# Guidelines for a Rural Hospitalist Term (PGY2)

## Background

The Postgraduate Medical Council of Victoria Limited (PMCV) has developed this guideline to support rural General Practices in applying the standards and requirements of the National Framework in a rural health service setting.

The PGY2 rural hospitalist terms within rural health services have been created to support the diminishing available local General Practitioners and Visiting Medical Officers medical workforce in small Rural Health services due to increased practice demands.

This guideline covers four main sections:

**Part A:** Key components of the National Framework
**Part B:** Rural Hospitalist Overview
**Part C:** Prevocational supervision of the Rural Hospitalist
**Part D:** Term discussions, assessments and education

## Audience

Key audience members include:

- Executive Directors of Medicine, Chief Medical Officers or equivalent
- Principal – General Practitioner
- Medical Education Unit
    - Directors of Clinical Training
    - Medical Education Officers
- Others relevant stakeholders involved in Prevocational Medical Training

## Objectives

This guideline aims to provide an overview of the requirements for accreditation of a PGY2 rural hospitalist term:

- What is a PGY2 Rural Hospitalist?
- Safe and effective delivery of prevocational medical education, training and supervision.
- High quality service delivery, as well as service improvement and sustainability.
- Future workforce planning when introducing new services and reviewing service delivery models.
- Effective implementation of the AMC revised National Framework.
- Compliance with Accreditation Standards.

# PART A: Key Components of the National Framework

## Overview

The revised Australian Medical Council (AMC) revised National Framework for Prevocational Medical Training (NFPMT) describes how prevocational doctors are trained and assessed in their first two years after medical school and sets the standards that contribute to good quality training.

The goals of the National Framework are:

- to better align prevocational training with community health needs
- to strengthen the Aboriginal and/or Torres Strait Islander and Māori Peoples health component of prevocational training
- to provide broad generalist experience in PGY1 and PGY2
- to increase the focus on clinical work
- to replace the previous term-by-term approach with a longitudinal approach to building skills across each year
- to improve supervision and feedback
- to increase the emphasis on prevocational doctor wellbeing
- to improve national consistency

The AMC recognises that prevocational medical training should reflect the health needs of the Australian community and therefore should occur in a range of settings, including hospitals in metropolitan, regional and rural communities, general practices and other community-based health services.

It is anticipated that community or non-hospital terms will become mandatory after the next revision of the National Framework (expected 2029).

Any Rural and/or Regional Health facilities seeking accreditation to become prevocational medical training providers are required to meet the revised AMC National Framework as outlined in Training environment – National standards and requirements for prevocational (PGY1 and PGY2) training programs and terms.

This requires being accredited by a state or territory postgraduate medical council (PMC) against the national standards and requirements for prevocational (PGY1 and PGY2) training programs and terms.

## Program Requirements

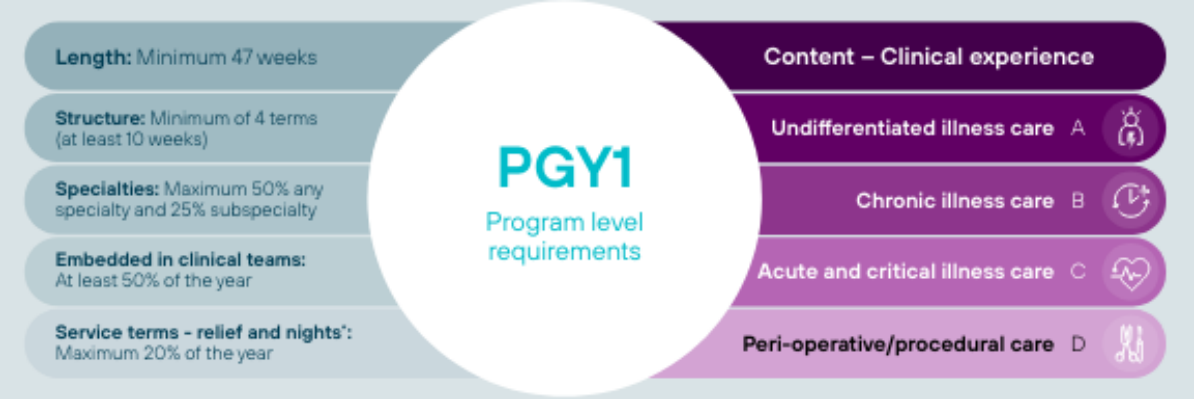
Prevocational training is a longitudinal program of supervised work-based learning over two years (PGY1 & PGY2) and is designed to support the development of broad generalist skills.

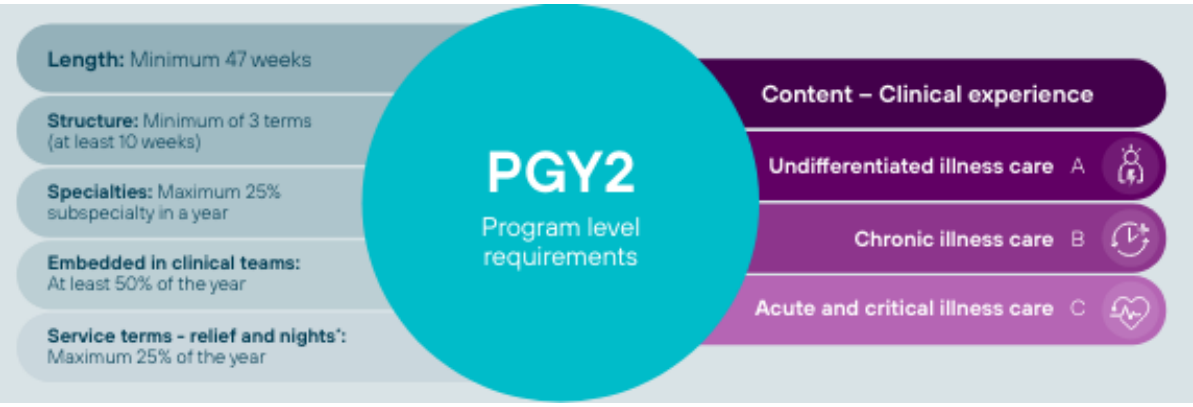
General Registration is still achieved at the satisfactory completion of PGY1, and a Certificate of Completion is achieved at the satisfactory completion of PGY2.

The below infographic provides an overview of the PGY1 and PGY2 program structure.

For more information refer to:

- PMCV PGY1 and PGY2 Program Guidelines
- AMC Requirements for Programs and Terms



# PART B: Rural Hospitalist Overview

The objective of the National Framework is to provide broad generalist experience for PGY1 and PGY2 doctors throughout their first two years of prevocational medical training.

Small rural hospitals have up until now been an underdeveloped resource for prevocational medical training opportunities. Small rural hospitals have access to patients with undifferentiated illnesses through their Urgent Care Centres, which may become Acute Inpatient admissions. The care often has to be negotiated in the context of geographical isolation, rural generalist led models of care and across organisational boundaries to access different levels of care (between the local hospital and the regional base hospital).

There has been a significant training gap in prevocational medical training pathways providing trainees exposure to rural health care settings. The Rural Hospitalist term will provide trainees with a rich experience of health care in a rural context, more direct access to clinical experiences and greater clinical autonomy, supported by Rural Generalists and General Practitioners working in close proximity to the rural hospital within their practices.

In rural hospitalist terms, it is important to distinguish that whilst the PGY2 doctor is supervised and supported by a General Practitioner within the hospital, the PGY2 doctor is not working within the GP clinic. This differs from traditional hospital-based terms where the supervision and support is provided by a non-GP specialist team of registrars and consultants.

The GP is required to provide direct supervision and support twice a day and is not more than 10 minutes to respond to an escalation prompted by the Rural Hospitalist onsite in the rural hospital.

A PGY2 doctor rotates from their Parent Health Service to a rural health service for a 13-week Rural Hospitalist term and may work in the hospital within the following areas:

- acute medical and surgical wards
- Urgent Care Centre
- aged care
- obstetrics
- anaesthetics

In all areas worked, the PGY2 doctor must have access to daily in person supervision with the General Practitioner who retains final responsibility for decisions around patient care. The PGY2 doctor must not be the only medical practitioner to see a patient in the Urgent Care Centre.

# PART C: Prevocational Supervision of the Rural Hospitalist

## Key Roles in Prevocational Medical Training

### Prevocational Supervisors

Prevocational trainees must be supervised at a level appropriate to their experience and responsibilities at all times. In each term the supervision arrangements should be clear and explicit and included in the term description.

There is usually more than one supervisor, each with different responsibilities:

**Director of Clinical Training (DCT):**

The DCT is appointed by the parent health service or training program (e.g. Hume Rural Generalist Training Program M2M).

A senior clinician with delegated responsibility for developing, coordinating, promoting and evaluating the prevocational training program. This individual also has an important role in longitudinal oversight, advocacy and support of prevocational doctors within the program. The DCT is the primary contact and escalation point for the Designated/Principal/Term Supervisor.

**Term Supervisor: (Designated/Principal)** A senior medical practitioner (FRACGP/FACRRM) responsible for orientation and coordination of the clinical training experience and assessment within a specific term. The Term supervisor should not change across the term. In a rural hospitalist term, the Term Supervisor is likely to be a General Practitioner who has been appointed as the key contact person for the Prevocational trainee.

**Primary Clinical (Daily) Supervisor:** A medical practitioner with consultant level responsibility (FRACGP/FACRRM) responsible for the daily supervision of the prevocational doctor (this may change daily and could also be the term supervisor).

In the rural hospitalist setting, the primary (daily) supervisor must be available by phone at all times and will answer when the prevocational doctor calls. If they are not present on-site then they must be able to respond and attend the health service in person within a maximum of ten (10) minutes.

An appropriate escalation protocol is required to clearly demonstrate clinical urgency levels and corresponding response to be undertaken by clinical staff. This protocol must be understood and adhered to by all members of staff at the health service.

**GP Registrars:** Although Registrars provide daily clinical supervision at metropolitan and regional health services, within the rural health services, they will not be credentialled to have admitting rights at the hospital and therefore do not meet the requirements of Prevocational doctor supervision.

**Assessment Review Panel**

The National Framework requires prevocational training providers (primary employment site) to appoint an Assessment Review Panel. The panel's primary purpose is to assess whether a prevocational trainee has met the learning outcomes appropriate to their level and can progress to the next stage of training. The prevocational outcomes do not need to all be met in each individual term.

Throughout the year, the panel will monitor progress and ensure that support and processes are in place to help PGY1 and PGY2 doctors successfully progress through each stage of training. To allow for this to occur, the primary and secondment sites will need to share relevant information about the prevocational doctor's progress. Rural hospitalist rotations are secondment sites. This information will be shared through the Term Assessments and Entrustable Professional Activities, in addition to any further discussions that may be set up in your context. See Part D below for additional information

For further information about the role and function of Assessment Review Panels, please refer to https://www.pmcv.com.au/nfpmt/assessment-review-panel/

**Nursing, allied health and other staff:**

As patient care is delivered by a team of practitioners, it is acknowledged that supervision and feedback may be provided from a range of people, however the responsibility for supervision sits with the DCT, Term Supervisor and Primary Clinical Supervisor.

Nursing, allied health and other staff provide a valuable contribution to the training of prevocational doctors in developing a Team based approach to healthcare. While these professionals do not complete term assessments for the prevocational doctors, it is anticipated that their experiences and feedback are sought to contribute to the overall assessment of the prevocational doctor. If trained, these professionals are permitted to assess EPAs for the prevocational doctor.

## Supervisor Training Requirements

The National Framework requires that all prevocational supervisors complete training in supervision. The PMCV and the Royal Australian College of General Practitioners (RACGP) have supervision resources available - please contact for further details.

# PART D: Term Discussions, Assessments and Education Opportunities

## Orientation

It is essential that prevocational doctors receive a formal orientation at the commencement of the term at the rural health service.

The Term Supervisor should be involved in the design of the orientation to ensure that relevant clinical information and expectations for the term is provided. The orientation should ideally occur on the first day and include the following:

- Introduction to appropriate health service/ unit staff
- Medical policies and procedures (including escalation protocols)
- information on using and accessing technology and resources
- A description of administrative arrangements (including rostering/leave management and relevant practice policies and procedures such as emergency procedures, work health and safety, grievances and leave)
- Details of formal education program

These components of orientation may be delivered by the relevant hospital staff.

In addition, health services must have a defined process by which patient consent is obtained regarding consultation with a prevocational doctor.

## Beginning of Term Discussion

At the beginning of each term, a mandatory discussion between the prevocational doctor and the Term Supervisor should occur covering the following:

- The role and responsibilities of the prevocational doctor
- Training and education opportunities for the term, including any specific learning outcomes the prevocational doctor wants to focus on
- Supervision arrangements and key contact people
- Escalation protocol
- Assessment processes for the term (including timing and contact for EPAs).

An endorsed Term Description should be utilised to guide this discussion.

Further information on the development of Term Descriptions is available here.

## Entrustable Professional Activities (EPAs)

The National Framework introduces four EPAs that describe essential components of the day-to-day work of PGY1 and PGY2 doctors. Assessments of these EPAs measure the prevocational doctor's level of entrustability – the supervisor's judgement of how much supervision the doctor needs to safely perform the piece of work that has been observed.

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| EPA 1<br>**Clinical assessment** | Conduct a clinical assessment of a patient incorporating history, examination, formulation of a differential diagnosis and a management plan, including appropriate investigations and communication with the patient and their family or carers. |
| EPA 2<br>**Recognition and care of the acutely unwell patient** | Recognise, assess, escalate appropriately and provide immediate management to deteriorating and acutely unwell patients. (This EPA recognises that PGY1 and PGY2 doctors are often called after hours to assess patients whose situation has acutely changed.) |
| EPA 3<br>**Prescribing** | Appropriately prescribe therapies (drugs, fluids, blood products and inhalational therapies including oxygen) tailored to patients' needs and conditions. |
| EPA 4<br>**Team communication – documentation, handover and referrals** | Communicate about patient care, including accurate documentation and written and verbal information to facilitate high-quality care at transition points and referral. |

The Term Supervisor must be involved in at least one of the two minimum EPAs undertaken during the term.

For more information on EPAs, such assessment requirements, approved assessors and how to apply in the General Practice setting, please refer to (INSERT LINK TO GUIDE).

## Term Assessments

All prevocational doctors must complete mid-term and end-of-term assessments every term. These assessments are completed with reference to the outcomes described in the prevocational outcome statements at a level appropriate for each year.

The assessments are part of the discussions about performance during the term and prevocational doctors are encouraged to complete a self-assessment using the form as a starting point for these discussions.

Term assessments should be undertaken by the Term Supervisor.

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| Midterm Assessment | Designed to provide timely feedback on the prevocational doctor's performance, to identify any specific learning needs that have emerged during the term and discuss how they can be addressed. |
| End-of-term Assessment | Designed to provide feedback on performance and evidence to support a global progress decision at the end of the year. |

## Formal education Program

- PGY1: It is a requirement that PGY1 doctors receive one hour of protected teaching time per week. The education program can be practice based or delivered through the health services or training program.
- PGY2: It is expected that PGY2 doctors should have exposure to education and there are a number of models that may be available for this such as:
    - On site delivery of a PGY2 specific education program
    - **Access to more general medical education programs**
    - Access (in person on online) to education sessions delivered at the employing health service

# Conclusion

The Guideline for a Rural Hospitalist Term has been developed to support rural General Practices in applying the standards and requirements of the National Framework in a rural health service setting.

The objective of the guideline is to create an understanding of the accreditation requirements that must be met to seek accreditation for a PGY2 term in a rural hospital. These hospitals are typically staffed medically by local General Practitioners and/ or Visiting Medical Officers VMOs), who would also be responsible for the supervision of the PGY2 during their term.

General Practices in conjunction with these rural hospitals seeking accreditation are required to complete a new post application (available on the PMCV website) and undergo an onsite visit by an PMCV taskforce (usually the Accreditation and Standards Manager and Medical Director or Chief Executive Officer).

The PMCV Accreditation program will continue to monitor the resources through survey visits with direct utilisation of this guideline.

# Glossary of Terms

It is recommended by the PMCV that MEUs work towards the use of standardised and consistent role titles and allocations in the coming years.

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| **Assessment Review Panel** | A panel that recommends whether a prevocational doctor can progress to the next stage of training, based on a global judgement of the doctor's achievement of the prevocational outcome statements.<br><br>The panel members have a sound understanding of procedural fairness and prevocational training requirements. The panel must have at least three members, who may include the director of clinical training (DCT), the director of medical services (DMS) / chief medical officer (CMO) or delegate, the medical education officer (MEO), an individual with HR expertise, experienced supervisor/s, or a consumer. |
| **Clinical Supervisors** | A medical practitioner who supervises the prevocational doctor while they are assessing and managing patients.<br><br>• Primary clinical supervisor(s) – is the supervisor with consultant level responsibility for managing patients in the relevant discipline that the prevocational doctor is caring for. The consultant in this role might change and could also be the term supervisor.<br><br>• Clinical supervisor(s) (day-to-day) is an additional supervisor who has direct responsibility for patient care, provides informal feedback, and contributes information to assessments. This occurs in many settings, and the person in this role should remain relatively constant during the term. They should be at least PGY3 level, such as a registrar. |
| **Director of Medical Education** | A senior clinician with delegated responsibility for the entire medical education function which may also include IMGs, speciality training as well as research projects. |
| **Director of Clinical Training (DCT)**<br>**Or**<br>**Director of Prevocational Training (DPT)** | A senior clinician with delegated responsibility for developing, coordinating, promoting and evaluating the prevocational training program at all sites. This clinician follows the progress of the prevocational doctor across the whole of their clinical year. |
| **Formal Education Program** | An education program that the training facility provides and delivers as part of its prevocational training program. For interns (PGY1), there are usually weekly sessions, which involve a mixture of interactive and skills-based face-to-face or online training. Education programs for |

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| | PGY2 doctors are more varied and may be adapted to address the career plans of these doctors. |
| **Medical Education Managers** | In larger units, a manager may be appointed to oversee the MEOs and MECs who usually has higher education qualifications. |
| **Medical Education Officers** | MEOs provide educational support for prevocational doctors. This includes administrative support to DCTs, SITs, Term Supervisors and other roles within Prevocational Medical Education. |
| **Supervisor of Intern Training (SIT)** | A medical practitioner who has primary responsibility for the supervision and learning of prevocational doctors. |
| **Term Supervisor** | The person responsible for orientation and assessment during a particular term. They may also provide primary clinical supervision of the prevocational doctor for some or all of the term. |

## Version Control

*Version approved along with date of next review.*

| Version | **Amendments by** | **Changes** | **Date** |
|---|---|---|---|
| 1.0 | Accreditation Manager | New document | 6 May 2025 |

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| Approved by: | PMCV Accreditation Committee |
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| Next Review: | May 2026 |

References


1. The Australian Medical Council (AMC) Training Environment: *National Standards for Prevocational training programs and terms*. Retrieved on 5 May 2025 from https://www.amc.org.au/wp-content/uploads/2022/12/Section-2-National-standards-for-prevocational-PGY1-and-PGY2-training-programs-and-terms.pdf