine their PDP following each clinical attachment. This will encourage ongoing further development with each clinical attachment building on the learning and identified gaps from the last clinical attachment.

Development and endorsement of the PDP for PGY2

Towards the end of PGY1 the prevocational educational supervisors should meet with their interns to discuss and develop a PDP for PGY2.

A PDP needs to be approved at the time the intern applies for registration in a general scope of practice.

The goals in the PDP should be targeted around the following:

- outstanding learning outcomes from the NZCF that have not been completed in PGY1
- learning outcomes from the NZCF that are stipulated for PGY2
- areas for further development identified on previous clinical attachments
- community based experience
- vocational aspirations.

The advisory panel will hold the responsibility for endorsing the PDP as appropriate for PGY2 when they make the overall assessment of the intern's performance and whether to recommend a general scope of practice.

The advisory panel will need to assure themselves that the goals set for PGY2 are appropriate. PGY2s will have an endorsement on their practising certificate which states that they are required to work in accredited clinical attachments and to maintain a professional development plan.

Advisory panel to recommend registration in a general scope of practice

Role of the advisory panel

The role of the advisory panel is to assess each PGY1's (interns who hold a provisional general scope of practice) overall performance and decide whether they have met the required standard to be registered in a general scope of practice and proceed to the next stage of training.

This assessment takes place at the end of PGY1 (between week 6 and 10 of quarter 4) when it is anticipated that the intern will satisfactorily complete four clinical attachments.

The use of an advisory panel adds further robustness to the assessment of interns and will ensure that prevocational educational supervisors are better supported, and not placed in the role of advocate and judge.

The advisory panel will make a recommendation to Council, who as regulator is the decision maker.

Composition of advisory panel

The panel will comprise of the following four members:

- a CMO or CMO delegate who will Chair the panel
- the intern's own prevocational educational supervisor
- a second prevocational educational supervisor
- a lay person (the lay person must not be a registered health professional, nor should they be an employee of any DHB or training provider).

The advisory panel assesses and makes its recommendations to Council in ePort. Please refer to the [Advisory Panel Guide & ePort guide for Advisory Panel members](#) for further information.

PGY2 – interns registered in a general scope of practice

Requirements for PGY2

An endorsement is placed on the practising certificates of PGY2 interns, reflecting the imposition of programme requirements under section 40 of the HPCAA. These requirements are that:

- Interns must complete four Council-accredited clinical attachments. All accredited clinical attachments will span for 13-weeks¹⁰.
- Interns must continue to set goals in the PDP and work towards achieving these goals.

During PGY2, interns must continue to record and show progress in attaining the remaining learning outcomes in the NZCF. To be considered sufficient, interns should record the attainment of at least 95% (354) of the learning outcomes by the end of PGY2.

There is flexibility in the amount of time an intern needs to complete in each clinical attachment, depending on the intern's individual circumstances. While ideally the PGY2 should complete a minimum of 10 weeks, the prevocational educational supervisor has the discretion and responsibility for determining whether an intern has satisfactorily met the learning of the attachment and where concerns exist, may escalate and discuss this with the Advisory Panel, Director of Clinical Training or the CMO. Prevocational educational supervisors can also contact Council for advice. Factors to be taken into consideration are the duration of, and reasons for leave, the intern's progress in meeting the prevocational requirements, previous end of clinical attachment assessments and feedback from supervisors. For example if leave taken was in relation to medical education then this might be appropriate.

Flexibility in meeting the PGY2 requirements

An intern may take time out from practice in New Zealand during PGY2 and their training will pause. On return to practice the intern will need to continue working towards the prevocational medical training requirements for PGY2. For example if an intern takes leave for a full clinical attachment they will need to complete an additional clinical attachment to meet the time requirements for PGY2.

Please refer to [Prevocational Medical Training Requirements for PGY2](#).

Working overseas in PGY2

It may be possible for an intern who wishes to practise overseas during PGY2 to have the time practised overseas counted towards their PGY2 requirements. Interns wishing to do so must create a goal outlining their intentions, with information about the position overseas and a proposed PDP. This information is considered either by:

- the advisory panel when they are reviewing their PGY1 progress OR
- their prevocational educational supervisor if applying part way through their PGY2 year.

The advisory panel at the end of PGY1, or prevocational educational supervisor during PGY2, may approve all or part of PGY2 requirements to be completed in Australia, the UK or Ireland subject to one of the following:

- Within Australia – a prevocational training position under the supervision of a vocationally (specialist) registered doctor in a position approved for prevocational training.
- Within the UK – a position in an approved practice setting that has been recognised by the General Medical Council (GMC) for prevocational training in the UK.
- Within Ireland – a supervised position approved by Irish Medical Council (IMC) for prevocational training.

¹⁰ Six month placements, for example a paediatrics placement, can be completed by PGY2 interns. However, the six month placement will comprise two prevocational medical training accredited clinical attachments. The clinical supervisor will need to complete the beginning, middle and end of clinical attachment meetings for both quarters.

Any PGY2 who wishes to practise overseas outside of the above specified criteria must submit an individual application for approval to Council **prior to going overseas**, which will be considered on a case by case basis. Refer to [Application for pre-approval of all or part of the PGY2 year to be completed overseas](#)

Vocational training in PGY2

Interns may join a vocational training programme in PGY2. Interns participating in a vocational training programme will need to undertake their training in prevocational medical training accredited clinical attachments, maintain their PDP and continue to record attainment of the remaining learning outcomes from the NZCF in ePort.

This means that **all PGY2s must undertake all of the prevocational medical training requirements**. That is, PGY2s must:

- satisfactorily complete four accredited clinical attachments,
- maintain their PDP, and
- continue to record attainment of the remaining learning outcomes in NZCF.

The clinical supervisor on each accredited clinical attachment should be recording beginning, mid and end of attachment meetings in ePort. Council does not require their vocational training programme (medical college) supervisor to complete any assessments in ePort. Of course, if the college supervisor is the same person and is in fact their clinical supervisor then they should complete ePort as described above.

The important point is that their requirements for the vocational training programme are additional to the PGY2 requirements.

Locum work in PGY2

A PGY2 intern can work in a locum position if it is a complete accredited clinical attachment. This is to ensure that the locum position provides sufficient supervision, support and learning. This does not preclude an intern from providing cover outside their allocated clinical attachment as long as the cover being provided is in an accredited clinical attachment and, providing such cover does not compromise the intern's ability to perform their usual duties and it is approved by the advisory panel or prevocational educational supervisor¹¹.

Overseas locum positions will only be pre-approved as appropriate if they comprise of a complete clinical attachment and in positions described below:

1. Within Australia – a prevocational training position under the supervision of a vocationally (specialist) registered doctor in a position approved for prevocational training.
2. Within the UK – a position in an approved practice setting that has been recognised by the GMC for prevocational training in the UK.
3. Within Ireland – a supervised position approved by IMC for prevocational training.

End of PGY2 – removal of endorsement

At the end of PGY2, interns must demonstrate through the information in their ePort that they have met the prevocational training requirements for PGY2 in order to have the endorsement on their practising certificate removed. The prevocational educational supervisor may make this decision. However, if the prevocational educational supervisor has concerns about whether the intern has met the programme requirements the decision must be escalated to the CMO or delegate. If the intern has not met the PGY2 requirements then the endorsement will remain.

¹¹ In addition a PGY2 intern may complete voluntary work for up to a week without seeking approval by the advisory panel or prevocational educational supervisor. For any work longer than this, it would need to be considered by the advisory panel or prevocational educational supervisor.

If an intern disagrees with the final recommendation from the prevocational educational supervisor and/or CMO, they have the right to seek review by Council.

On satisfying the requirements, as evidenced by the removal of the endorsement, the doctor will be required to, either:

- enrol and participate in the Council approved recertification programme for doctors registered in a general scope of practice, administered by bpac^{nz}, OR
- enrol and participate in an accredited vocational training programme.

If an intern returns to practise in New Zealand after completing PGY2 overseas and is not employed by an accredited training provider, the supervision reports and progress in ePort will be reviewed by Council's Education Committee Chair or Medical Adviser.

Refer to [Application for PGY2 endorsement to be removed](#) for further information.

Additional information

Community-based attachments

By 2020 every intern will be required to complete one clinical attachment in a community-based setting over the course of the intern training programme. Council approved a staged transition working towards 100% compliance by November 2020. Training providers will need to demonstrate progress towards this goal during the transition period.

Completing a clinical attachment in a community setting will familiarise interns with the delivery of health care outside the hospital setting.

A community-based clinical attachment must meet the following criteria:

- The clinical attachment is community-focused and provides for direct contact with patients or public health services.
- The community-based clinical attachment provides opportunity for the community management of medical illness and/or mental health, which may include early detection of disease, population health, and acute and chronic care management.
- The community-based clinical attachment familiarises interns with the delivery of health care outside the hospital setting, including an understanding of the interface between primary and secondary care and the wider health care network.

Community-based clinical attachments can take place in a wide variety of settings, including but not limited to general practice and urgent care. This may include rural and regional locations, and settings that provide experience in the provision of health care to Māori.

A community-based clinical attachment should include provision for the intern to access the weekly formal education sessions delivered by the training provider. If this is not practicable, alternative arrangements for formal education need to be put in place.

The community-based clinical attachments will not usually include a hospital-based attachment, with the exception of rural hospitals that have been accredited for rural hospital vocational training and that are run predominately by doctors registered in the vocational scopes of general practice or rural hospital medicine. Prevocational educational supervisors may be involved in creating these attachments.

Refer to the [Accreditation standards for clinical attachments](#) for further information.

Informed consent

Doctors are responsible for ensuring a patient makes an informed choice and gives appropriate consent before initiating treatment. The patient must have the opportunity to consider and discuss the relevant information, including risks, with the treating doctor.

Obtaining informed consent is a skill best learned by interns observing consultants and experienced registrars in the clinical setting. The signing of a consent form is simply an end-point to an ongoing discussion.

Interns should never be placed in the position of having to manage the entire process and should refuse to take informed consent when they do not feel competent to do so. It is the responsibility of the treating doctor to obtain informed consent from a patient.

Training providers are responsible for ensuring adherence to Council's policy on obtaining informed consent.

For further information refer to *Information, choice of treatment and informed consent* and [Accreditation standards for training providers](#) (Standard 3.1.10 and the related note (vi)).

Night cover

Interns may not be rostered on nights during the first six weeks of PGY1. Interns may be rostered on nights within the first six months of registration if a doctor registered in a vocational scope of practice is available onsite for assistance.

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
- ensure the intern can document adequately the approach they have taken
- ensure that a doctor registered in a vocational scope of practice is available to call when there is no onsite supervision and they are available, approachable and supportive.

Handover

Appropriate handover is essential for training in a safe clinical environment and to ensure quality clinical care. Training providers are responsible for ensuring there are mechanisms in place for appropriate structured handovers between clinical teams and between shifts (morning, evening, nights and weekends) to promote continuity of quality care. Training providers are also responsible for ensuring that the interns' roles and responsibilities in handover are clearly explained. Handover procedures should be documented.

For further information please refer to [Good Medical Practice](#) and [Cole's Medical Practice in New Zealand](#).

Taking time out of practice

If an intern who holds registration in a Provisional General scope of practice takes time out of practice, they must complete the prevocational training requirements on their return in order to progress to a General scope of practice.

If an intern has gained registration in a General scope of practice and practises overseas for 3 years or more, then Council's [Policy on doctors returning to medical practice in New Zealand after an absence of 3 or more years working overseas](#) will apply.

If an intern takes time out of practise for 3 or more years then Council's [Policy on doctors returning to medical practice after an absence from practice for 3 or more years](#) will apply.

Developing the intern

Managing the intern well requires a significant commitment in time and energy from the prevocational educational supervisor. The prevocational educational supervisor needs to be easily contactable and readily available for the more pastoral aspects of the role. For the more structured aspects of the role, the key for prevocational educational supervisors is to ensure that the right people and processes are in place for orientation, induction, education, supervision and individualised support for the intern.

Orientation and induction

One of the many important roles of a prevocational educational supervisor is to ensure that adequate orientation and induction for interns occurs on commencement of employment. Starting as an intern can be very stressful involving grappling with the complexities of clinical care and the newly acquired responsibilities as a doctor. Complicating this can be the difficulty of not knowing the layout of the new training provider and services, inability to access patient management systems and pathology results, and coping with the new pager systems.

Orientation is considered by Council to be an introduction to and an overview of medical practice in New Zealand. This is especially important for Australian graduates and NZREX doctors. Induction on the other hand is considered to provide familiarisation of the systems and processes within the worksite - both the training provider as a whole and the individual service departments.

It is important that any interns who commence part way through the year complete a structured orientation and induction programme.

Organisational wide induction programmes

Orientation must occur prior to the intern's commencing practice. It may be over three to five days depending on the numbers of interns and the size and complexity of the training provider. Feedback from interns shows they find the following important to be included in the induction programme:

- the cardiac arrest procedure
- call out scenarios and how to deal with them (pain relief, shortness of breath, chest pain)
- when to call intensive care
- who to call for help
- CPR training requirements
- death certification
- computer training for pathology results and patient management systems
- the requirements for a general scope of practice
- human resource issues – for example, leave and pay
- prescribing safely and optimally (interns need to adhere to Council's statement [*Providing Care to Yourself and to those Close to You*](#))
- the frequency and content of teaching programmes
- informed consent guidelines.

Other aspects of induction which SMOs and management recommend:

- a session on 'looking after yourself'
- introduction to the Council assessment process
- roles, responsibilities and accountabilities for prevocational educational supervisors
- introduction to key people involved with PGY1 and PGY2 education and administration
- importance of good documentation
- the role of the multi-disciplinary team a tour of the training provider and library facilities.

Note: As part of the organisational induction, allocating a morning for interns to visit the ward on which they are due to start has proved very popular. This allows an opportunity to meet with the exiting intern(s)

and members of the medical team and to receive a hand-over of the patients. It also allows an opportunity to meet with the nursing staff and members of the multi-disciplinary team. Organising a social event with the outgoing PGY1s and senior staff has also proved popular. For those commencing employment during the year, a video could be made with key information on topics as outlined above.

Clinical attachment specific induction

Clinical attachment specific induction throughout the year remains the responsibility of the respective departments in each training provider. The responsibility of the prevocational educational supervisor in this situation is to ensure that induction in each department occurs at the start of each attachment.

Meetings with interns

Prevocational educational supervisors are encouraged to formally meet with interns after each attachment to discuss their end of clinical attachment assessment. Generally allow 15 minutes for each intern. If the intern has received a satisfactory report and is doing well without problems, this will usually be sufficient time. If there are problems then a further appointment for a longer period of time to discuss the issues in more detail is recommended. The e-portfolio should be used to record progress.

Providing feedback

Feedback is a valuable tool in the teaching process and has been found to be a very powerful way to improve competence. Constructive feedback should increase self-awareness, identify areas for improvement, offer options and encourage skill development. Destructive feedback refers to feedback given in an unskilled way that leaves the intern simply feeling bad with seemingly nothing on which to build, and should be avoided.

Feedback tips

- Positive feedback can be effective when given in the presence of peers or patients. Constructive feedback should be given in a private and undisturbed setting. Allow adequate time and minimise distractions when giving feedback.
- Feedback on performance should be a frequent feature of a relationship with an intern. The aim should be to give feedback informally every day during interaction with interns.
- Allow the intern to begin with a self-assessment.
- Assess whether there is conscious or unconscious incompetence in areas of concern; this will affect your approach to feedback.
- Seek feedback from other colleagues, which may be helpful with your own observations, particularly the clinical supervisor.
- Feedback should be given promptly unless the intern is not in a receptive frame of mind.
- Be specific and descriptive. Vague and generalised praise or criticism is difficult to act upon. Be specific and the intern will know what to do.
- Begin by emphasising the positive. Interns need encouragement, to be told when they are doing something well. If the positive is registered first, any negative is more likely to be listened to, and acted on.
- Provide constructive feedback as to how something could have been done differently.
- Refer only to behaviour which can be changed. It is not likely to be helpful to give an intern feedback about something over which they have no control.
- Interns should be given the chance to comment on the fairness of the feedback and to provide explanations for their performance. A feedback session should be a dialogue.
- Finish by stating your confidence in the intern to be able make the changes you have both agreed to, reinforcing the positive behaviours you have commented on already
- Discussions should be documented. Send your intern a copy to act as a reminder about what you covered for them to reflect on.

Skills training

A clinical skills programme is seen as being critical to providing high quality care for patients and minimising the risk of interventional procedures. Skills training where possible should be learnt during clinical attachments in a supervised setting. Recognising the variability in skills training however, skills laboratories have been established in many training providers where skills can be learned, practised and assessed in a controlled environment. Although not the same as dealing with real patients, skills laboratories are a valuable teaching resource. To achieve consistently high levels of clinical expertise, each clinical skill or procedure should be standardised in accordance with international best practice, and taught in the same manner to all clinical staff. Setting time aside for interns to attend skills laboratories is supported by Council. E-learning and simulation courses are also recognised as important teaching and learning resources. Smaller centres may benefit from sharing such learning resources from bigger training providers.

Advanced cardiac life support

All interns must certify in basic and advanced life support to the equivalent of level seven of the New Zealand Resuscitation Council (NZRC) guidelines before applying for registration in a general scope of practice. If the intern holds the CORE Advanced certification that is more than 12 months old at the time of applying for registration in a general scope of practice they must either re-sit the full course or do a shorter refresher course.

If an intern indicates or demonstrates a lack of confidence or competence during the refresher course they must complete the full training at the standard of NZRC CORE ADVANCED. The advisory panel will require confirmation of certification to inform their recommendation for registration in a general scope of practice.

The role of the prevocational educational supervisor should be to ensure that this is taking place.

Stream-lining training provider systems to help the intern

All training providers should have mechanisms to enable interns to deal with time and work pressures.

Examples of this include:

- systems to prioritise call urgency on the locator system
- systems available on the ward whereby the most senior nurse screens requests for interns
- wards being encouraged to keep lists of jobs so that calls to interns are kept to a minimum
- reviews undertaken to assess the demands placed on interns by other training provider staff
- provision of training to interns on time management and organisational skills, and teaching of relaxation methods.

Stress and time management of interns

Prevocational educational supervisors have an important role in these areas. Reduction of stress and good time management can be achieved by:

- providing sessions on 'looking after yourself' included in orientation and the formal teaching programme
- providing sessions on time management included in orientation and the formal teaching programme
- providing information on managing stress being included in the orientation information pack
- ensuring free counselling services are readily available
- interns being encouraged to have their own general practitioner; a list of local general practitioners should be provided at orientation
- a ratio of up to 1:10 to provide pastoral care
- ensuring that the training provider has sufficient relievers to cover annual leave requests for interns.

Professional support

There should be well publicised, confidential and accessible networks available for providing interns with professional support and resolving disputes. Examples of this include (but are not limited to):

- employee assistance programmes available to all staff and advertised all around the training provider. This is a free, confidential service and there are posters on notice boards all around the hospital
- a harassment policy in place at the training provider which interns are aware of. Interns are conversant with avenues to explore should they require further information/assistance
- mechanisms in place for supporting interns dealing with patient death, a colleague's suicide, appearing before a coroner.

Dealing with complaints about interns

It can be very stressful for an intern to receive a complaint about them from another staff member or a patient. The prevocational educational supervisor should ensure:

- the *Code of Patient's Rights* are discussed with the intern
- if a complaint is made, the correct processes within the training provider are followed for incident reporting and patient complaints
- interns are provided with sessions on both the internal complaints processes and advocacy service procedures when a patient complaint is received or for issues relating to other staff should be included in the intern education programme.

Detecting and helping the underperforming intern

Introduction

Underperformance by an intern is often a difficult task for the prevocational educational supervisor to manage, and occurs often enough that it is important that the supervisor should know how to deal with the situation. Underperformance can be caused by many factors. There is a strong association with underperformance in the early years and ongoing poor performance in the later years of the doctor's career; therefore there is good reason for detecting underperformance in interns and attempting to remediate it as early as possible to protect the doctor as well as their patients.

The purpose of this part of the guide is to explore factors leading to underperformance, how underperformance can be identified, and once identified, how it can be dealt with effectively to help the intern perform better. This guide should be used in conjunction with local training provider policies on disruptive behaviour or poorly performing staff.

Symptoms of the intern in difficulty

These can be varied and include:

- anger
- rigidity
- absenteeism
- increased sick leave
- failure to answer pager
- poor time keeping
- poor personal organisation
- change of physical appearance
- lack of insight, clinical mistakes
- failing assessments
- rudeness, bullying
- poor teamwork/being uninvolved
- undermining colleagues
- defensive reaction to feedback
- verbal or physical aggression
- erratic or volatile behaviour.

Who detects underperforming interns?

Often it is not the prevocational educational supervisor who identifies underperformance. In fact underperformance is often detected by:

- **Charge nurses or senior nursing staff** - They see interns daily or even hourly, and usually have had a long and thorough experience in the environment where interns work.
- **Registrars** - These are the people to whom the intern normally reports. They will usually have a clear idea of the level of behaviour expected.
- **Other interns** - These may occasionally be a source. It is a big step for an intern to make potentially adverse comment about one of their colleagues.
- **Clinical supervisors** - Are less often the source of comment. They do not always see interns as frequently as they used to. The corollary is that asking a consultant to verify an underperforming intern may elicit a comment that no concerns have been identified.
- **RMO Unit/HR staff** - Often family, monetary or other stresses may be picked up by the RMO unit staff, who may notice absences, excessive additional duties etc.

Regardless of who identifies an underperforming intern, all members of staff should be aware of the benefits of addressing these issues early. There should be clear mechanisms to report these concerns to the prevocational educational supervisor or in their absence to the CMO or delegate.

Role of the prevocational educational supervisor in addressing poor performance

Prevocational educational supervisors should be the first point of contact when concerns of underperformance have been identified. They play an integral role in determining why underperformance is occurring, and in determining how the intern can be aided. Accordingly, prevocational educational supervisors should:

- be able to recognise the symptoms of underperformance
- have a basic understanding of human resource management and employment assistance available
- be able to empathise with an underperforming intern and offer career advice, and referral for support and counselling where necessary
- understand when the Medical Council should be contacted and Medical Council processes
- the prevocational educational supervisor also needs to develop and maintain good avenues of communication with nursing staff, RMO unit and other RMOs including interns.

Factors leading to underperformance

Understanding the context of an intern's personal and work life may help direct the support and referrals that need to be instituted by the prevocational educational supervisor. These include:

- **Training environment** - mismatch between trainer and trainee, inadequate orientation, excessive workload, harassment, bullying, wrong level of expertise expected, lack of knowledge, inadequate equipment or tools, lack of supervision.
- **Personal issues** – mental and physical health, alcohol and drug abuse, emotional difficulties, family stresses, wrong career path.
- **Craft development** - problems with procedures, manual dexterity, depth of understanding & clinical decision-making.
- **Generic professional development**- rapport, respect, cultural acclimatisation, teamwork, motivation, maturity, insight, personal or time organisation.
- **Professional behaviours** - integrity, probity, substance abuse.

It is also useful to consider whether:

- The intern has been underperforming from the outset. This may indicate that other external problems are impacting on the intern's performance, for example health issues, family stress or for NZREX interns, adjustment to the New Zealand health system.
- The intern has initially performed well and then suddenly or gradually deteriorates. Some common reasons for the intern's decline in performance include:
 - Fatigue and or illnesses. The most common illnesses are depression, stress/burnout and alcohol or substance abuse. Fatigue is included here because its management is similar to that for physical illness.
 - Recognition of a wrong career choice. Interns may go through this phase but usually it is temporary. The important determination is how profound the dissatisfaction with medicine as a career choice is, and how much it influences performance.
 - A traumatic clinical event. This is a common scenario for interns. Interns may assume far more responsibility than is reasonable in cases where the outcome is a death or serious complication. ("If only I had done a urinalysis?") Some traumatic clinical events are devastating: for example, the death of a child, the first cardiac arrest. Interns may worry about potential patient or family complaints or about minor decisions they have taken, etc.
 - An escalating sequence of external events. Relationship problems, money worries, illness of family members and trouble with the law are issues that cause stress.

Managing the underperforming intern

Employment law prescribes that all employees be treated in a fair and equitable manner in all circumstances. This includes being fully informed on matters that affect their employment, with the opportunity to have their views/opinions considered. Where an employee is considered to have performance shortcomings, all interactions and interventions pertaining to these shortcomings must be carefully managed. This should not be a punitive process, rather one which is intended to assist the intern to achieve required standards.

Having a well-established process for dealing with underperforming interns is essential. 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.

The aim of a performance development plan is to guide and support an employee with the required work standards and outputs of their designated role, to measure their progress along the way and to provide feedback to allow the employee to take corrective action.

The following considerations should be made at the beginning of any performance management process whether the issues that have arisen are minor or of a more serious nature:

1. Good documentation - records of conversations should be held confidentially with the knowledge and consent of the intern. Documentation should also be kept of informal discussions that occur outside of planned meetings. Copies should be given to the intern. If the doctor moves to another training provider and the issue is not resolved the consent of the intern should be obtained in order to set up supports in their new workplace.
2. Support for the intern - the intern should be well supported through the process and supports discussed with them. It is useful to consider the employee assistance programmes, where these are available.
3. Council recommends seeking advice from HR - this is to ensure that correct employment procedures are followed and help in putting together performance improvement plans is obtained.
4. Help from Occupational Health shall be sought as required, as they may provide support to the intern that ensures confidentiality on other issues.
5. It is important to advise the CMO or delegate about an intern who is not performing satisfactorily.

Medical Council requirements

Prevocational educational supervisors are agents appointed by Council and as such they need to keep in mind Council's primary purpose - to protect the health and safety of the public. Council does however recognise the difficult balance a prevocational educational supervisor faces when an intern is identified with performance concerns. As an agent of Council the prevocational educational supervisor must report to Council, however they may also need to advise the CMO and training providers HR department of ongoing poor performance.

When performance concerns are identified with an intern, Council requires:

- the CMO is advised and engaged throughout the process
- notification to the Council in a timely manner either in the form of the *End of Clinical Attachment Assessment* or in other written form if it is not the end of the clinical attachment
- that support is put in place to ensure public health and safety is protected.

The prevocational educational supervisor will need to be able to gauge when concerns have met a threshold for informing Council office and Council does recognise that minor issues are often best addressed in-house. If you are in doubt, Council are happy to have an informal discussion about what would be appropriate in individual cases.

With that in mind Council suggests one of the following courses of action when intern performance concerns arise. Council does emphasise that any action taken to address performance concerns, should be done in accordance with the employer's HR policies and protocols.

The informal meeting

When the prevocational educational supervisor has been notified of concerns relating to an intern, a starting point might be to arrange an informal meeting with them. If they are likely to fail or have failed their most recent clinical attachment, a formal meeting to draft a performance management plan would be a more suitable option (see below).

Minor cases should still be closely monitored, to provide a good opportunity for any performance difficulties to be addressed and remediated early. Remediation in this instance can range from merely addressing the issue with the intern, to developing solutions to address underperformance.

The prevocational educational supervisor should create a relaxed and positive atmosphere with appropriate 'protected bleep free time' for all. The prevocational educational supervisor should endeavour to gain the confidence of the intern before you clearly outline the concerns as reported to you and compare this to the expected level of performance of an intern at a similar stage. The prevocational educational supervisor should discuss how the intern is currently performing and the gaps as the prevocational educational supervisor sees them.

The most important issue for the prevocational educational supervisor and the intern to explore and agree on is what the main underlying reason for the poor performance is. The prevocational educational supervisor should reassure the intern that their issues are important. The prevocational educational supervisor can use open ended questions (who, what, when, where, how, why, tell me ...) in order to fully understand the intern's position.

The prevocational educational supervisor needs to notify the intern that if they feel the issues are not going to be adequately addressed in this meeting, there may need to be a formal meeting with other members of staff and that a performance development plan may need to be considered.

The formal meeting

If the prevocational educational supervisor feels the issues discussed at an informal meeting have not been addressed sufficiently or when an intern is failing or about to fail a clinical attachment, the formal meeting would be an appropriate course of action. Some general guidelines are provided below, but it is very likely that the employer has set requirements for this process and the prevocational educational supervisor will be required to inform themselves of these, and adhere to them.

Before the meeting

- The intern should be invited to a meeting, notified of the reason and offered the opportunity to bring someone as a support.
- The prevocational educational supervisor should ensure that they have all relevant documentation prepared for the meeting. This may include speaking to other key personnel about any concerns they may have noticed, to getting some advice from HR/Occupational Health on a confidential basis. A good understanding of the concern, the symptoms, and environment is needed. Comprehensive documentation of any investigation or discussion should be taken, and copies given to the intern for their reference. Managing the serious case of underperformance requires well informed judgement and all relevant information should be taken into account before any action is taken. This may include referral on health matters, referral to an employee assistance programme on matters causing stress, and so on.
- The prevocational educational supervisor should prepare a checklist of the important points to discuss.
- The prevocational educational supervisor can consider which other people should attend this meeting. An HR representative should be present. It may also be appropriate to include the clinical supervisor.

During the meeting

- The prevocational educational supervisor should explain that the purpose of the meeting is to assist the intern to improve their performance.
- The meeting should try and identify the problem and the area/category that the poor performance falls into for example, educational, health, and so on.

Developing a performance management plan

- The prevocational educational supervisor should discuss actions that are needed to raise the intern's performance standard - which may include inputs of training, coaching, mentoring and counselling. The plan for improvement should include some clear measurable outcomes, for example, skills (IV lines) or performance (scripts not requiring correction). Think about how other areas of the training provider can help, for example, pharmacists, skills lab, and so on.
- If there are concerns about patient safety because of an intern's performance this needs to be clearly acknowledged and reflected in the plan for improvement. It is likely in such cases that there will need to be restrictions on an intern's duties, for example, prescriptions may need to be counter signed, after hours duties may need to be withdrawn depending on the level of supervision that exists in the training provider. A 'buddying' system may also be necessary.
- In a serious case (if patient safety is an issue) then the prevocational educational supervisor may need to step the intern down after consulting with their team, HR and CMO. The intern will need to be buddied/restricted in their duties until the issues raised are addressed. Such measures may seriously disrupt intern work patterns but patient safety must be paramount.

After the meeting

- Points discussed and resulting actions should be documented and copies given to the intern. Any performance improvement plans should be developed with HR input and agreed by the intern and the prevocational educational supervisor. Any actions that require intervention by the intern's medical or surgical team will need to be discussed with the intern's permission.
- A performance improvement plan may include:
 - a period of ongoing review, for example, three months
 - regular meeting dates with the prevocational educational supervisor to discuss progress against the action points (typically every 2 weeks)
 - ongoing meetings will be against an agenda which states the areas where improvement is required
 - documentation of the ongoing process and progress must be made
 - likely outcomes should performance not improve.
- At the end of the review period (or earlier if appropriate), the judgement will be made as to whether the intern has reached the required standard. If so, the process ends. If not, judgement is made regarding the ongoing shortcomings and what is the appropriate action to take, for example, continuing the improvement plan with further inputs.
- It may be appropriate to move into the disciplinary process when performance has not reached the required standards, despite the performance management process having been applied. All employers should have a well-defined process for disciplinary action which should be followed. HR assistance should be sought early.

Competence referrals to Council

When an employer feels that public health and safety may be compromised by the performance of an intern, they may consider referring the matter to Council for consideration of a competence review. Please note, this is usually a separate process to submitting unsatisfactory supervision reports, but it can be done in tandem if you specifically request it.

Referring an intern for consideration of a competence review would usually be done in extreme circumstances so it may be useful to have a neighbouring training provider assess the intern initially so that the intern can feel they have an independent viewpoint and are not under the gaze of their peers.

If you are aware that an intern is resigning from their position in order to avoid performance management processes that may adversely affect them, you will need to notify Council of this immediately.

Intern health

Introduction

Interns are vulnerable to the same physical and psychological disorders as the rest of the community. The PGY1 year presents interns with a new set of challenges and pressures. In addition to the stresses and hazards of working long hours in a busy and often new environment, there is the increased responsibility interns have while they make the transition to a practising doctor.

Prevocational educational supervisors and training providers face challenges too. In particular:

- creating a positive and supportive work environment that is conducive to learning and the acquisition of skills, which is critical to the successful training of healthy and competent doctors
- promoting interns' health and wellbeing during this key learning year, to help establish a platform that will support them throughout their practising lives. This is not only important for individuals and their families, but it is vital for the provision of quality health care.

Training providers will already be using a range of strategies to meet these challenges, such as those set out below.

Promotion of mental health and wellbeing

Prevocational educational supervisors have a role in normalising:

- the seeking of help by interns
- an intern's right to be a patient
- an intern's right to receive timely and high quality medical care free from the threat of negative consequences.

This requires prevocational educational supervisors to be trained to adequately respond to mental health and stress-related problems among interns. Stress-related problems have been defined as the physical, emotional and mental strain which results from a three-way relationship between demands on a person, that person's response to those demands, and their ability to cope with those demands.¹² This definition captures the essence of stress in medical practice as being a dynamic process that changes in quality and quantity in response to internal and external factors.¹³

During orientation, the following can be covered:

- assisting interns in preparing for the expectations required of them when they work in their various clinical attachments
- encouraging interns to make the most of supervision from senior medical staff
- promoting awareness of any occupational health services available in your training provider and how to access them
- giving interns information about any confidential Employee Assistance Programme service your organisation has, what the EAP provides, and how it can be accessed so that confidentiality is preserved.

Training should incorporate:

- discussion on stress management and healthy lifestyles as part of being a doctor. The opportunity for interns to discuss the stresses they experience, and strategies for dealing with those stresses are an important component of such training. This training should also include:
 - the importance of having a general practitioner
 - stress related to role transition and increasing levels of responsibility

²Bynoe G. 'Stress in Women Doctors'. *British Journal of Hospital Medicine*, 51 (6): 170–173, 1994.

³Stress and General Practice. Royal College of General Practitioners Information Sheet No 22

- why it is generally unwise for doctors to self assess and self prescribe (Council’s *Statement on providing care to yourself and those close to you* is a useful resource, along with any policies you have in your organisation has about using training provider or practice prescription forms, and drugs and medicines). It should be noted that the limitation on an intern’s scope of practice means they are not permitted to prescribe for themselves, or for anyone who is not under their care in their designated clinical attachment
- the ability to recognise, acknowledge, and deal with mental health and stress-related problems
- the risk of substance abuse
- the importance of developing and maintaining interests outside medicine
- recognition of healthy lifestyle practices such as the need for adequate exercise and nutrition
- the importance of regular holidays
- maintaining contact with peer medical groups for professional and social support
- communication and conflict resolution skills, to help interns deal with the range of roles they will encounter in their professional career, with the aim of enhancing relationships with patients and colleagues of all disciplines.

Early detection and intervention

Council’s experience is that effective early intervention usually enables doctors with a treatable illness to keep practising while receiving treatment. Key points to note are:

- it is vital that mental health and stress-related problems are identified and treated at the earliest opportunity
- interns, like other doctors, are at risk of not having a problem recognised through denial or concealment, self diagnosis and treatment, or the reluctance of colleagues to suggest a peer may be unwell
- promotion of open and honest discussion about mental health, and other health issues, and treatment, can assist interns to seek assistance when necessary
- interns need to be assured that seeking help will not jeopardise their career prospects.

Education programmes can lay the foundation for a number of issues that will support interns through PGY1, and beyond. These include:

- identifying the social and psychological factors that can lead to stress-related problems, highlighting the importance of recognition of early warning signs, and the value of early intervention
- raising the issue of stigma and discrimination in relation to mental health problems (psychiatry should be promoted as a discipline possessing effective tools for the treatment of mental health problems)
- emphasising that interns have a responsibility to monitor their own emotions and behaviour and to seek help if they suspect mental health or stress-related problems
- raising awareness about the role every doctor has in ‘looking out for colleagues, especially their peers’, and supporting and assisting them to seek referral and treatment if required.

Management and intervention

Key points here include:

- the need to develop procedures that ensure the confidentiality of all matters related to interns’ health, with open discussion on any limitations arising from the organisations clinical governance process
- the need to encourage interns who have problems to receive treatment and regular monitoring by a suitable health practitioner (wherever practicable, services provided should not be associated with their employment)
- being open when interns need to secure ‘reasonable’ time to attend health-related appointments.

External sources of support for interns

1. Resident Doctors Association
2. The Medical Protection Society and Medical Assurance Society (MPS/MAS) offer a confidential free support service. Those who wish to access counselling support can ring the MPS 0800 number – 0800 Call MPS (0800 22 55 677) at any time. MPS/MAS give an assurance that all calls to this number are kept in the strictest confidence. Calls are answered by a medical doctor who will liaise with EAP Services – the independent professional counselling service MPS/MAS have contracted to assist in this endeavour – and set up an appointment. The number can also be used for general information about the service.
3. The Doctors' Health Advisory Service assists doctors and their families with personal and health problems. People who wish to know more about DHAS, or who have a problem with which they need advice, can freephone 0800-471-2654, fax (04) 499-3239 or write to DHAS, PO Box 812, Wellington or email: dhas@clear.net.nz website: www.doctorshealth.co.nz
4. Interns with a hearing disability may welcome direction to the Association of Medical Professionals with Hearing Losses (AMPHL). This was set up to address issues surrounding hearing loss that arise for a variety of healthcare professionals. The Website address is www.AMPHL.org.

The Medical Council's role

Interns' fitness to practise

When TI's first apply for registration within a provisional general scope of practise they must declare if they have ever been, or are currently, affected by a physical or mental condition or impairment that could affect their capacity to practise. Also the Deans of the medical schools must advise the Council if anyone completing a course would not be able to practise safely.

TI's must provide information about any disclosures made, with access to treatment providers, to inform Council's consideration of their fitness to practise. Depending on the circumstances, Council might decide to obtain independent advice. This could apply if the condition is ongoing, a remitting or relapsing one, if there has been recent treatment or if the TI has not been well engaged in treatment or with a relapse management plan.

If the TI has a transmissible major viral infection, or if there is to be any ongoing monitoring, Council will advise the prevocational educational supervisor of the situation.

The TI will be asked to inform their prevocational educational supervisor if they:

- have certain physical conditions or disabilities, for example they have a hearing or visual disability, have had a head injury, or are recovering from a serious physical illness
- have had treatment for certain conditions that may become an issue when they step up to a new level of responsibility, even if the Council may not intend to have any monitoring in place. Examples would be significant depressive illnesses, stress-related problems, and anxiety and so forth. These TI's are usually asked to arrange to have a general practitioner if they don't already have one, or if they are moving to a new area, and to have a low threshold for seeking help if any symptoms recur.

When to involve the Medical Council when there are health concerns about practising interns

It needs to be acknowledged that an intern seeking health care is not necessarily impaired. Many problems arising can be dealt with by the prevocational educational supervisor. Examples include having a discussion with the intern and asking them to see a relevant health care provider, getting an assurance that any problems are being managed, and if necessary, asking to have that assurance from their treating doctor. Within the training provider setting, referral to the occupational health service is another option. Often some extra support (or mentoring) is all that is needed.

Under the HPCAA, doctors must notify the Council if, because of a mental or physical condition, a doctor, or any other registered health professional, is unable to perform the functions required for the practice of medicine. Those functions include:

- making safe judgments
- demonstrating the level of skill and knowledge required for safe practice
- behaving appropriately
- not risking infecting patients with whom the doctor comes in contact
- not acting in ways that impact adversely on patient safety.

Other inquiries that can help determine whether the threshold for notification is reached include:

- is any condition likely to be short lived, respond quickly to treatment with a full recovery? Can any consequent risks to patients be managed during treatment and recovery, for example with sick leave or modified hours or duties?
- is any behaviour or conduct a one-off incident, or is there a pattern emerging that may be attributable to an illness process?
- is any behaviour or conduct causing concern likely to be due to personality disorder or dysfunction? Should these be managed through the usual HR processes?
- is any suspected condition, or consequent behaviour and conduct, actually impacting on the intern's practice? Is it likely to if the condition progresses?
- have any local interventions failed?
- is there a risk to the intern themselves? How big is that risk, and how serious are the consequences?

The HPCAA notes that a 'mental or physical condition means any mental or physical condition or impairment, and includes, without limitation, a condition or impairment caused by alcohol or drug abuse'. This supports a lower threshold for referral than that of alcohol or drug dependence.

If the threshold for notifying is reached and no notification is made, this could be seen to be a breach of professional obligation, and give rise to disciplinary proceedings. A key threshold is that of 'reasonable belief', and once anyone has a reasonable belief the obligation to notify takes effect. Supporting the obligation to notify, the legislation provides protection for the person notifying. S 45, which deals with mandatory notifications, states under ss (6) that '*No civil or disciplinary proceedings lie against any person in respect of a notice given under this section by that person, unless the person has acted in bad faith*'.

If a concern is raised or referred to the Council, this doesn't need to interfere with any of the usual HR, clinical governance, or occupation health processes, which can run simultaneously.

Notification to the Council should also be considered if the prevocational educational supervisor or other colleagues are not satisfied that a health problem is being addressed, and that it has the capacity to affect the intern's practice.

Can the prevocational educational supervisor discuss any concerns with the Council before making a notification?

A conversation is usually helpful, even if it needs to be hypothetical initially. Options for managing an issue can be discussed, along with the threshold for referral to the Council. You can speak to one of Council's Health Case Managers or to the Health Manager by phoning the Council's 0800 number, 0800 286 801.

The Health Case Manager can also discuss with you the scope of any report you might need to make, and how that should be submitted.

What other external advice can prevocational educational supervisors get?

Anyone considering making a notice is entitled to seek medical advice to assist them in forming an opinion, for example through occupational health or treating doctors. Any formal notice to the Council made subsequently must state whether such advice has been obtained.

Council accreditation of training providers

The Education Committee (the Committee) on behalf of Council is required to accredit and monitor training providers for the purpose of providing prevocational medical education. Council accredits training providers every three years; however prevocational educational supervisors can contact the Council office in the interim if there are concerns which may warrant a Council visit.

The accreditation process includes a visit to the training provider, the purpose of this visit is to ensure the education, training, supervision and facilities available for interns at the training provider meet Council's standards. The Committee has found that external reviewers are usually very successful in influencing positive changes in clinical teams and support services.

As part of the documentation that is prepared for the visit, Council staff will also request a report directly from the prevocational educational supervisors. This report provides a good opportunity for the prevocational educational supervisor to feedback to Council about any aspect of intern training at their training provider. The written documentation supplied before the visit is important, but the most valuable information comes from the opportunity to meet with:

- interns
- the prevocational educational supervisor(s)
- Director(s) of Clinical Training (if applicable)
- CMO
- clinical supervisors
- CEO
- RMO unit staff
- chair of the advisory panel (if not already listed)
- other individuals and groups who have responsibility for training programme management, management of clinical attachments, medical education.

The meeting with the interns is to allow candid feedback to the accreditation team. Council recognises that interns may feel vulnerable when providing feedback on their supervisors, however, viewpoints and information must be passed on if they are to lead change. The accreditation team are also careful to ensure that any feedback given represents a consensus of views, not those of a single person. It is the overall systems and processes that are being assessed.

Council asks prevocational educational supervisors to inform interns about upcoming visits to their training provider in order to improve attendance at the private group meeting and to give interns time to gather their thoughts and concerns. A link to an anonymous survey is sent to interns by Council staff ahead of the site visit.

Council publishes finalised accreditation reports on its website [here](#).

The focus of the accreditation team will include:

- assessing the training provider's self-assessment against Council's *Accreditation standards for training providers*
- assessing the training provider's process of quality assurance
- assessing the implementation of the training provider's policies and processes
- exploring discrepancies between what is written and what is said
- observing aspects of the accreditation standards to judge their robustness
- seeking clarification and confirmation when required
- concentrating on major rather than minor issues or technical points
- distinguishing between opinions that fairly represent the group being interviewed as a whole and those which may be views of the few.

NZREX interns

NZREX interns are subject to the same requirements as New Zealand and Australian graduates and are required to undertake prevocational training. NZREX interns are not eligible for registration under any other pathway and have sat the NZREX exam to be eligible to gain registration in New Zealand. Many of these interns come from different ethnic, cultural, language and medical backgrounds and successful integration frequently requires a high level of support.

The needs of the NZREX intern are complex. NZREX interns are a very diverse group with some at the start of their careers, and others having had many years experience in a specialised field before immigrating to New Zealand. Some may have lived in New Zealand for many years before passing NZREX, and not practised at all during that time. For these reasons close supervision is needed to identify the intern's strengths and weaknesses, to ensure public safety, and to give the doctor a supportive start to a career in New Zealand.

Employers and supervisors have reported that NZREX interns often experience difficulties in two distinct areas and Council would expect any induction/orientation to cover the following:

- New Zealand culture, for example, communication in the broadest sense, understanding of cultural issues, patient expectations and rights, informed consent, ethical principles, medico-legal framework, working in a multi-disciplinary team, especially with female team members.
- Clinical and practical skills, for example, clinical judgement, application of medical knowledge, management and assessment of common problems, problem solving and decision making skills, dealing with emergencies and acute work, clinical record keeping, documentation, prescription writing, completion of certificates, insertion and removal of intravenous lines.

It is important for employers to provide appropriate supervision and orientation to support NZREX interns to transition into medical practice in New Zealand:

- induction to New Zealand culture and clinical practice
- support and close supervision by the clinical team
- assessment and feedback by the approved supervisor
- overall assessment by the prevocational educational supervisor.

English language difficulties

For most NZREX interns English is not their first language. Registration authorities have rigorously sought reliable English language prerequisites for the NZREX clinical examination (NB. these language tests are not Council examinations). However, even with high standards of English examination, communication issues can become apparent in the clinical setting. For a small but increasing number of New Zealand graduates English is also not their first language.

If language is identified as an issue referral to an English language specialist is recommended. Language courses should take into account factors including first language, when English was first learnt, under what circumstances, by what method, what use has been made of it since first contact and other similar concerns.

Language courses should ideally concentrate on the socio-linguistic skills associated with clinical practice. If possible using a language specialist who has some knowledge of the intern's country of origin and customs can be very helpful. Video and audio recordings of clinical scenarios using actors can be very helpful with feedback.

Cultural issues

Cultural matters can be challenging. It is recommended that Australian and NZREX interns have a mentor who is familiar and sympathetic to the needs of these interns. Where possible, having someone from a similar cultural background can be helpful. The mentor may be in addition to a designated prevocational

educational supervisor. The mentoring programme will include guidance on the development of attitudes, skills and knowledge relevant to the New Zealand situation. It will also provide guidance and advice on the cultural appropriateness of care provided.

To identify in the early stages those interns experiencing difficulties in their new role, and to ensure resources are put in place, the following options could be considered:

- self-assessment questionnaire to identify areas of weakness
- clinical skills assessment and training
- English language assessment
- matching of previous clinical experience to their first attachment to facilitate integration into their new role
- comprehensive multi-disciplinary orientation
- a two week buddy system on their first attachment
- assistance with language and communication skills with a language expert.

Orientation and induction

NZREX interns often start work at different times during the PGY1 year, sometimes even halfway through the year. It is important that NZREX interns receive robust orientation and induction to the training provider and to each clinical attachment before commencing work. The orientation needs to enable NZREX interns to become familiar with the training provider and services relevant to their practice. The induction needs to provide NZREX interns with familiarisation of the systems and processes (protocols, policies etc) within the worksite - both the training provider as a whole and the individual service departments.

Glossary

Term	Explanation/Definition
6 th year medical student	<p>A medical student in the final year of medical school and where students participate in medical teams in a junior capacity.</p> <p>Also known as a trainee intern (TI).</p>
Accreditation standards for clinical attachments	<p>Clinical attachments must meet these standards in order to be accredited by Council. Interns must work in accredited clinical attachments.</p>
Accreditation standards for training providers	<p>Training providers must meet these standards in order to be accredited to train interns. Interns can only work in accredited attachments and for accredited training providers.</p>
Additional accreditation standards for community based attachments	<p>Clinical attachments which take place in the community must meet the clinical attachments standards as well as these additional standards, to be accredited by Council.</p>
Advisory Panel	<p>Advisory Panel(s) are established at each training provider to assess each PGY1's overall performance and decide whether they have met the required standard to be registered in a general scope of practice and proceed to the next stage of training.</p> <p>The use of an Advisory Panel adds further robustness to the assessment of interns. Each Advisory Panel comprises:</p> <ul style="list-style-type: none"> • a Chief Medical Officer (CMO) (or their delegate) • two prevocational educational supervisors (the intern's own and one other) • a lay person. <p>The Advisory Panel will make a recommendation to Council, who as regulator is the final decision maker.</p>
Clinical attachment	<p>A Council-accredited 13 week (14 weeks maximum) rotation worked by an intern.</p> <p>Previously referred to as a 'run'.</p>
Clinical supervisor	<p>A vocationally-registered senior medical officer named as a supervisor of interns as part of the accreditation of a clinical attachment.</p> <p>Previously referred to as a 'run supervisor'.</p>
Community-based attachment	<p>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.</p>

Continuing professional development (CPD)	Involvement in clinical audit, peer review and continuing medical education, aimed at ensuring a doctor is competent to practise medicine.
End of Clinical Attachment Assessment	The electronic form the clinical supervisor completes at the end of a clinical attachment for each PGY1. This form is stored in ePort. A PGY1 requires four satisfactory <i>End of Clinical Attachment Assessments</i> to be considered by the advisory panel who make a recommendation for registration in a general scope of practice.
ePort	An electronic record of learning for each intern to record and track the skills and knowledge acquired.
Formal education programme	The regular formal teaching sessions organised by the training provider and attended by interns. Interns must attend two thirds of these.
General scope of practice with an endorsement	When an intern is approved registration in the General scope of practice an endorsement reflecting the requirements for PGY2 is included on their practising certificate for the PGY2 year.
Intern	A PGY1 or PGY2 doctor who has graduated from an accredited New Zealand or Australian medical school or a doctor who has passed the NZREX Clinical. An intern is usually employed as a House Officer and maybe referred to as: <ul style="list-style-type: none"> • an intern • a house surgeon • a house officer • a resident medical officer (RMO).
Intern training programme	The training and education programme for PGY1 and PGY2 doctors at each training provider.
Multisource feedback (MSF)	Feedback collected from an 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.
NZCF log	A record of the learning outcomes from the NZCF that an intern has attained. Stored in ePort.
New Zealand Registration Examination (NZREX Clinical)	An examination approved by Council to assess IMGs whose primary medical qualifications render them ineligible to apply for registration without having passed the examination. This examination must be passed before IMGs enter any form of clinical practice to ensure they are competent to practise.
Postgraduate year 1 (PGY1)	For New Zealand and Australian graduates, the year following graduation from medical school and for doctors who have passed NZREX Clinical, in the provisional general year.

	PGY1 is a minimum of 12 months, however an intern remains a PGY1 until the requirements for each year are completed.
Postgraduate year 2 (PGY2)	For New Zealand and Australian graduates and NZREX Clinical doctors the year after first gaining registration in a general scope of practice. PGY2 is a minimum of 12 months, however an intern remains a PGY2 until the requirements for each year are completed.
Provisional General scope of practice	PGY1 interns work in the Provisional General scope of practice for the time it takes them to complete the requirements for PGY1.
Prevocational educational 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. Previously referred to as an 'intern supervisor'.
Prevocational medical training	The 2 years* following graduation from an Australian or New Zealand medical school or for doctors that have passed NZREX Clinical, the first 2 years* of registration in New Zealand. *Both PGY1 and PGY2 are a minimum of 12 months, however an intern remains a PGY1 or PGY2 until the requirements for each year are completed. For most interns this will be 2 years.
Intern professional development plan (PDP)	A live electronic document stored in ePort outlining the intern's high level goals and how they will be achieved.
Training provider	The organisation (DHB) accredited by the Council to deliver an intern training programme for PGY1 and PGY2 doctors.