



# **GUIDELINES FOR PREVOCATIONAL MEDICAL TRAINING IN THE GP SETTING**

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## Purpose

General practices seeking accreditation as prevocational medical training providers are required to be 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. Please check with your local PMCs to determine the process.

In collaboration with the Royal Australian College of General Practitioners (RACGP) and the Australian College of Rural and Remote Medicine (ACRRM), the Postgraduate Medical Council of Victoria (PMCV) has developed this Victorian guidance document to support general practices in applying the standards and requirements of the Australian Medical Council (AMC) revised National Framework for Prevocational (PGY1 and PGY2) Medical Training (National Framework) in the community setting.

This guidance document has been broken down into four main sections:

**Part A:** An overview of the National Framework and the key components

**Part B:** Community term requirements

**Part C:** Prevocational supervision in the community setting

**Part D:** Term discussions and assessments

## PART A: The National Framework – Key Components

### Background

The National Framework describes how doctors are trained and assessed in their first two years after medical school and sets the standards that contribute to good quality training.

The National Framework is the most significant change to Australian prevocational training for several decades. 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's wellbeing
- to improve national consistency

The AMC recognises that prevocational 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. It is unclear how these prevocational terms will be funded, but there is considerable advocacy from the Colleges and State departments to re-introduce funded prevocational places.

The National Framework can be accessed [here](#).

## Accreditation Requirements

PMCV will consider all General Practice applications with preference given to the ones who have achieved the following accreditations:

- **RACGP and/or ACRRM Accreditation as a training practice**
- **AGPAL or QPA accreditation for clinical practice**

PMCV will visit all new General practices either virtually or in person prior to accreditation being granted.

PMCV will grant provisional accreditation for one year from the initial approval. Ongoing accreditation will be dependent on trainee and parent health service feedback.

## 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: Community Term Requirements

The AMC National Framework is intended to provide generalist experience for PGY1 and PGY2 doctors throughout their prevocational medical training.

### **Most time must be spent in traditional GP roles:**

- Seeing patients in a community-based clinic by appointment.
- Accompanying an accredited Designated/Principal/Term Supervisor or other accredited supervisor to external sites, such as aged care facilities, schools (adolescent health) and/or hospital ward rounds.

During this time the prevocational doctor should be provided with the opportunity to see a diverse range of patients and conditions which may involve time spent with multiple practitioners in the clinic.

Larger multi-disciplinary clinics may provide opportunities for prevocational doctors to work with on-site nurses undertaking procedural work, and on-site allied health professionals, including dietitians, physiotherapists etc.

*Note: The maximum planned leave that may be taken by the prevocational doctors is two weeks for each 10-week (PGY1) and three weeks for each 13-week placement (PGY2).*

To maintain the integrity to provide generalist experience, the following principles have been set:

**Non-Rural Generalist rotations:** A prevocational doctor can spend a maximum of 20% of their time in special interest areas such as:

- Skin check clinic
- Women's health
- Men's health
- Adolescent health
- Sexual health

**Rural Generalist rotations:** A prevocational doctor can spend a maximum of 40% of their time in any subspecialty discipline in support of rural generalism. For example:

- Emergency Medicine
- Paediatrics
- Obstetrics and Gynaecology
- Anaesthetics
- Palliative care
- Mental health
- Other disciplines may be considered through discussion

## PART C: Prevocational Supervision in the Community Setting

### Key Roles in Prevocational Medical Training

#### Assessment Review Panel

The revised 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 doctor has met the learning outcomes appropriate to their year level and can progress to the next stage of training. The prevocational outcomes do not need to all be met in each individual rotation.

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. For this to occur, the primary and secondment sites will need to share relevant information about the prevocational doctor's progress. GP rotations are usually included as secondment sites and DO NOT need to develop an Assessment Review Panel.

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

#### Prevocational supervisors

Prevocational doctors must always be supervised at a level appropriate to their experience and responsibilities. In each term, the supervision arrangements should be clear and explicit and documented 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.

**Designated/Principal/Term Supervisor:** A senior medical practitioner (FRACGP/FACRRM) responsible for orientation, coordination of the clinical training experience and assessment within a specific term. The Designated/Principal/Term Supervisor should not change across the term.

At the discretion of the Term Supervisor and within the Entrustable Professional Assessment discussions, it may be possible for the prevocational doctor to do supervised ordering of pathology and imaging and prescribe.

The prevocational doctor will use a “Request and Refer” Provider Number so they can order pathology and imaging. They can use their Prescriber Number while on placement for prescribing medications.

**Other supervisors:** Individuals with consultant level responsibility (FRACGP/FACRRM) for managing patients in the relevant discipline that the prevocational doctor is caring for.

### **Supervisor Training Requirements**

#### **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, Designated/Principal/Term Supervisor and Other 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.

The National Framework requires that all prevocational supervisors complete training in supervision.

The PMCV and the Royal Australian College of General Practitioners (RACGP) have developed specific training material relevant for the primary care setting.

The Primary Care Provider must meet the accreditation criteria for a Community Term under the National Framework for Prevocational Medical Training. Supervisors in the primary care setting must have completed mandatory training as specified by the PMCV prior to the Prevocational doctor commencing in the Practice.

To access the training module, please complete the form on the PMCV website:

<https://www.pmcv.com.au/education-training/digital-training-resources/>

## Work-based Teaching and Training

During PGY1 and PGY2, prevocational doctors take increasing responsibility for patient care as they progress towards independent practice.

Providing safe, high-quality patient care is paramount, and prevocational doctors should never be put in a position where they are asked to take on responsibilities beyond their scope of practice or perform procedures without appropriate supervision.

To maintain the integrity of this intent, the following principles have been set:

### Prevocational supervision – a phased approach

It is recommended that all prevocational doctors, both PGY1 and PGY2, commence their rotation at phase 1 and transition to phase 2 and 3 as deemed appropriate by the Delegated/Principal Supervisor. The phases are defined as:

Phase 1: Prevocational doctor shadows supervisor

Phase 2: Supervisor physically reviews each patient seen by the prevocational doctor

Phase 3: Supervisor discusses each patient with the prevocational doctor

*The last part of the consultation, usually a 15-minute slot, allows the prevocational doctor to discuss the patient with the Delegate/Principal/Term Supervisor or other accredited supervisor. The Supervisor will then determine the need for physical review (always in Phase 2 and by discretion in Phase 3). This enhances patient safety and provides feedback to the prevocational doctor on this consultation.*

### Prevocational supervisor proximity

- PGY1: An accredited prevocational supervisor must always be on site. Ideally this is the Delegated/Principal/Term Supervisor
- PGY2: An accredited prevocational supervisor should always be on site or must be available within 10 minutes. Ideally this is the Delegated/Principal/Term Supervisor

Variations to the above will need to be discussed with PMCV.

### Escalation protocol

It is a requirement that there must be a defined escalation protocol or clinical supervision plan for each phase of supervision.

## Parallel Consulting Model

The Community Training Term commonly adopts a Parallel Consulting model of supervision, where a patient is booked to see the supervising doctor in one consulting room and another patient is booked at the same time to see the prevocational doctor. Once the prevocational doctor has taken a full history, completed the examination and prepared a management plan they call the supervisor in to confirm the plan and complete the consultation. An outline of a suggested scheduling under a Parallel Consulting model is provided in the table below.

	Supervisor	Prevocational Doctor
9am	Sees patient 1 – standard consult approx. 15-20 mins	
9.20am	Sees patient 3 – standard consult approx. 15-20 mins	Sees Patient 2 – approx. 45-50 mins
9.40am	Sees patient 4 – quick script or telehealth approx. 10 mins	
9.50am	Called into Prevocational Doctor Room	Present findings to supervisor, agree on management plan Supervisor completes consultation and bills Medicare under their provider number

## Curated Patient List and Feedback

The National Framework places significant emphasis on prevocational doctor wellbeing and support.

To maintain the integrity of this intent, the following principles have been set:

- Prevocational doctors should be active in the practice with a curated patient list that includes a wide range of conditions and patients, both new and for review, in their own clinic room.
- At the completion of the shadowing period of supervision (Phase 1), prevocational doctors should undertake consulting, with patients seen commencing at 1-hour intervals.
- Consultation times should gradually decrease over time based on the feedback and assessment and should be determined by the progress of the prevocational doctor. Factors that may be considered include:
  - Timing of rotation (e.g. Term 1 vs Term 4)
  - Is this the first exposure to GP setting?
  - Is the prevocational doctor ready to decrease consultation time?
- It is recommended that regular (initially daily) feedback sessions are scheduled with the prevocational doctor to discuss the patients that have been seen over the

preceding period.

Suggested questions or points for discussion include:

- What do you feel went well?
- Is there a component of the day which took a lot longer than you expected?
- Is there anything you wish to discuss that you found difficult or so can you improve next time?
- Provide feedback on areas where the prevocational doctor is doing well.
- Planning for learning – “Perhaps you could use X reference to further explore the management of this patient.”
- Planning for closing the loop on feedback – “we will revisit this at . and further discuss...”

### **Improving performance**

Early identification of the need for additional support is encouraged. This may require the development of an improving performance plan (IPAP). Further information will be provided on this process.

Discussion should take place with the DCT if concerns are raised in the midterm assessment.

## **PART D: Term Discussions, Assessments and Education Opportunities**

### **Formal education Program**

- PGY1: It is a requirement that PGY1 doctors receive one hour of protected teaching time per week. The education program may be provided in the Practice by the supervisors or delivered through health services or training program.
- PGY2 doctors are expected to gain experience in education, and several models may be available to support this exposure. Although there is no minimum time requirement it is expected that PGY2 doctors are included in education within the practice and released for relevant education provided by the health service or training program.

### **Orientation**

It is essential that prevocational doctors receive an orientation to the GP clinic/rotation.

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

- Introduction to Practice staff and 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

In addition, general practices 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 there is a mandatory discussion between the prevocational doctor and Delegated/Principal/Term Supervisor. This discussion should cover:

- 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
- Assessment processes for the term (including timing and expectations of the prevocational doctor)

A Term Description should be utilised to guide the 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.

EPA 1 <b>Clinical assessment</b>	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 <b>Recognition and care of the acutely unwell patient</b>	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 <b>Prescribing</b>	Appropriately prescribe therapies (drugs, fluids, blood products and inhalational therapies including oxygen) tailored to patients' needs and conditions.
EPA 4 <b>Team communication – documentation, handover and referrals</b>	Communicate about patient care, including accurate documentation and written and verbal information to facilitate high-quality care at transition points and referral.

For more information on EPAs, such as assessment requirements, approved assessors please refer to the [PMCV EPA webpage](#).

## Term Assessments

All prevocational doctors undergo midterm and end-of-term assessments every term. These assessments are based on achieving 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 Delegated/Principal/Term Supervisor.

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.

## Feedback and Surveys

During the rotation the Parent Health Service is encouraged to meet with the prevocational doctor to seek feedback on the quality of the rotation and to inform improvements to program policy and delivery.

*Version approved along with date of next review.*

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2.0	CEO	Updated	21/04/2026

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