

THE

CURRICULUM

FRAMEWORK

**Prepared for the Medical Training Board and the
Medical Council of New Zealand as a proposal for
discussion**

September 2008

Acknowledgements

The Medical Training Board is most grateful to those who worked with it on the medical training continuum. The Board has valued greatly the collaboration with the Medical Council of New Zealand on this work, although the Medical Training Board is responsible for this paper. The Board has benefited tremendously from the work it has now published by Professor Tim Wilkinson, Professor Phillipa Poole and Barbara O'Connor. This work will be the basis of our wider discussions over the next few months.

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Preface

The Curriculum Framework document was commissioned by the Medical Training Board to define the competencies expected at stages in the educational continuum from the final year of undergraduate medical training through to entry to a vocational training programme. The competencies are not new to medical practice in New Zealand and are designed to assure high quality outcomes and safety for patients.

The challenges lie in the proposals for assessment and implementation of the framework.

As a commissioned document, its purpose is to stimulate discussion and consultation and does not necessarily reflect the views of the Medical Training Board.

The Curriculum Framework should not be viewed in isolation. It is only one component of the complexity in the early clinical years where trainees are gaining experience, assuming greater clinical responsibility, and providing a service in a health care system which is itself changing. It should be read in conjunction with the complementary Medical Training Board discussion documents, also released on 30 September 2008, called *The Future of the Medical Workforce* and *Integrated and Coordinated Medical Training*.

The Medical Training Board is very aware that the introduction of *Modernising Medical Careers* in the United Kingdom, a programme intended to assure the fundamental abilities of doctors in the future, was not seen to have been preceded by appropriate consultation and feedback. This has been identified as one of the key failings in that process.¹ To that end, the release of this report on *The Curriculum Framework* will be accompanied by the opportunity for significant consultation and feedback. This will include a series of focus group meetings to gain initial feedback and identify key issues that will inform the subsequent wider consultation process. The feedback will lead to revision of both the concepts and the underpinning documentation.

¹ Department of Health, UK, February 2008 *The Secretary of State for Health's response to Aspiring to Excellence: Final report of the Independent Inquiry into Modernising Medical Careers*

Introduction

The Medical Training Board was established by the Minister of Health and the Minister for Tertiary Education in response to a recommendation from the Workforce Taskforce which reported to the Ministers in May 2007.²

Key issues

The Taskforce had identified the following key issues from earlier reports that needed urgent attention:³

1. There is an overall shortage of medical practitioners, evidenced by the use of locums and reliance on overseas-trained doctors, which will be exacerbated in the future as the population ages and competition for medical practitioners increases in the international market.
2. New Zealand needs to train more medical practitioners locally to meet the demand. To achieve this, the level of the cap on funded undergraduate medical places should be raised and further clinical training positions made available.
3. There is a 'maldistribution' of the available medical workforce, with rural and non-metropolitan areas finding it increasingly difficult to recruit and retain doctors.
4. Māori and Pacific peoples are currently under-represented in the medical profession in New Zealand. Those from lower socioeconomic backgrounds are also under-represented. There is a need for strategies to increase recruitment into medical schools from these groups.
5. The quality and relevance of medical education and training could be improved by greater continuity between undergraduate medical education and subsequent clinical training and increased responsiveness of the whole system to the needs of the health sector.
6. The health sector is complex, and there are many players involved in educating and training medical practitioners. There is a need for a central body to coordinate and oversee medical education and training.
7. The difficulties for training in clinical settings created by the inherent tension between service delivery and training needs, the changing service delivery patterns in public hospitals, and the implications of industrial agreements over the last 20 years, are putting pressure on the current apprenticeship model.

The Taskforce recommendations follow similar themes to those identified in other countries with similar health systems such as the United Kingdom (UK), Australia, Canada and the Netherlands. The *Aspiring to Excellence* inquiry led by Sir John Tooke documents the development of the Modernising Medical Careers (MMC) programme

² *Reshaping Medical Education and Training to Meet the Challenges of the 21st Century*. May 2007

³ *Fit for Purpose and for Practice: Advice to the Minister of Health on the Issues Concerning Medical Workforce in New Zealand; The Training of the Medical Workforce 2006 and Beyond*

and highlights the strengths and weaknesses of the programme designed to change postgraduate medical education and training in the UK.⁴

Deficiencies in the MMC highlighted in the Tooke report included the:

- lack of meaningful consultation with the profession;
- lack of funding and incentivisation for those delivering education and training;
- failure to ensure that changes in the structure of postgraduate training were guided by clear principles that embraced a broad base in the early years, flexibility, and the pursuit of excellence; and
- need for workforce planning to account for the impact of changing patterns of healthcare on future medical workforce size and structure.

The MMC covered foundation, specialist and general practice training programmes. It was found to lack clear policy objectives and little cognisance of consultation with the medical profession.

There were wide ranging misconceptions of the educational and workforce objectives of MMC as well as inconsistent objectives required of it. The emphasis defaulted to the development of competency-based training without adequate consideration of workforce and service implications.

Further criticism of MMC centred on: (a) the failings of the computerised matching system for entry to specialty training places (MTAS), and (b) that many trainees were not ready to decide on their career specialty midway through Foundation year 2.

On the positive side it was noted that for the first time, the Foundation years comprised of a formal programme with a national curriculum and structured assessment of clinical competences. But criticism was made of the lack of linkage with the undergraduate curriculum and a perpetuation of the student role with "tick boxes".

In New Zealand currently the Medical Council has overall responsibility to recognise, accredit, and set programmes to ensure the ongoing competence of medical practitioners. The undergraduate curriculum is set and taught by the Universities, and colleges have curricula and assessments for those in vocational training. There is a disconnect with the interval years from university to college-based vocational training with no clearly defined national curriculum, standardised teaching or assessment programme, or quality control of run placements.

The Medical Training Board has been charged with providing strategic oversight of the training of an appropriate workforce for the health care of New Zealanders for the next 20 years. While work is in progress for predicting workforce needs, a parallel stream

⁴ *Aspiring to Excellence: Final Report of the Independent Inquiry into Modernising Medical Careers.* 4 January 2008.

has been looking at the transition years and how time spent in that period can be best used to produce doctors fit for purpose.

Recommendations 1b and 4b of the 2007 Workforce Taskforce report to the Minister specifically request the development of a national curriculum and a process for competency-based assessment for the transition years.

Previous committees and Taskforce groups have identified the need for change. The medical profession itself is looking for the Medical Training Board to take the lead in recommending the required changes. No one change will solve the problems in a complex system. Any change needs to be justified and in the context of clearly stated goals for the system delivering healthcare. That system involves institutions responsible for education, service, and funding. Any proposals made by the Training Board require wide consultation with all stakeholders, consideration of feedback, and modification if necessary, before they become firm recommendations.

Problem definition

The Taskforce identified that:

- “The difficulties for training in clinical settings created by the inherent tension between service delivery and training needs, the changing service delivery patterns in public hospitals and the implications of industrial agreements over the last 20 years, are putting pressure on the current apprenticeship model.”

Successive reports on medical education and training have confirmed that the “apprenticeship model”, although it has its roots in the 18th century, is still the most appropriate training format for trainee doctors. The reports have recognised, however, that service delivery today is vastly different than it was in the 18th century and even as it was 10 years ago.

Now:

- the level of acuity of hospital inpatients has increased;
- the average length of hospital stay has decreased;
- there is greater delivery of health care in the community and primary care sector;
- demographic changes have increased the demand for, and changed the nature of health services; more can be done technologically and pharmaceutically;
- working hours and conditions have changed with an increased focus on service delivery, creating the loss of continuity of care and a diminished importance placed on education and training;
- there are changes occurring in vocational college requirements, undergraduate education and community experience;
- some treatments are provided only by the private sector;
- there are changes occurring in traditional health care roles with the evolution of health care teams;
- New Zealand has to compete in the global market for health practitioners; and
- there are changes in the availability and delivery of clinical information.

In addition, anecdotally, there are reduced opportunities for resident medical officers (RMOs) to receive training/education and, when it is offered, service commitments often prevent participation.

To strengthen medical education and training so it can adapt to the health environment now and into the future, some significant changes will have to occur. Some short-term measures could involve an increase in time in clinical training, placing trainees in general practice and private hospitals, and introducing a curriculum framework. Longer-term measures may include changes in service delivery and system structure. In making any changes and in improving workforce retention, all staff have to feel valued both for their contributions to service and for their roles in teaching, mentoring and leadership.

Training time

In the UK, MMC recommended two years in a Foundation Programme prior to general registration and specialty training. The Tooke report went further to suggest one Foundation year and three core specialty years prior to advanced specialist training.

There is pressure from some quarters in New Zealand to either shorten the time to general registration or at least maintain the existing seven years to general registration. Below are some options to be considered. Option 1 is the current structure. Options 2 and 4 would see the university years shortened, and Option 3 would allow a more flexible timeframe in which to meet the requirements of the prevocational years.

| Option | Year 1 | year 2 | year 3 | year 4 | year 5 | year 6 | year 7 |
|----------------|----------------|-----------------------------|------------------------------|------------------------------|------------------------------|---------------------|--------|
| 1 (current) | Health Science | Basic science +clinical | Clinical + basic sciences | Clinical +basic sciences | Clinical + basic sciences | Trainee Intern | PGY1 |
| 2 | Health Science | Basic Sciences +clinical | Clinical +basic sciences | Clinical + basic sciences | Trainee intern | PGY1 | PGY2 |
| 3 | Health Science | Basic sciences +clinical | Clinical + basic sciences | Clinical + basic sciences | Clinical +basic sciences | Trainee intern/PGY1 | PGY1/2 |
| 4 | First degree | Basic sciences +clinical | Clinical +basic sciences | Clinical +basic sciences | Trainee intern | PGY1 | PGY2 |

In any of these options, degree conferment could take place at end of year 5 or year 6.

There appears to be little appetite to increase the total time for training to independent practice, but it could be a point for discussion and consultation.

Increasing the time spent in clinical training prior to registration may or may not address the problems of inadequate experience and clinical responsibility. Without drivers for change in the service environment and increased structure around teaching and learning, trainees risk spending two years in service for little gain in competence or experience.

Lead-in times for change in the university course are determined by accreditation requirements and capacity to run a parallel stream in the changeover.

Training sites for the “transition” years

Currently, all prevocational service and training occurs in the public hospital sector except for around 20 posts per run in PGY2 which are sited in rural general practice.

There is a proposal that all PGY1 or PGY2 trainees will have at least one run in a general practice setting prior to general registration. This has huge implications for capacity in terms of physical space, numbers of teachers, funding, and expected outcomes. There could be alternatives to a “run” in general practice such as sessional work, teaching clinics, trainee exchanges and so on. Private hospitals and clinics are also considered to be potential sites for training.

Alongside the expansion of sites for training there must also be quality assurance for standards of teaching. This would encompass commitment to resourcing teachers in terms of remuneration, “teaching to teach”, accreditation of teachers, and the teaching environment, as well as ensuring access to and dedicated time to attend teaching for trainees.

A national placement unit for undergraduate and postgraduate training in general practice has been established as a collaboration between the Universities and the Royal New Zealand College of General Practitioners (RNZCGP). The concept of having a RMO placement unit at a national or regional level is open for discussion.

What body or bodies should be responsible for the governance, the setting of standards, and the provision of education for prevocational training should be included in this discussion. The possibilities include a stand-alone unit, the Universities, or a combination of Universities and colleges.

The Curriculum Framework

The Medical Training Board's complementary paper entitled *The Future of the Medical Workforce* sets the context for curriculum development. A draft curriculum framework has been produced for discussion with all stakeholders. It is proposed that a competency-based assessment system for trainee doctors will be meshed with the apprenticeship model where time and experience are as important as achievement of competencies.

Competence is not the same as excellence but both are essential in the provision of high quality healthcare. A competency framework will guide teaching and learning but is unlikely to drive excellence. Role modelling, mentoring, patient expectations, competition in high stakes assessment, and experience will all drive excellence.

There is the option of using the competency assessment system for formative feedback and for there to be a summative exit examination in the form of a performance/practice review assessment.

Progression through the "transition ears"

Waypoints have been developed as a means of demonstrating when trainees are ready to assume increased clinical responsibility such as prescribing, accepting night call duties, managing and discharging patients without a supervisor checking them. These waypoints take account of clinical experience, competence, confidence and patient safety. Registration is conferred by the Medical Council and determined by its criteria. Waypoints could be linked with registration if the criteria were deemed compatible.

Implementation

This consultation document attempts to raise some of the implementation issues for discussion. They are germinal and by no means comprehensive. The Medical Training Board is keen to explore other options arising from the consultation process.

The Board has determined some key principles for the implementation process:

- Excellence in health care requires excellence in training;
- Redesigned training programmes must foster excellence and continuous quality improvement;
- Training needs to be recognised as having equal importance as service delivery;
- Trainers need to be adequately remunerated for the investment of their time and have adequate time available for training;
- Training and support for trainers will be provided;
- Directives for rosters, work practice and facilities to foster training are a vital component of an ongoing training programme;

- Use must be made of modern, efficient training techniques, skills laboratories, and student responsibility for adult learning;
- Use must be made of all health service delivery settings, including primary care and other private specialist services;
- Programmers should be nationally consistent, coordinated and supported;
- Programmers should be integrated between undergraduate and Australasian and New Zealand college programmers;
- The system should include appropriate incentives and support for service providers to strive for excellence in training, facilitate training, provide release time and provide appropriate facilities to do so. Service providers must be permitted to provide excellence in training without detrimental effects on excellence in service delivery;
- Service providers should be given increased flexibility to adapt their workforce to meet service demands while simultaneously permitting excellence in training; and
- Any increased regulation and structure around training should be designed to absolutely minimise any added burden upon students or teachers and should enhance both the learning and current work experience.

Funding

Funding is integral to the success of any change. The Clinical Training Agency (CTA) currently funds training in the transition years through the District Health Boards (the DHBs). Unfortunately the funding stream is not transparent so it is hard to account for how much gets through to the teaching coalface or to quantify its value. Vote Education funds the trainee intern year. Both the CTA and the Tertiary Education Commission have actively participated in the Medical Training Board workstreams to date, and their input is pivotal in progressing this project after the initial consultation round.

Workplace, Employment, Service

It is expected that the impact of the workplace culture on training and education will feature prominently in the consultation round. The Medical Training Board expects that the dialogue will be constructive and that some solutions and innovative ideas will emerge.

NZ Education Framework for Prevocational Training

- **Joint MTB and MCNZ Working Party for Prevocational Medical Training**
- **Competence, Levels and Assessment Principles Discussion Document**

This paper was commissioned by the Medical Training Board

- *It is intended to stimulate discussion and does not necessarily reflect the views of the Training Board.*
- *Similarly, the Medical Council of New Zealand does not endorse the content of this paper in its entirety. While the Council agrees there needs to be change in the current delivery of education and training, the concepts within this paper are suggestions only and do not necessarily reflect the Council's opinion.*

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A. Project Scope

A.1. Problem definition⁵

The current processes for education and training of doctors in the years leading to admission to a vocational training programme, the funding for which is split between education and health, should be improved and should more adequately measure competence to practice. It is important that the expectations of all relevant stakeholders are aligned, and that there is transparency in how Doctors in Training (DIT) make transitions.

A.2. Objectives of project

1. To define the competencies that must be achieved at agreed Waypoints before entry to a vocational training programme.
2. To develop a process for assessing the achievement of competencies.
3. To provide guidelines for the curriculum needed to attain the competencies.

A.3. Principles

The process is based on the following principles:

- the project should focus on appropriate educational objectives. It should not be determined exclusively by current practice, for example, in relation to the conferment of a medical degree, registration to practise, service delivery models and teaching methods;
- the years to entry to a vocational training programme are part of a continuum of lifelong learning which should incorporate a well-developed curriculum commencing at entry to medical school;
- this would involve, among other things, the acquisition of knowledge and skills in clinical sciences, communication and professional skills;

⁵ This project scope was agreed at the February 2008 meeting of the Joint Working Party of the Medical Council of New Zealand (MCNZ) and the Prevocational Workstream of the Medical Training Board (MTB). See Section L for members. The Joint Working Party has developed the proposed New Zealand Education Framework for Prevocational Training.

- there must be significant periods of apprenticeship-style learning in a range of clinical settings;
- all doctors should acquire a set of general core competencies before entering the vocational training programme of their choice – a general grounding approach;
- entry to a vocational training programme should be based on the achievement of an agreed set of competencies rather than a purely time based learning period;
- there should be a common national framework for the educational objectives and for achieving the competencies, as well as for assessment of achievement of the competencies. Assessment should be modular, with formative components, rather than one off “high stakes” assessment examinations;
- the process should include appropriate incentives to encourage the learners “to learn” and the teachers “to teach”;
- the process should be flexible, efficient and provide good value for money.

A.4. Process

The first stage of the process was to establish a draft framework of the competencies that need to be achieved by Doctors in Training before entering a vocational training programme. Within this framework, levels of performance needed to be indicated for this end point and initially for two Waypoints:

- at entry to closely supervised clinical practice (currently end of year 5, potentially may give a limited form of student registration);
- at the completion of prevocational training.

At the April 2008 meeting of the Joint Working Party, it was agreed that a third Waypoint was needed – refer to Section B.

The parties worked jointly to develop the competencies further using the Australian Curriculum Framework for Junior Doctors (ACFJD) as the starting point.

Stage 2 was to develop a system for assessing whether the competencies have been met. When completed it is envisaged the framework will include:

- assessment processes for each of the Waypoints;

- an indication of the type and location of learning experiences required to achieve the standards including guidance on senior medical officer support, training, and assessment;
- recommendations on training in a community setting including timing and guidance on the structural arrangements necessary to accommodate this.

A.5. Key decisions of the Joint Working Party

For each meeting of the Joint Working Party, a series of issues for discussion were identified, with the purpose of gaining agreement. The following is a brief summary only of some key decisions of the Joint Working Party.

- An amalgam of conceptual and task-based definitions of competence is likely to be needed for the NZ Education Framework for Prevocational Training.
- Agreement that both 'higher-level' and 'task-based' competencies need to be incorporated in the NZ Education Framework for Prevocational Training.
- Three Waypoints are needed, with general consensus on the descriptions for each.
- Adopt the five levels of expertise for performance and ladders.
- Reposition attitudinal aspects into an overarching structure, using AMC attitudes as a basis, but with modifications to reflect the MCNZ statements.
- Broad adoption of the ACFJD, especially to encompass domains and breadth, and to blend with the previous work of the MCNZ.
- Merge statements from the ACFJD to reduce redundancy / overlap, and to even out granularity.
- Endorsement of the proposed New Zealand Doctor in Training Competency Framework, noting that specific detail in some sub-categories is likely to be modified over time, on the basis of further discussion, consultation, and continuous quality improvement processes.
- All Doctors in Training should be on either the proposed training programme or some form of professional development.
- All Doctors in Training should keep a Record of Professional Development (ROPD).
- Endorsement of the purpose and principles of the Assessment Framework.
- An incentive may be needed to keep all Doctors in Training in the NZ Education Framework for Prevocational Training. Options may be:

- minimum requirements to pass Waypoint 3;
 - proposed ‘certificate’ equivalent to that given in UK (Foundation Achievement of Competence Document (FACD));
 - mandatory to achieve registration, and/ or;
 - other (e.g. loyalty bonus, retention incentives, bonded appointments, funded travel).
- Endorsement of the Principles for the Learning and Training Pathways.
 - New positions are likely to be needed (e.g. Education Directors) and a joint national body will be recommended to oversee the implementation of the New Zealand Training Framework and Assessment System.

A.6. Scope and Components of Prevocational Training Framework

For the purposes of this consultation document, a Doctor in Training includes those who are currently Trainee Interns, through to Registrars⁶.

There are five major components of the New Zealand Education Prevocational Framework

1. Identification and Characteristics of Waypoints
2. Attitudes and Behaviours
3. New Zealand Doctor in Training Competency Framework
 - Levels and Performance
 - Curriculum and Competencies
4. Assessment System
5. Learning and Training Pathways

⁶ A modified descriptor may be needed for those who have not yet qualified with the MBChB.

B. Waypoints

B.1. Purpose of Waypoints

During the process of ‘becoming’ a vocationally registered medical practitioner, there are natural steps in the levels of competencies, responsibilities, accountabilities and supervision requirements. These might form the basis of defining the Waypoints for the proposed NZ Education Framework for Prevocational Training. These Waypoints could/ should be linked eventually to the granting of qualifications, change in status of registration, approval to proceed to the next phase of training, and/or to work in defined scopes.

B.2. Current perceived Waypoints

The current perceived Waypoints and steps towards vocational registration are:

- The award of the MBChB, which allows a graduate to move from a relatively structured learning environment in a clinical setting under the auspices of a University, to a workplace-based learning environment in a DHB, with an emphasis on “on-the-job” learning.
- General Scope Registration
 - Granting of Provisional General Scope – a doctor who has graduated from NZ or Australian medical school who must then work under supervision for a minimum period of 12 months in approved positions. Once fulfilling all conditions (at least four three-month runs, with at least one in medical and one in surgical, and no less than 10 weeks in each; certified in ACLS, and working at the standard required in the NZ health care system, as assessed by supervisors) they may apply for General Scope Registration. If this is not completed within two years, there is a referral of the annual practising certificate to Council.
 - Granting of General Scope – a doctor who has met requirements for provisional scope registration; and will work under a collegial relationship to meet ongoing CPD requirements.
- Entry to basic vocational training – a doctor has met College entry requirements; may require a competitive selection process.
- Entry to advanced vocational training – may be approved after completion of specific time and rotations and/ or specialty-specific barrier assessment(s) (e.g. Part 1).
- Award of Fellowship - after completion of specific time and rotations and / or a specialty-specific barrier assessment (Part 2).

- Granting of Vocational Scope Registration – when a doctor has completed specialist training’ is registered as a specialist and is participating in an approved recertification programme.

The MCNZ also has a “Special Purpose Scope”, which is for doctors who are teaching as a visiting expert, undertaking postgraduate training, undertaking research or are Locum tenens in a specialist post. This is not a pathway to registration within a general scope or in a vocational scope of practice.

B.3. Conceptualisation of Waypoints for new Proposed Framework

Framework of scopes of responsibility/ levels of supervision

The Joint Working Party agreed that there should be a smooth progression in learning across the Prevocational training period and that it is important to ensure that assessment does not introduce too much discontinuity. Nonetheless, there need to be some Waypoints within the framework to foster learning and to allow for a pragmatic determination of whether or not the requisite competencies have being achieved.

The Joint Working Party agreed initially that there needed to be a minimum of two Waypoints. After subsequent discussion it became clearer that there were at least three stages within the Prevocational training period, with one Waypoint marking the entry to the Prevocational period, followed by two interim Waypoints. A further Waypoint coincides with entry to independent specialty practice and is not fully spelled out in this document. An important component of this proposed NZ Education Framework for Prevocational Training is for the colleges to accept and recognise Waypoint 3.

| Waypoints | Description and Distinguishing Features of Doctor in Training (DIT) |
|--|--|
| <p style="text-align: center;">After Waypoint 1 becomes Category 1 Doctor in Training</p> | <p>This doctor is relatively inexperienced and requires close supervision. The DIT may have significant elements of 'unconscious incompetence' so face-to-face supervision is needed. Performance of defined tasks occurs in closely-supervised controlled and clinical settings. There are aspects of inexperience in the application of medical knowledge and skills beyond straightforward clinical problems. Senior supervision (e.g. by other DIT, educational advisors or consultants) is regular (e.g. hourly) and close at hand.</p> <ul style="list-style-type: none"> • Has a role in service provision alongside education and training • May assess patients independently, but case reviewed with Supervisor before any significant treatment instituted • Every patient must be seen by a more senior colleague within hours after DIT assessment • May undertake limited prescribing according to protocol • May request limited range of significant investigations (e.g. chest x-ray) |
| <p style="text-align: center;">After Waypoint 2 becomes Category 2 Doctor in Training</p> | <p>This doctor is still relatively inexperienced but elements of the doctor-patient interaction can be done reliably so telephone contact for supervision may be sufficient for most encounters. DIT uses increasing initiative, medical knowledge and skills, but still refers frequently to guidelines/supervisor. Performance is undertaken in an increasing range and complexity of clinical scenarios from chronic to acute and emergency care clinical settings without face-to-face supervision. More senior supervision is regular (e.g. daily) and supervisor(s) readily available if called.</p> <ul style="list-style-type: none"> • Role in service provision is significantly greater than time in formal learning activities • May assess patients independently and treatment initiated independently before discussion with Supervisor • Patient reviewed within 24 hours (review could be face-to-face, by phone or by email discussion) • Patient reviewed by senior colleague before discharge or end of consultation • May prescribe within institutional guidelines / pharmacopoeia • May request routine investigations • May recommend referrals in acute situations |

| Waypoints | Description and Distinguishing Features of Doctor in Training (DIT) |
|--|--|
| After Waypoint 3 becomes Category 3 Doctor in Training | <p>This doctor is able work independently for most day-to-day tasks. Depending on speciality, performance occurs in a wide range of clinical settings with minimal or no face-to-face supervision. Has contact daily to weekly with supervisor. This doctor will be looking to work in areas in which they have an interest in specialising. This doctor may enter vocational training when they have met the requirements.</p> <ul style="list-style-type: none"> • Independent safe management and responsibility for an entire patient episode of care • Supervision and oversight as per training programme requirements • If not in a specialty training programme, must continue to be involved in some form of ongoing training programme / CPD • Ability to know limitations and to make appropriate referrals |
| After Waypoint 4 becomes Category 4 Doctor | <p>This doctor is expert in some fields and may work independently but requires mentorship from time to time to ensure practice is remaining benchmarked with others in his/her field. Independent vocational practice</p> |

The following table outlines how the stages of training might be represented using an extended clarification of roles and responsibilities.

| | After Waypoint | After Waypoint | After Waypoint |
|-------------------|---|--|---|
| Feature | 1 Category 1 Doctor in Training | 2 Category 2 Doctor in Training | 3 Category 3 Doctor in Training |
| Role in Care Team | <p>Works as junior team member in a medical team under clinical supervision of the senior doctor in charge of the patient(s). May work directly with that senior doctor if there are no other DITs in the team.</p> | <p>Works as team member in a medical team under supervision of clinical supervision of the senior doctor in charge of the patient(s). May work directly with that senior doctor if there are no other DITs in the team. May help supervise Cat 1 DITs.</p> | <p>May work independently or in a health care team as a more senior DIT. May help supervise Cat 1 and 2 DITs.</p> |

| | After Waypoint | | After Waypoint | | After Waypoint | |
|---|---|-------------------------------|--|-------------------------------|---|-------------------------------|
| Feature | 1 | Category 1 Doctor in Training | 2 | Category 2 Doctor in Training | 3 | Category 3 Doctor in Training |
| Supervisor frequency and availability | Supervision by senior clinician or more senior DITs: <ul style="list-style-type: none"> • Hourly, face-to-face contact • More senior help immediately available by phone, or to come if called. Supervisor reviews patient and management plan before it is instituted. There may be other educational supervisors for specific purposes e.g. professionalism / CPD. | | Supervision by senior clinician or more senior DITs: <ul style="list-style-type: none"> • Daily face-to-face contact, • Supervisor available by phone, or to come if called. Supervisor reviews patient and management plan before patient is discharged. There may be other educational supervisors for professionalism / CPD etc. | | Supervision by senior clinician or more senior DITs: <ul style="list-style-type: none"> • Regular face-to-face contact dictated by level of experience, training programme requirements • Supervisor contactable but not immediately available. Not all patients may need to be reviewed with supervisor during their episode of care. There may be other educational supervisors for professionalism / CPD etc. | |
| Types of patient episodes and Limitations in range of cases | Responsibility for initial assessment and performing aspects of care of a wide range of patients in close collaboration with more senior staff. Acute care, ward calls, chronic and ambulatory care. Should not assess / manage unstable or potentially unstable patients without close supervision. | | Responsibility for initial assessment and day-to day care of a wide range of patients in collaboration with more senior staff. Emergency care, acute care, ward calls, chronic and ambulatory care. Should not manage critically unwell patients without more senior assistance. | | May take responsibility for whole episodes of care of groups of patients (e.g. acute call, or clinic). Emergency care, acute care, ward calls, chronic and ambulatory care, house calls. Should be competent to provide initial care in nearly all settings. | |
| Contexts of Practice | Hospital, GP and/or community. NZ or overseas (elective). | | Hospital, GP and/or community. NZ or Australia. | | Hospital, GP and/or community. NZ or Australia. | |

| | After Waypoint | | After Waypoint | | After Waypoint | |
|---------------------|----------------|---|----------------|--|----------------|---|
| Feature | 1 | Category 1 Doctor in Training | 2 | Category 2 Doctor in Training | 3 | Category 3 Doctor in Training |
| | | Full range of acute and chronic care services. | | Range of acute and chronic care services where is not necessary to have the ability to take responsibility for a patient care alone for any length of time. May undertake night shifts in DHBs under supervision. | | Range of acute and chronic care services where the DIT must take responsibility for a complete episode of patient care. Supervises others on night shift in DHBs May undertake night shifts in GP / community settings. |
| Range of experience | | Has had experiences in most specialties but not taken responsibility for whole episodes of patient care. <i>Clinical management Level 2-3 for common and important adult problems; others as specified in Appendices</i> | | Increasing experience, makes more clinical decisions in more settings commensurate with competence and confidence. Has developed an approach to all common and important conditions. <i>Clinical management Level 3-4 for common and important adult problems; others as specified in Appendices</i> | | Has an approach to any clinical presentation. <i>Clinical management</i> - minimum Level 4 at entry for common and important problems; others as specified in Appendices - Level 5 at exit, if speciality area |
| Legal duties | | Limited prescribing, discharge summaries and routine letters, work certificates. | | Prescribing within local guidelines. ACC certificates, death certificates, letters. | | Mental Health Act Letters Court |

| | After Waypoint | | After Waypoint | | After Waypoint | |
|--|----------------|--|----------------|--|----------------|---|
| Feature | 1 | Category 1 Doctor in Training | 2 | Category 2 Doctor in Training | 3 | Category 3 Doctor in Training |
| | | Informed consent for straightforward minor procedures e.g. venesection, AB, IV line insertion. <i>Professionalism Level 3</i> | | Informed consent for non- or minor interventional procedures e.g. blood transfusion. <i>Communication Level 4</i> | | Informed consent for major interventional procedures e.g. surgery. <i>Professionalism</i> – <i>Minimum level 4 at entry</i> – <i>Level 5 at exit</i> |
| Communication and Professionalism | | <i>Communication Level 3</i> <i>Professionalism Level 3</i> Note: should exhibit AMC attributes at all stages of training | | <i>Communication Level 4</i> <i>Professionalism Level 4</i> | | <i>Communication Level 4-5</i> <i>Professionalism Level 4-5</i> |

The assessment methodologies adopted will need to match the competencies, performance and roles of the DIT.

For example:

- work as a team member and professionalism may be assessed by multisource feedback
- patient management may be assessed by a long case and/or Case Based Discussion
- Professionalism may be assessed by Case Based Discussion
- CPD may be assessed/ validated by MOPS-type portfolio
- Clinical skills may be assessed by a mini-CEX, Direct Observation of Procedural Skills (DOPS) and mastery-type modules (e.g. resuscitation)
- Ward calls and night shift may be assessed by Case Based Discussion around a Log

C. Competency Definitions

It is agreed that a combination of competency definitions will be reflected in the Education Framework for Prevocational Training and the design of the Assessment System. The MCNZ definitions of competence and performance have also informed the discussions of the Joint Working Party. In simplistic terms the MCNZ regards competence as ‘can do’; and performance as ‘does do’.

C.1. Definitions

The literature gives no consistently adopted definition of what constitutes a competency, or how it differs from an objective, goal or task.

Govaert’s (2008) conceptual definition includes:

“Competency is an individual’s ability to make choices from a repertoire of behaviours for handling situations and tasks in specific contexts of professional practice.”

“Competencies are context-dependent and always imply integration of knowledge, skills, judgements and attitudes.”

“Knowing is not enough for doing and nor is doing enough for learning; competencies require experience of, and reflection on, professional practice at any level of experience.”

Albanese et al (2008) take a more task-focused approach, which fits well with the detail of the Competency Framework

“Propose 5 criteria that define a competency:

- It focuses on the performance of the end-product or goal-state of instruction
- It reflects expectations that are external to the immediate instructional programme
- It is expressible in terms of measurable behaviour
- It uses a standard for judging competence that is not dependent upon the performance of other learners
- It informs learners, as well as other stakeholders, about what is expected of them.”

Harden et al (1999), note that competency-based education focuses on the result of the educational process, not the process itself.

C.2. Determining competence and performance

For most professional (and other) situations there is a useful series of key questions that can be applied to elicit understanding, outcomes and responsibilities. They are:

- What to do? (task-oriented, performance- and practice-based)
- Why to do it? (knowledge-based; cognitive-based, clinical reasoning-base)
- When to do it and when not to do it? (clinical reasoning, limits of personal practice et al)
- Where to do it? (e.g. rural, primary, community, secondary, tertiary, quaternary; referral process)
- How to do it? (task-oriented, performance- and practice-based, alone or with team/supervisor)

When considering competence and performance, the Working Party identified some shortcomings in the ACFJD approach as follows:

- it doesn't adequately capture key aspects of a professional doctor's role, such when to do and when not to, why it is done and where;
- it is possible to do discrete tasks without necessarily being a good doctor; hence it is important to foster the integration of learning;
- it provides no indication of the level of competence expected;
- it doesn't give adequate context, nor does it relate tasks to scopes of practice.

The proposed NZ Education Framework for Prevocational Training attempts to overcome these shortcomings.

D. Domains

The three domains used in this New Zealand Education Framework for Prevocational Training are those of the *Australian Curriculum Framework for Junior Doctors*:

1. Clinical management
2. Communication
3. Professionalism

While a unanimous decision has been made to use the Australian Domains, especially for benchmarking and equivalence purposes, these domains align very closely with the set of Domains currently informing the work and publications of the MCNZ. Its current set of domains is:

- Clinical Expertise/ Medical Care
- Communication
- Collaboration
- Management
- Scholarship
- Professionalism

The following table demonstrates the clear links between the two sets of domains.

| MCNZ domains and subsets | Match with Proposed NZ Prevocational Training Framework |
|--|---|
| Clinical expertise/ Medical care <ul style="list-style-type: none">• diagnostic and management skills (skills that may be specific to each branch of practice, but may be generic to several - such as prescribing, surgical skills, psychotherapy)• expert adviser skills | Clinical management |

| MCNZ domains and subsets | Match with Proposed NZ Prevocational Training Framework |
|---|---|
| Communication <ul style="list-style-type: none"> • with patients and families • with colleagues • medical recordkeeping | Communication |
| Collaboration <ul style="list-style-type: none"> • teamwork | Professionalism |
| Management <ul style="list-style-type: none"> • personal management (including insight and recognising limits) • management within systems • use of time and resources | Professionalism |
| Scholarship <ul style="list-style-type: none"> • life long learning • teaching • research • critical appraisal | Professionalism |
| Professionalism <ul style="list-style-type: none"> • honesty • integrity • probity • respect for patients (including cultural competence with respect to gender, ethnicity, boundaries, and New Zealand's biculturalism) • respect for colleagues • moral reasoning & ethical practice | Professionalism |

The Medical Council's core document, *Good medical practice* is now used, variously modified, by many regulatory authorities around the world. Perceived gaps in the Prevocational Training Framework, compared with the material currently outlined by MCNZ in *Good medical practice* are

the central role of the general practitioner, financial and commercial dealings, conflicts of interest (hospitality, gifts, inducements) and financial interests in hospitals, nursing homes and other medical organisations.

E. Attitudes and Behaviours

The Australian Medical Council (AMC) attributes and behaviours (with minor adaptations) will be used in the New Zealand Education Prevocational Framework, as these transcend and are intrinsic across all three domains. Some aspects of the ACFJD are included here instead of in the Competency Framework, to give a consistent approach.

- Recognition that the doctor's primary professional responsibilities are the health interests of the patient and the community.
- Recognition that the doctor should have the necessary professional support, including a primary care physician, to ensure his or her own well-being.
- Respect for every human being, including respect of sexual boundaries and sexual orientation.
- Respect for community values, including an appreciation of the diversity of human background and cultural values.
- A commitment to ease pain and suffering.
- A realisation that it is not always in the interests of patients or their families to do everything that is technically possible to make a precise diagnosis or to attempt to modify the course of an illness.
- An appreciation of the complexity of ethical issues related to human life and death, including the allocation of scarce resources.
- A realisation that doctors encounter clinical problems that exceed their knowledge and skills, and that, in these situations, they need to consult and/or refer the patient for help, in clinical, cultural, social and language related matters as appropriate.
- An appreciation of the responsibility to maintain standards of medical practice at the highest possible level throughout a professional career.
- An appreciation of the responsibility to contribute towards the generation of knowledge and the professional education of junior colleagues.
- An appreciation of the systems approach to health care safety, and the need to adopt and practise health care that maximises patient safety including cultural safety.
- A commitment to communicating with patients and their families, and to involving them fully in planning management.
- A desire to achieve the optimal patient care for the least cost, with an awareness of the need for cost-effectiveness to allow maximum benefit from the available resources.
- A preparedness to work effectively in a team with other health care professionals.

- A realisation that one's personal, spiritual, cultural, sexual orientation or religious beliefs should not prevent the non-judgemental provision of adequate and appropriate information to the patient and/or the patient's family, or the provision of appropriate management including referral to another practitioner.

F. Competence and Performance Levels for Prevocational Training

F.1. The number of levels and their dimensions

Formal medical education is necessary to move learners from incompetent to expert. The number of discernable levels within the educational continuum is moot, and has been variously depicted in:

- three (the 'see one, do one, teach one') approach;
- four ('knows about', 'can do', 'shows', 'does') of Miller's pyramid, or
- five or more [Illot and Allen, Dreyfus and Dreyfus stages].

It is worth noting that Dreyfus described two higher levels, to a total of seven:

- Virtuoso - has a higher degree of competence, advances the standard and has an easy and creative way of doing things; and
- Maestro - changes the history in a field by inventing and introducing radical innovations.

There is little consensus in the literature about the optimal number of levels, with this, in part, depending on the ability to describe and assess them in a meaningful way (Robinson et al, 1995). Nor is there consensus about the dimensions of learning that may relate to levels, with the range being from three to 16 (Robinson et al, 1995). Nonetheless, in medicine there are a number of key dimensions to be considering in the training from student doctor to experienced clinicians. These include (list not exhaustive):

- Experience
- Cognitive demand (e.g. technical task versus clinical reasoning; diagnostic versus management orientation; patient complexity and comorbidities; illness of patient)
- Age of patient
- Range of settings from acute to chronic
- Relative amount of support, independence and supervision
- Confidence (often scope-dependent)
- Efficiency of decision-making
- Responsibility for outputs
- Follower versus innovator

Many of these are reflected in the proposed Waypoints and the Education Framework for Prevocational Training.

F.2. Number of levels for the New Zealand Framework

The Joint Working Party proposes to adopt the five levels that are currently being used for aspects of their curriculum and assessment, especially procedural skills. It also agreed that five levels should be used for all domains and components, for ease of simplicity and understanding.

These five levels thus form an important component of the New Zealand Doctor in Training Competency Framework. Loosely, the first three levels correspond to the competencies at the end of the three phases of Medical School; i.e. at the end of current Years 5 and 6 (TI) respectively; the fourth level corresponds to performance in prevocational training; with the 5th to specialty training and/or vocational practice.

For this framework, ‘competence’ is regarded as doctors in training can do safely in supervised environment; ‘performance’ refers to the ability to decide when to do the task and to complete the task/ role safely (does do), unsupervised. Note the shift at Level 3 from competence, to performance and accountability in specific roles. It is assumed that those achieving at higher levels retain the attributes of earlier competencies.

F.3. Framework and descriptors for levels

The framework links to the three domains of the ACFJD. This framework is intended to give guidance for determining levels of competence for all essential aspects of the New Zealand Doctors in Training Competency Framework.

| Level | General descriptor | Clinical Management Domain | Communication Domain | Professionalism Domain |
|-------|--|---|--|--|
| 5 | <p>EXPERT</p> <p>Performance in wide range of clinical settings with minimal or no supervision.</p> <p>Innovative, efficient, ‘seamless’, accurate.</p> | <p>Rapid and accurate identifier of all main problems, differential diagnoses and management plans.</p> <p>Performs procedural skills competently and routinely without direction and assists</p> | <p>Timely and effective communicator with patients, families, health care workers, students and other relevant persons, in both routine and complex situations.</p> <p>Effective member of</p> | <p>By experience, nature and conduct, is a leader in health care settings.</p> <p>Accountable for patient management, and supervision of others in a wide range of clinical scenarios.</p> |

| | | | | |
|---|--|--|---|--|
| | | learners. Makes decisions of when skills best done/not done. | multidisciplinary team/s. Identifies innovative ways of incorporating technology for improvements in patient care. | Positive role model, with high level of development of emotional intelligence. Active teacher and researcher. Performs more complex medicolegal duties (e.g. Mental Health Act). |
| 4 | PROFICIENT Increasing initiative, medical knowledge and skill, but still refers frequently to guidelines/supervisor. Performance in increasing range and complexity of clinical scenarios from chronic to acute and emergency care clinical settings without direct supervision. Senior supervision is regular (e.g. daily) and available if called. | Accurate identifier of all main problems with multi-problem patients. Increasingly proposes and initiates comprehensive management plan, in consultation with team or supervisor. Performer of straightforward procedural skills / tasks competently most times without direction. | Timely and effective communicator with patients, families, health care workers, students and other relevant persons, in routine / straightforward situations. Effective user of wide range of information technologies. Reliable and constructive team member; takes lead in pre-determined settings. | Well-developed self-awareness of competence and limits. Accountable in increasing range and complexity of clinical scenarios from chronic to acute and emergency care. Performs simple medico-legal duties independently (e.g. work certificate, prescribing). Assists learners. |
| 3 | COMPETENT Performance of defined tasks in closely-supervised controlled and clinical settings. Aspects of inexperience in the application of medical knowledge and skills beyond straightforward clinical problems. | Accurate identifier of main problems and differential diagnoses. Proposes and initiates basic management plan around all main issues identified, in consultation with team or supervisor. | Effective communicator with patients, families, health care workers, students and other relevant persons, in routine / straightforward situations. User of wide range of information technologies. Reliable and constructive team | Limited integration of professional roles and responsibilities. Accountability in selected basic clinical scenarios. Very selected medico-legal duties (e.g. prescribe under protocol). |

| | | | | |
|---|--|--|---|--|
| | Senior supervision is regular (e.g. several times per day) and close at hand (e.g. pre-vocational doctors). | Performer of selected procedural skills / tasks independently from start to finish (either supervised or unsupervised). | member. | |
| 2 | <p>EXPERT NOVICE</p> <p>Competence in controlled and closely supervised clinical settings</p> <p>Direct supervision</p> <p>Knowledge and skills increasingly integrated in clinical scenarios.</p> | <p>Performs in controlled and clinical settings under direct supervision. Integrates and synthesises key patient problems, main differential diagnoses and proposes basic management plan (investigation and treatment).</p> <p>Performer of completed skill under supervision or with step-by-step direction (may have been a simulation or similar).</p> | <p>Communicator with patients, families, health care workers, students and other relevant persons, in controlled and clinical settings under supervision.</p> | <p>Limited accountability for aspects of patient care.</p> <p>Implement and evaluate a number of personal approaches to professionalism in clinical settings.</p> |
| 1 | <p>NOVICE</p> <p>Experience in controlled settings</p> <p>Supervision constant</p> <p>Knowledge and skills at 'building block' level – focus is on skill acquisition</p> | <p>Performs elements of history and/ or examination techniques in controlled settings.</p> <p>For each problem proposes a short differential diagnosis.</p> <p>Knows about, observed or performed an element of the procedural skill / task.</p> | <p>Performs elements of communication within controlled and clinical settings under supervision.</p> | <p>No accountability for patient care.</p> <p>Identify essential features of professionalism in range of settings.</p> <p>Develop a self-reflective model for development of personal professionalism.</p> |

G. New Zealand Doctor in Training Competency Framework

The New Zealand framework is closely aligned with Australia's, in recognition of the Australasian collaboration for accreditation between the AMC and MCNZ for the undergraduate and vocational training phases on either side of the training continuum.

The framework's structure and content has largely been adopted from the *Australian Curriculum Framework for Junior Doctors (ACFJD)*, but also takes cognisance of the standards of the MCNZ. The key changes are:

- Repositioning of most attitudinal aspects into overarching structure, using AMC attitudes with minor adaptations
- Broad adoption of ACFJD, especially to encompass and retain domains and breadth
- Merging of statements to reduce redundancy / overlap, and to even out granularity
- Re-ordering of the components of the ACFJD to reflect the Working Party members' strong desire to have the primacy of a doctor's role in the first section of the Framework.

The following section closely aligns with the ACFJD, together with adopting a better balance of doing (task-focused work) with other essential cognitive skills of the doctor in training, and emphasising practice in New Zealand.

G.1. Clinical Management

G.1.1. Patient assessment

| | Waypoint 1 Entry to Cat 1 | Waypoint 2 End of Cat 1 Entry to Cat 2 | Waypoint 3 End of Cat 2 Entry to Cat 3 | Vocational End of Cat 3 Entry to Cat 4 |
|--|------------------------------|--|--|--|
| Through the application of knowledge, skills, clinical reasoning and organisational procedures, perform comprehensive patient assessment for a range of problems and conditions, to the expected level (See Appendix 1a, 1b and 2 for lists of conditions and problems with expected levels of performance for each stage) | | | | |

| | Waypoint 1 Entry to Cat 1 | Waypoint 2 End of Cat 1 Entry to Cat 2 | Waypoint 3 End of Cat 2 Entry to Cat 3 | Vocational End of Cat 3 Entry to Cat 4 |
|---|------------------------------|--|--|--|
| • Apply the stages of a verification process to ensure the correct identification of a patient and to avoid patient misidentification | 3 | 5 | 5 | 5 |
| • Describe the modes of presentation of a range of problems and conditions, and elicit relevant symptoms and signs for each | 2 | 3 | 4 | 5 |
| • Perform comprehensive patient assessments, including obtaining histories and targeted examinations | 2 | 3 | 4 | 5 |
| • For each assessment: | | | | |
| – generate a ranked problem list and provisional diagnosis | 2 | 3 | 4 | 5 |
| – propose/ confirm differential diagnosis for the main problem(s) | 2 | 3 | 4 | 5 |
| • Identify and select (with justification) the initial investigations relevant to a patient's presenting problem or condition | 2 | 3 | 4 | 5 |
| • Prepare a patient management plan using the outcomes of history, examination and initial test investigations | 2 | 3 | 4 | 5 |
| • Demonstrate clinical reasoning by regularly re-evaluating the patient's problems, based on outcomes of investigations and natural history | 2 | 3 | 4 | 5 |
| • Describe the criteria and processes for any relevant referral or consultation | 2 | 3 | 4 | 5 |
| • Prepare relevant, succinct information for use by a range of health professionals in the referral / | 2 | 3 | 4 | 5 |

| | Waypoint 1 Entry to Cat 1 | Waypoint 2 End of Cat 1 Entry to Cat 2 | Waypoint 3 End of Cat 2 Entry to Cat 3 | Vocational End of Cat 3 Entry to Cat 4 |
|----------------------|--------------------------------------|---|---|---|
| consultation process | | | | |

G.1.2. Patient management

| | Waypoint 1 Entry to Cat 1 | Waypoint 2 End of Cat 1 Entry to Cat 2 | Waypoint 3 End of Cat 2 Entry to Cat 3 | Vocational End of Cat 3 Entry to Cat 4 |
|---|--|--|--|--|
| Management Options <ul style="list-style-type: none"> Describe, justify, implement and monitor optimal management plans for a range of common problems and conditions, together with a rationale for the importance of considering alternative management options. | 2 | 3 | 4 | 5 |
| General Patient Care <ul style="list-style-type: none"> Monitor and prevent complications from changes in patient status - hydration, nutrition, mobility, excretion and mentation. Manage supplemental feeding and its complications | 2 2 | 3 3 | 4 3 | 5 5 |
| Fluid & electrolyte management <ul style="list-style-type: none"> Apply individualised plans of fluid and electrolyte management, using knowledge of the requirements for all age groups. | 2 | 2 | 4 | 5 |
| Therapeutics (also See Appendix 4 prescribing) <ul style="list-style-type: none"> Review the actions, indications, contraindications and adverse effects of medicines and monitor the effects of therapies Outline the respective roles of nurses, pharmacists and allied health professionals in medication management Prescribe appropriately and safely | 2 2 1 (at present, desirably 3) | 3 4 3 | 4 4 4 | 5 5 5 |

| | Waypoint 1 Entry to Cat 1 | Waypoint 2 End of Cat 1 Entry to Cat 2 | Waypoint 3 End of Cat 2 Entry to Cat 3 | Vocational End of Cat 3 Entry to Cat 4 |
|--|------------------------------|--|--|--|
| Pain management | | | | |
| • Describe the hierarchy of therapies and options for pain control | 2 | 3 | 4 | 5 |
| • Explain why pain therapies need to match a patient's analgesia requirements | 2 | 3 | 4 | 5 |
| • Apply a plan of timely pain control appropriate to an individual patient's needs | 1 | 3 | 4 | 5 |
| Blood products | | | | |
| • Prescribe blood products only when indicated, and in accordance with local guidelines | 1 | 2 | 4 | 5 |
| • Recognise and manage transfusion reactions | 2 | 3 | 4 | 5 |
| Glycaemic control | | | | |
| • Propose, institute and monitor appropriate regimens for glucose control in a range of settings (perioperative, hyperglycaemic crisis, elderly, comorbidities, etc) | 1 | 3 | 4 | 5 |
| Oxygen and Ventilation | | | | |
| • Prescribe oxygen when indicated | 1 (at present, desirably 2) | 3 | 4 | 5 |
| • Propose, institute and monitor oxygen delivery in Type 1 and 2 respiratory failure | 1 | 3 | 4 | 5 |
| • Initiate ventilation when indicated | 1 | 2 | 3 | 4 |
| Anticoagulation | | | | |
| • Prescribe DVT prophylaxis where appropriate | 1 (at present, desirably 2) | 3 | 4 | 5 |
| • Propose, institute and monitor anticoagulant therapy (e.g. DVT/ PE , atrial fibrillation) | 1 | 3 | 4 | 5 |

| | Waypoint 1 Entry to Cat 1 | Waypoint 2 End of Cat 1 Entry to Cat 2 | Waypoint 3 End of Cat 2 Entry to Cat 3 | Vocational End of Cat 3 Entry to Cat 4 |
|--|------------------------------|--|--|--|
| Primary and Integrated Care⁷ | | | | |
| • Manage patients with common self-limiting disorders, chronic illnesses, and non-specific illnesses | 2 | 3 | 4 | 5 |
| • Describe the importance of primary care teams, comprehensive records and prolonged therapeutic relationships in the promotion of continuity of care | 3 | 3 | 4 | 5 |
| • Identify and describe the roles of healthcare and community services available, and select appropriate service for patient referrals | 2 | 3 | 4 | 5 |
| • Describe the indications for and implications of a change to a palliative approach to management | 2 | 2 | 2 | 4 |
| • Identify patients suitable for rehabilitation programmes and older people's health services and other integrated care programmes | 2 | 3 | 4 | 5 |
| • Communicate effectively with the health care professionals involved with patient's ongoing care | 2 | 3 | 4 | 5 |
| Ongoing care planning | | | | |
| • Demonstrate the various elements of effective and safe ongoing care planning (e.g. early, continuous, multidisciplinary) within local guidelines | 2 | 3 | 4 | 5 |
| • In liaison with the multidisciplinary team, identify and arrange appropriate external services to ensure an efficient and safe transition from the inpatient to community setting for patients | 2 | 3 | 4 | 5 |

⁷ Renamed from Sub-acute Care to reflect NZ Context

| | Waypoint 1 Entry to Cat 1 | Waypoint 2 End of Cat 1 Entry to Cat 2 | Waypoint 3 End of Cat 2 Entry to Cat 3 | Vocational End of Cat 3 Entry to Cat 4 |
|--|------------------------------|--|--|--|
| <ul style="list-style-type: none"> Describe indication for and regulatory requirements of various levels of residential care Determine appropriate follow-up arrangements. | 2 | 3 | 4 | 5 |
| Health promotion <ul style="list-style-type: none"> Identify environmental and lifestyle risks to health and advocate for healthy lifestyles Incorporate health and wellness promotion into patient management plans Explain the positive and negative aspects of health screening and prevention programmes | 3 | 4 | 4 | 5 |
| | 2 | 3 | 4 | 5 |
| | 3 | 4 | 4 | 5 |

G.1.3. Safe Patient Care

| | Waypoint 1 Entry to Cat 1 | Waypoint 2 End of Cat 1 Entry to Cat 2 | Waypoint 3 End of Cat 2 Entry to Cat 3 | Vocational End of Cat 3 Entry to Cat 4 |
|---|------------------------------|--|--|--|
| Apply a range of practices and resources to ensure health care is optimally safe <ul style="list-style-type: none"> Describe the essential features of risk management in health care, including audit and its uses Differentiate between systemic, system, and individual error, and compare and contrast the responsibilities and responses to each Work within institutional guidelines to minimise medication errors and adverse effects Identify and manage adverse events and near misses | 2 | 3 | 4 | 5 |
| | 2 | 3 | 4 | 5 |
| | 2 | 3 | 4 | 4 |
| | 1 (at present, desirably 3) | 3 | 4 | 5 |

| | Waypoint 1 Entry to Cat 1 | Waypoint 2 End of Cat 1 Entry to Cat 2 | Waypoint 3 End of Cat 2 Entry to Cat 3 | Vocational End of Cat 3 Entry to Cat 4 |
|---|------------------------------|--|--|--|
| <ul style="list-style-type: none"> Outline and use the procedures to be followed in real and potential public health emergencies, including notification to public health bodies | 1 | 2 | 3 | 4 |
| <ul style="list-style-type: none"> Use best-practice methods to minimise transmission of infection between patients and to reduce antibiotic/antiviral resistance, especially hand-washing | 4 | 4 | 5 | 5 |
| <ul style="list-style-type: none"> Request radiological investigations and procedures prudently with regard to risk and safety | 1 (at present, desirably 3) | 3 | 4 | 5 |
| <ul style="list-style-type: none"> Negotiate a management plan with patients | 2 | 3 | 4 | 5 |

G.1.4. Common Problems and Conditions

See Appendices 1a, 1b and 2 for New Zealand list of problems and conditions, and the performance levels. The list is provided to GUIDE learning and the construction of suitable junior doctor terms.

G.1.5. Skills and Procedures

(see Appendix 3 for Procedures and expected level of performance)

| | Waypoint 1 Entry to Cat 1 | Waypoint 2 End of Cat 1 Entry to Cat 2 | Waypoint 3 End of Cat 2 Entry to Cat 3 | Vocational End of Cat 3 Entry to Cat 4 |
|---|------------------------------|--|--|--|
| Decision-making | | | | |
| <ul style="list-style-type: none"> Demonstrate knowledge of the listed procedures by describing their indications and contraindications and appropriately explaining the proposed procedure to the patient | 2 | 3 | 4 | 5 |
| <ul style="list-style-type: none"> Consider and select procedures necessary to diagnose and manage individual patients | 2 | 3 | 4 | 5 |

| | Waypoint 1 Entry to Cat 1 | Waypoint 2 End of Cat 1 Entry to Cat 2 | Waypoint 3 End of Cat 2 Entry to Cat 3 | Vocational End of Cat 3 Entry to Cat 4 |
|---|----------------------------------|--|--|--|
| <ul style="list-style-type: none"> Recognise one's own limitations in regard to selection and performance of the listed procedures | 2 | 3 | 4 | 5 |
| Informed Consent <ul style="list-style-type: none"> Describe and apply the principles of informed consent in day-to-day practice, and recognise self-limitations in this role | 1 (at present, desirably 2 or 3) | 3 | 4 | 5 |
| Preparation and anaesthesia <ul style="list-style-type: none"> Position and prepare the patient appropriately, including provision of appropriate sedation and / or pre-medication where required Identify the need for and arrange local / general anaesthesia as appropriate | 1 1 | 3 2 | 4 4 | 5 5 |
| Procedures <ul style="list-style-type: none"> Demonstrate the appropriate technique using correct equipment Arrange appropriate support staff and orientate to their roles | 2 2 | 3 4 | 4 4 | 5 5 |
| Post-procedure <ul style="list-style-type: none"> Monitor the patient and provide appropriate aftercare, including the identification and management of common complications Interpret, explain and evaluate the results of treatment | 2 2 | 3 3 | 4 4 | 5 5 |

G.1.6. Emergencies

(see Appendix 4 for New Zealand list of emergencies.)

| | Waypoint 1 Entry to Cat 1 | Waypoint 2 End of Cat 1 Entry to Cat 2 | Waypoint 3 End of Cat 2 Entry to Cat 3 | Waypoint 3 End of Cat 3 Entry to Cat 4 |
|---|------------------------------|--|--|--|
| • Describe and recognise the clinical features of acutely ill, deteriorating or dying patients | 2 | 3 | 4 | 5 |
| • Describe and recognise critical and potentially critical physiological disturbances | 2 | 3 | 4 | 5 |
| • Identify situations where resuscitation may need to precede full assessment | 2 | 3 | 4 | 5 |
| • Describe and apply the principles of medical triage | 2 | 3 | 4 | 5 |
| • Recognise the need for immediate resuscitation and display the ability to call for prompt, appropriate assistance | 2 | 3 | 4 | 5 |
| • Certify as competent in basic and advanced cardiac life support (ACLS) | 3 | 4 | 4 | 5 |
| • Identify and appropriately manage transport and patient factors that need to be addressed prior to transfer | 2 | 2 | 3 | 4 |
| • Explain the rationale for and importance of maintaining or increasing the level of care provided during patient transport | 2 | 3 | 3 | 5 |

G.2. Communication

G.2.1. Patient interaction

| | Waypoint 1 Entry to Cat 1 | Waypoint 2 End of Cat 1 Entry to Cat 2 | Waypoint 3 End of Cat 2 Entry to Cat 3 | Waypoint 3 End of Cat 3 Entry to Cat 4 |
|---|------------------------------|--|--|--|
| Apply the principles of good to communication to healthcare relationships with patients, families and other carers, including | | | | |

| | Waypoint 1 Entry to Cat 1 | Waypoint 2 End of Cat 1 Entry to Cat 2 | Waypoint 3 End of Cat 2 Entry to Cat 3 | Waypoint 3 End of Cat 3 Entry to Cat 4 |
|---|------------------------------|--|--|--|
| active listening, the use of interpreters and appropriate use of language | | | | |
| • Identify and explain the impact of the environment on communication, e.g. privacy, location | 4 | 4 | 4 | 5 |
| • Develop and explain strategies to deal with the challenging or vulnerable patient | 3 | 3 | 4 | 5 |
| • Provide clear, honest information to patients, respect their treatment choices and maintain their privacy and confidentiality | 2 | 3 | 4 | 5 |
| • Recognise the language differences between doctors, patients and colleagues | 2 | 3 | 4 | 5 |
| • Recognise and explain the impact of family dynamics on effective communication | 3 | 3 | 4 | 5 |
| • Include relevant family / carers appropriately in healthcare decisions and meetings | 2 | 3 | 4 | 5 |
| • Identify the key features of loss and bereavement | 3 | 3 | 4 | 5 |
| • Participate in breaking bad news to patients and carers | 2 | 3 | 4 | 5 |
| • Support patients after an adverse event | 2 | 3 | 4 | 5 |

G.2.2. Complaints

| | Waypoint 1 Entry to Cat 1 | Waypoint 2 End of Cat 1 Entry to Cat 2 | Waypoint 3 End of Cat 2 Entry to Cat 3 | Waypoint 3 End of Cat 3 Entry to Cat 4 |
|---|------------------------------|--|--|--|
| • Explain and demonstrate the principles of 'open disclosure' | 2 | 2 | 3 | 4 |

| | Waypoint 1 Entry to Cat 1 | Waypoint 2 End of Cat 1 Entry to Cat 2 | Waypoint 3 End of Cat 2 Entry to Cat 3 | Waypoint 3 End of Cat 3 Entry to Cat 4 |
|---|------------------------------|--|--|--|
| <ul style="list-style-type: none"> Identify and explain the roles of the office of the Health and Disability Commissioner, Medical Council of New Zealand, Health Practitioners Disciplinary Tribunal (HPDT), and Advocacy Services (<u>check accuracy of names</u>) | 2 | 3 | 4 | 5 |
| <ul style="list-style-type: none"> Describe the key aspects of the Code of Health and Disability Services Consumers' Rights | 2 | 3 | 4 | 5 |
| <ul style="list-style-type: none"> Identify factors likely to lead to complaints and practice behaviours that appropriately minimise the risk of complaints | 2 | 3 | 4 | 5 |
| <ul style="list-style-type: none"> Respond appropriately to complaints, including notifying more senior staff | 2 | 3 | 4 | 5 |

G.2.3. Information management

| | Waypoint 1 Entry to Cat 1 | Waypoint 2 End of Cat 1 Entry to Cat 2 | Waypoint 3 End of Cat 2 Entry to Cat 3 | Waypoint 3 End of Cat 3 Entry to Cat 4 |
|---|------------------------------|--|--|--|
| Apply information management appropriately and in accordance with legal and institutional requirements to optimise patient care | | | | |
| • Identify and comply with organisational policies and the NZ Health Information Privacy Code | 3 | 3 | 4 | 5 |
| • Demonstrate concise, timely, legible written skills in all correspondence and written requests | 3 | 3 | 4 | 5 |
| • Explain the uses and limitations of electronic patient information and decision-support systems | 2 | 3 | 4 | 5 |
| • Document and communicate drug prescriptions | 1 (at present, desirably 3) | 3 | 4 | 5 |
| • Explain the role and importance of the health records for appropriate coding and continuity of care | 3 | 4 | 4 | 5 |
| • Identify and demonstrate the use of evidence-based practice in clinical decision-making | 2 | 3 | 4 | 5 |
| • Critically appraise information sources | 3 | 3 | 4 | 5 |

G.2.4. Working in teams

| | Waypoint 1 Entry to Cat 1 | Waypoint 2 End of Cat 1 Entry to Cat 2 | Waypoint 3 End of Cat 2 Entry to Cat 3 | Vocational End of Cat 3 Entry to Cat 4 |
|--|------------------------------|--|--|--|
| • Identify the purposes and functions of a range of healthcare teams, their leadership and the roles of patient and carers in the team | 2 | 3 | 4 | 5 |
| • Explain the characteristics of effective teams and | 2 | 3 | 4 | 5 |

| | Waypoint 1 Entry to Cat 1 | Waypoint 2 End of Cat 1 Entry to Cat 2 | Waypoint 3 End of Cat 2 Entry to Cat 3 | Vocational End of Cat 3 Entry to Cat 4 |
|---|------------------------------|--|--|--|
| team members, apply to self and adapt in response to feedback | | | | |
| • Participate in a range of teams and adopt a variety of roles | 2 | 3 | 4 | 5 |
| • Concisely present structured cases to senior medical staff and other health professionals in a range of contexts | 2 | 3 | 4 | 5 |
| • Communicate effectively with team members in a variety of situations (range to include team meetings, telephone consultations, ward rounds) | 2 | 3 | 4 | 5 |
| • Describe the importance of and perform effective written and verbal handover at different stages of medical care, (e.g. team-member to team-member, hospital to general practice) for patient safety and continuity of care | 2 | 3 | 4 | 5 |

G.3. Professionalism

G.3.1. Doctor and Society

| | Waypoint 1 Entry to Cat 1 | Waypoint 2 End of Cat 1 Entry to Cat 2 | Waypoint 3 End of Cat 2 Entry to Cat 3 | Vocational End of Cat 3 Entry to Cat 4 |
|--|------------------------------|--|--|--|
| Provide equitable access to and through culturally appropriate and non-discriminatory health care while adhering to professional responsibilities and standards. | | | | |

| | Waypoint 1 Entry to Cat 1 | Waypoint 2 End of Cat 1 Entry to Cat 2 | Waypoint 3 End of Cat 2 Entry to Cat 3 | Vocational End of Cat 3 Entry to Cat 4 |
|--|------------------------------|--|--|--|
| <ul style="list-style-type: none"> • Explain ethnic inequalities in health, especially Māori Health, and how these have been created and maintained at both systemic and individual levels (includes colonisation and racism) | 3 | 4 | 4 | 5 |
| <ul style="list-style-type: none"> • Identify the impact of Māori tradition, culture and spirituality on illness and health | 3 | 4 | 4 | 5 |
| <ul style="list-style-type: none"> • Identify and respect traditional Māori practices such as Karakia (prayers), Tangihanga (mourning and burial rites) and whānau involvement | 3 | 4 | 4 | 5 |
| <ul style="list-style-type: none"> • Describe potential barriers to accessing healthcare services (range includes physical, educational, economic, social, geographic and cultural) | 3 | 4 | 4 | 5 |
| <ul style="list-style-type: none"> • Critically reflect on own cultural values that may impact on your role as a doctor, including stereotyping | 2 | 3 | 4 | 4 |
| <ul style="list-style-type: none"> • Respect patients' cultural beliefs, values and practices and identify how these may impact on health | 2 | 3 | 4 | 5 |
| <ul style="list-style-type: none"> • Demonstrate prudent use of finite healthcare resources to achieve the best outcomes, using knowledge of the nature and costs of healthcare | | | | |

G.3.2. Professional behaviour

| | Waypoint 1 Entry to Cat 1 | Waypoint 2 End of Cat 1 Entry to Cat 2 | Waypoint 3 End of Cat 2 Entry to Cat 3 | Vocational End of Cat 3 Entry to Cat 4 |
|---|------------------------------|--|--|--|
| <ul style="list-style-type: none"> • Explain and apply the appropriate standard of professional responsibilities and contractual requirements relevant to your position, including | 3 | 3 | 4 | 5 |

| | Waypoint 1 Entry to Cat 1 | Waypoint 2 End of Cat 1 Entry to Cat 2 | Waypoint 3 End of Cat 2 Entry to Cat 3 | Vocational End of Cat 3 Entry to Cat 4 |
|---|------------------------------|--|--|--|
| punctuality | | | | |
| • Reflect on personal experiences, actions and decision-making | 3 | 3 | 4 | 5 |
| • Demonstrate integrity and honesty in own practice, including working within personal capabilities | 5 | 5 | 5 | 5 |
| • Comply with the legal requirements of and professional standards associated with being a doctor, including the completion of appropriate medicolegal documentation | 4 | 4 | 4 | 5 |
| • Comply with national standards regarding professional boundaries, e.g. sexual and financial boundaries in doctor-patient relationships, providing care to yourself and those close to you | 3 | 4 | 4 | 5 |
| • Respect patient privacy and confidentiality | 2 | 3 | 4 | 5 |
| • Prioritise daily workload and meet multiple demands within a limited timeframe | 2 | 3 | 4 | 5 |
| • Identify and minimise personal health risks of medical practice | 3 | 3 | 4 | 5 |
| • Optimise personal health and well-being to minimise risk to others | 3 | 3 | 4 | 5 |
| • Explain the ethical complexity of medical practice and apply professional and ethical codes of practice | 2 | 3 | 4 | 5 |
| • Accept responsibility for own ethical decisions, including the need to consult colleagues about ethical concerns | 2 | 3 | 4 | 5 |

| | Waypoint 1 Entry to Cat 1 | Waypoint 2 End of Cat 1 Entry to Cat 2 | Waypoint 3 End of Cat 2 Entry to Cat 3 | Vocational End of Cat 3 Entry to Cat 4 |
|---|--------------------------------------|---|---|---|
| <ul style="list-style-type: none"> Identify the services available for practitioners in difficulty, recognise when they are needed and refer appropriately and with empathy (e.g. Doctors Health Advisory, MCNZ) | 2 2 | 3 3 | 4 4 | 5 5 |
| <ul style="list-style-type: none"> Identify the leadership roles and leadership qualities that may be required of a doctor | 2 | 3 | 4 | 5 |

G.3.3. Teaching and Learning

| | Waypoint 1 Entry to Cat 1 | Waypoint 2 End of Cat 1 Entry to Cat 2 | Waypoint 3 End of Cat 2 Entry to Cat 3 | Vocational End of Cat 3 Entry to Cat 4 |
|---|------------------------------|--|--|--|
| • Demonstrate commitment to continuous learning by identifying and addressing personal learning needs | 3 | 3 | 4 | 5 |
| • From the use of varied approaches to learning and teaching as part of your professional practice, identify the relative strengths and weaknesses of various methods | 2 | 3 | 4 | 5 |
| • Participate in effective supervision, learning, assessment, and feedback to others, using elements of good educational practice | 2 | 3 | 4 | 5 |
| • Predict and plan your future career options using a range of resources, experiences and mentors | 2 | 3 | 4 | 5 |
| • Evaluate and present research findings, based on common research methodologies and processes | 3 | 3 | 4 | 5 |

H. Assessment

H.1. Purposes of Assessment

The vast majority of Doctors in Training pass assessments deservedly and unreservedly. It is important that the clinical experience and career progression for the majority is not stifled by an unduly heavy burden.

There are a number of key purposes that assessment should fulfil.

- Determine who has achieved the competencies to progress to the next/ new phase of practice and/or work in a specified context or role.
- Enhance the practice of medicine and professional development.
- Reinforce intrinsic motivation so that learning is undertaken to improve practice.
- Provide feedback to a Doctor in Training on his/her performance.
- Inform decisions about registration.
- Identify those who may require remediation and/ or advice on alternative career(s).

H.2. Principles for assessment

It is important that a set of principles is established and agreed as this will form the basis of any assessment design and structure.

Assessment for Doctors in Training in the prevocational years:

- emphasises the developmental process of 'becoming' a doctor at a vocationally independent level, as well as the assessment of skills acquisition;
- has a positive effect on learning by allowing regular, structured and constructive feedback to doctors in training, for formative development purposes;
- as far as possible is embedded within everyday work to give authenticity and a focus on performance;
- is 'parsimonious' and feasible:

- it should not overburden those responsible for the assessment in terms of cost, time and training
- Doctors in Training should not be over-assessed, to the detriment of learning from clinical contexts;
- is matched transparently to the competency framework. It will sample all domains, and hence will require multiple methodologies in a range of clinical settings;
- provides opportunities to identify the underperformer who needs remediation;
- provides for flexibility in terms of capacity for exit and re-entry, and ability to work and train part-time;
- is relevant, salient and engaging;
- allows credit for prior learning and competencies achieved;
- at the Waypoints, provides a binary decision of those ‘ready to progress’ or ‘not ready to progress’, based on valid and reliable evidence, but with provision to trigger an amplified process for those near the borderline in 2-3 settings;
- allows competent learners to progress at a faster pace, acknowledging that a minimum time will probably need to be stipulated;
- has some modular elements that may also fulfil some requirements of basic vocational training programmes.

H.3. Structure and Methods

The following table outlines a proposed structure for a National Assessment System for New Zealand. To a great extent it will be determined by what is agreed for the New Zealand Curriculum Framework and the purposes and principles of assessment.

For a brief explanation of the feature of each respective assessment method, refer to Appendix 5.

| Stage of Training | Potential Foci | Predominant methods & explanations | Other important considerations |
|---|--|---|--|
| For Waypoint 1 thence progress to Category 1 Doctor in Training | <ul style="list-style-type: none"> • Emergency management • Procedural Skills • Knowledge base • Reflection and practice for core tasks, writing prescriptions and discharge letters • Professionalism and communication included in many methods, especially in Multisource feedback • Learning from sentinel events on practice (also likely to include professionalism) | <ul style="list-style-type: none"> • Completion of ACLS course • DOPS⁸ for specified core skills • OSCEs or mini-CEXs • Written test • Supervisor Report Forms • Projects/assignments • Multisource feedback assessment • A Case Based Discussion (CBD) on a sentinel event. | <ul style="list-style-type: none"> • Variety of methods to assess across each domain of the framework • Should lead to restricted or student provisional registration • Needs to be capable of identifying early those who require remediation • Supervisor report forms will incorporate the three domains of the New Zealand Framework • To progress to the next category, there must be an absence of major FtP issues |
| For Waypoint 2 thence progress to Category 2 Doctor in training | <ul style="list-style-type: none"> • Depends on contexts of training • Discussions should come from a night shift, ward calls and a sentinel event of a professional issue • Enhanced and more complex procedural skills | <ul style="list-style-type: none"> • Multiple Mini-CEX (4-6) • Long case • 3 Case Based Discussions • Multisource feedback assessment • DOPS for more complex skills • Supervisor Report Forms • Project(s) | <ul style="list-style-type: none"> • Variety of methods to assess across each domain of the framework • Will require experience of supervised night shifts • Supervisor report forms will incorporate the three domains of the New Zealand Framework • To progress to the next category, there must be an absence of FtP issues |

⁸ DOPS refers to the Direct Observation of Procedural Skills. Refer also to Appendix 5.

**For Waypoint 3
thence progress to Category 3 Doctor in Training**

- Some differentiated into vocational area
- A more refined (depth and breadth) of procedural skills (still to be determined) and should relate to compulsory scopes of practice
- Particular emphasis on professionalism and communication
- Useful for one CBD to include one of patient death on handling whānau /legal aspects, 2nd could focus on an acute shift, 3rd demonstrates qualities of professionalism
- Teaching capability is an important new focus
- Multiple Mini-CEX (4-6)
- DOPS
- Supervisor(s) Reports
- 2 Multisource assessments (with emphasis on professionalism and communication)
- 3 Case Based Discussions (CBD)
- Project(s)
- 1 Teaching presentation (could be journal club, grand round or similar)
- Range of settings used
- Greater maturity to handle 360° feedback, two are proposed to emphasise the importance of professionalism and teamwork
- Certification of death will always be a function of doctors and is complex
- Supervisor report forms will incorporate the three domains of the New Zealand Framework
- To progress to the next category, there must be an absence of FtP issues

Explanatory notes

The foci and potential methods are indicative only and may need further refinement once the Waypoints and associated competencies to be achieved are finalised.

1. Each year, it is expected that each Doctor in Training will complete:
 - Several mini-CEXs, related to the contexts of training
 - A minimum of 1 DOPS
 - A minimum of one CBD
 - A minimum of 1 project (with choice available)
2. A reasonably heavy assessment load has been designed for Waypoint 1 after which the learner becomes a Category 1 Doctor in Training.
3. Assessment of Professionalism

Professionalism has traditionally been very difficult to assess, and often there is reliance on either indirect approaches or a lack of Fitness to Practice concerns to determine if this dimension is met. There is a danger that this approach may lead to a unidimensional view of professionalism when it is crucially multidimensional. Internationally, there is increasing attention being given to the professional domain of Doctors in Training. A number of interesting presentations were given at the Ozzawa Conference held in Melbourne from 5-8 March 2008, with a variety of approaches being adopted internationally to assess this core domain more effectively. Most Australian specialty curricula are incorporating 'professional qualities' type domains. The Working Party believes that Professionalism should be an important component of all major assessments. In addition to it being an integral aspect assessed during a mini-CEX and on Supervisor forms, the Working Party is proposing that one Case Based Discussion should be dedicated to the assessment of professional issues at each Waypoint (see point 4 below). The proposed Fitness to Practice component is outlined in H.3.1 below.

4. One multisource feedback has been included in the assessment for Waypoint 1.
 - While this may be a daunting experience for quite young Doctors in Training, especially if feedback is somewhat critical, it is important that they are cognisant of their respective role(s) in healthcare teams and how they interact/ work/ communicate with other members.
 - It is noted that the learners will have had limited time to complete a variety of roles within a team.
 - Not all health professionals may be aware of the competencies expected at this point along the journey, and it is important the Multisource feedback assessment is carefully designed for Waypoint 1.
5. Case Based Discussions (CBDs) have been included in the assessment for each of the Waypoints.
 - For Waypoint 1, this will focus solely on a professional issue of a significant event that the student has actually experienced.
 - For Waypoints 2 and 3, at least one of the CBDs will focus solely on a professional issue, which may be a sentinel event from practice.
 - This serves to emphasise that professionalism is extremely important for all Doctors in Training.
 - The other CBDs at each of Waypoints 2 and 3 have been included to draw on learning, competence and performance of significantly important aspects of increasing responsibility and complexity, such as from night shifts, ward calls, a patient death or acute shifts. These types of CBDs require an advanced level of knowledge and the ability to draw on a number of parallel cases to highlight essential aspects. If the Category 2 Doctor in Training is to be able to work at night from the start, it is logical to enable an

experience under close supervision as a Category 1 Doctor in Training, with an ensuing CBD about the cases seen. It is anticipated that the results of these will help determine the readiness of the Doctor in Training to proceed to taking increasing responsibilities for ward calls, night shifts, locum positions and similar.

6. Projects for assessment

A minimum of one project has been incorporated as a component of the assessment for each Waypoint. Their purpose is to allow a Doctor in Training to focus on a scholarly activity that promotes depth of learning as well as the acquisition of other skills e.g. writing, communication, presentation, teamwork. Dedicated time is likely to be needed to enable completion of projects alongside service commitments, to ensure this component does not overburden Doctors in Training.

- projects should be easily incorporated into clinical activities, relevant, and allow for personal choice
- the project could be a literature review, a presentation, an audit, a critical appraisal, a creative piece, a strategy to improve health service delivery, evidence of being involved in a clinical team's research activity et
- it is possible that the project may also contribute to the requirements needed by MCNZ each year for APC re-certification

7. It is recommended that members of the MCNZ and the workplace are invited to be members of the Board of Examiners for the final year of the MBChB. There are two reasons for this:

- to bring closer links to the Prevocational Training Framework;
- to ensure (and to assure) that the assessment of these students is linked to workplace competence and performance.

8. All Doctors in Training will be expected to complete Prevocational Training within a maximum of four years if working and learning full-time, with a pro-rata system used for Doctors in Training working and learning part-time. Anyone not completing within this timeframe will be considered by the governing body.

9. No written examination of clinical knowledge is designed beyond Waypoint 1, as learners will be applying their medical knowledge to varying depths in different attachments, and the workplace will increasingly be the most important context for assessment.

10. It is anticipated that Doctors in Training may collate an 'electronic archive' that they could take from employer to employer to demonstrate that levels of performance achieved, responsibilities and autonomy given.

11. It is expected that all Doctors in Training will keep a Record of Personal Learning that will be made available annually, and which should provide a continuum with college requirements.

H.3.1. Proposed Fitness to Practice component

There appears to be no clear definitions of professionalism or Fitness to Practice, and there is overlap between them. Many of the presentations at the March 2008 Ozzawa Conference in Melbourne highlighted the potential ‘problem’ areas that give rise to concern, and many of these encompass behavioural and attitudinal aspects of a doctor’s work. For the purposes of this Assessment System it is proposed that the Fitness to Practice (FtP) component is considered specifically and separately from the routine assessment system, while acknowledging the important overlaps with professionalism. FtP should relate to particular health and personal conduct, legal and disciplinary issues, and that these should be the responsibility of the MCNZ, because of close links to registration.

Notwithstanding this approach, it possible that Doctors in Training could be referred to this pathway from:

- University ‘education’ advisers
- Comments on Supervisors’ forms
- The governance body for the Assessment System
- Multisource feedback

The MCNZ will continue to have a dual role for those in this pathway:

- consideration of registration issues
- remediation and supportive actions as necessary, including communication with those responsible for ensuring educational standards are met.

It is important that those in this pathway are interviewed by independent colleagues who are not involved in any regular assessment of the Doctor in Training. Hence the FtP issues will be handled alongside progression in the clinical environment. There are two options to consider for implementing this – a supervisor certifies that there are no FtP issues, or the supervisor can indicate if there were any FtP issues.

H.3.2. International Medical Graduates

The Working Party considered some questions in relation to International Medical Graduates (IMGs), especially how they would be assessed in relation to the proposed Waypoints. The authority of the MCNZ was also noted in this regard, which could be supported by the proposed national body to oversee the implementation of the NZ Education Framework for Prevocational Training (see Section I).

In principle, clear definitions of the Waypoints, and clear assessments of readiness to progress between the Waypoints, should help to determine where IMGs can enter the system - could be at any one of the Waypoints. The IMGs will need access to workplace clinical environments before assessment against many of the criteria and standards at the Waypoints can be considered. Cultural competency will continue to be an important component of the assessment of IMGs. It is also likely that not all relevant competencies of IMGs can be assessed using workplace-based assessments only. Thus it is anticipated that some form of the current NZREX will continue to be necessary for many.

I. Implementation Proposal for NZ Education Prevocational Framework

Implementation of the New Zealand Education Prevocational Framework (Doctors in Training Competency Framework and associated Assessment System) will require educational and organisational infrastructure to ensure its success. In addition to a governance body with oversight of the whole Doctors in Training Prevocational Training and Assessment, additional roles will need to be created to provide support to individual Doctors in Training and Supervisors.

The Working Party considered an initial minimalist model of a DIT National Directorate and Education Directors, but it was agreed that a third level of regional support would be necessary, especially in the early stages of implementation.

The governance body will have a number of roles. Some have been identified here, and others are likely to be added once the curriculum structure and possible pathways have been discussed and approved. It is likely that this body will have oversight of over 2,000 Doctors in Training, spanning Trainee Interns to Registrars.

A possible name for this governing body is the “Doctors in Training Directorate” (“Postgraduate Medical Education Network” has also been suggested).

I.1. DIT National Directorate

It is proposed that a national directorate body is established. This Directorate will have strategic, governance and organisational roles, and may need to establish some subcommittees to fulfil its roles.

I.1.1. Draft Terms of Reference

Draft terms of reference for the DIT National Directorate responsible for the implementation of the New Zealand Education Prevocational Framework are:

- Maintain oversight of the quality and effectiveness of the New Zealand Doctors in Training Competency Framework, its learning pathways and the Assessment System, to ensure that national standards are met and maintained
- Review and adopt modifications to the Levels of Competence and Performance in the Training Competency Framework, based on experience of its implementation, sound evidence and advice

- Oversee the implementation of the Assessment System
 - Provide an advisory and mentor service to the Education Directors (see below)
 - Review the efficacy of the Assessment System and recommend changes/ improvements (to whom - MTB or a designated subcommittee?)
 - Confirm that the skills and performance of Prevocational Doctors in Training have been met, and make recommendations to MCNZ for Registration
 - Consider any issues raised from the FtP pathway for which the MCNZ is responsible and confirm recommended outcomes
 - Ensure adequate evaluation of the system
- Oversee the delivery models associated with the Learning and Training Pathways. It is anticipated that some regional variation may be necessary to make best use of resources
- Monitor the quality of training, supervision and assessments conducted in Learning and Training Pathways for Doctors in Training
- In association with the MCNZ, consider applications from IMGs, and advise of suitable pathways to complete the requirements for the New Zealand Prevocational Training Framework
- Consult with key health service providers to ensure they support the New Zealand Education Prevocational Framework
- (could be a cost-effective body for maintaining an electronic storage database for DIT E-learning ‘portfolios’ – likely to serve multiple functions in the future, including for research purposes)

I.1.2. Potential Membership

To implement a change of this magnitude, it is important that an inclusive approach is taken to membership, and that all key stakeholders work together, and learn from each other, for its success.

It is difficult to propose the appropriate membership at this stage, until further consideration has been given to the proposed Learning and Training pathways for the Prevocational years. At the very least the following organisations will provide membership:

- The New Zealand Universities awarding medical degrees
- The Medical Council of New Zealand

- Employers of Doctors in Training
- Doctors in Training
- Education Directors (see below)

It may also be desirable to consider whether Colleges should be members.

I.1.3. Skill Set of Members of National Directorate

An essential aspect to consider is the credibility of this body and the decisions that it will be charged with making. It must have credence with:

- The Doctors in Training (first and foremost, as their careers are dependent on the decisions of this body, at least in part)
- The Colleges who are going to ‘admit’ those who have completed Waypoint 3 of the Doctors in Training Competency Framework to their programmes
- The employers of the Doctors in Training who provide the environment and many resources to enable Doctors in Training to complete the curriculum and assessment
- The University Medical Schools (and potentially their governing bodies)
- The Medical Council of New Zealand

Given the above, it is proposed that the following principle to be adopted in regard to the membership of the governance body. Membership of the governance body should be determined by considering the appropriate mix of expertise and should include those who collectively have:

- educational expertise and experience
- assessment expertise and experience
- postgraduate education expertise and experience
- expertise for registration
- expertise required for employment in medical clinical settings
- broad knowledge and expertise of the requirement of medical colleges

Consideration should also be given the length of term for the membership of any one individual (noting that this will need a rolling introduction).

It is unlikely that a membership based on representation would provide the right mix of people.

I.2. Educational Support and Infrastructure

The implementation of the New Zealand Education Prevocational Framework needs to be accompanied by more educational support for the Doctors in Training than is currently provided. The current environment will need to change to ensure there is a better balance between active advisory, mentoring, supervision and coordination roles in learning and assessment, and service provision.

One model to consider is that of the UK for its Foundation Programme. However, adopting this model for New Zealand would require a significant number of new appointments and structures (14 postgraduate deaneries, each headed by a Postgraduate Dean; each has a number of Foundation Training Programme Directors (FTPD), and with each being responsible for between 20-40 foundation doctors. In addition it has a number of supporting education supervisors working with each Programme Director (there is a named educational supervisor in each of the foundation doctor's placements). In New Zealand, intern supervisors are currently funded by trainee for their quota of trainees.

I.2.1. Educational Directors

It is proposed that a new role of Educational Director is established, to support the implementation of the New Zealand Education Prevocational Framework to minimise the effect on service provision. It is anticipated that the equivalent of about 5-6 full-time positions will be needed nationally (noting that most are likely to also maintain clinical practice in their specialty). They will need to take specific responsibility for the organisational and educational aspects of the Assessment System, as a minimum, because there will need to be continuity in tracking the competence and performance of Doctors in Training, to overcome some of the disjunction that occurs in current practice. It is anticipated that each will be associated with several teaching practices and hospitals. They could also assist and advise on the most efficient and effective delivery options for the Learning and Training Pathways within their sphere of influence.

The anticipated roles of an Educational Director are:

- To advise Health Service Providers (DHBs, PHOs, and others) on the requirements to implement the NZ Education Prevocational Framework, Assessment System and the Learning and Training Pathways (once approved)
- To provide educational support and advice to the Doctors in Training, especially in regard to
 - ensuring understanding of the overall requirements of the Assessment System
 - assisting with, advising, and participating in some elements of assessment (appropriate range of encounters for mini-CEX assessment, CBD)
 - assisting with the gathering and collation of high quality data and evidence
 - providing formative feedback about competence and performance
 - providing additional tutorials to enhance learning of Doctors in Training
 - providing advice in regards to Study leave, flexible study options, careers et al
- Tracking the progress of Doctors in Training through their assessments towards achieving the relevant Waypoint
- Identify early those Doctors in Training that need to be recommended for a remediation programme
- To advise and assist Clinical Supervisors with the implementation of the Assessment System, and to provide appropriate training and advice to Clinical Supervisors
- To undertake the organisation required for implementing new assessment types, especially Multisource feedback and Case Based Discussions
- To contribute to the delivery of small group teaching and learning within their region (or to develop and delivery modules of learning)
- To interact and collaborate with other Educational Directors to share best practice and implement improvements

I.2.2. Regional Infrastructure and Support

Especially in the early stages of implementation, the Working Party perceives advantages in having some regional infrastructure and support. Each Educational Director would have a pivotal role in the regional support structure, which would also provide them with the necessary reciprocal support. This could be a standardised model, drawing on some of the existing RMO units that are accredited for training and service.

There are currently diverse models in operation and these would need to be standardised and aligned to meet the needs of the New Zealand Education Prevocational Framework.

There may also need to be some dedicated senior RMOs appointed to assist the Educational Directors with the educational advice and assessment (one suggestion was to call these Learning and Training Pathway Supervisors, but this could give rise to overlapping functions with the Educational Directors).

While time has precluded the development of a 'best practice' regional model, the Working Party agreed that five important principles need to be incorporated into the model.

1. There needs to be incentives established to protect time for Supervisors to meet the learning needs and assessment requirements of the Doctors in Training.
2. There needs to be flexibility to allow at least the Educational Directors and dedicated senior RMOs to move across DHBs to support the Doctors in Training for whom they have responsibility.
3. There needs to be protected teaching time built into the model for those Doctors in Training working towards the achievement of Waypoint 2 and Waypoint 3, to ensure they can continue to contribute to the teaching of peers.
4. The regional structures should provide an important peer support mechanism for Educational Directors and dedicated senior RMOs.
5. There needs to be an administrative system set up for determining in a timely fashion who has met the requirements to pass the Waypoints.

I.2.3. Clinical Supervisors

Clinical Supervisors will continue their important role in the day-to-day supervision of clinical and professional practice. It is anticipated that the current ratios of Doctor in Training to Supervisor will remain the same. However, their role should be strengthened to encompass:

- Supporting the assessment process required of each Doctor in Training for which they are responsible
- Ensuring Doctors in Training have the appropriate range and mix of clinical experiences and exposures to meet the competencies and levels
- Arranging a work programme that enables Doctors in Training to:

- attend fixed educational sessions
- have a minimum time each week to complete assessments and undertake self-reflection

I.3. Essential elements

- The workplace environment needs to be conducive to, and encourage, learning, and finding a way to balance this with its service provision.
- Doctors in Training will need some protected time to complete their learning and associated assessments (could be a specified time each week, or a block of time within each attachment)
- Training will need to be provided to all assessors, especially in the new proposed methods of assessment.
- The necessity for DHBs to develop appropriate action plans and relevant Key Performance Indicators (KPIs) to determine their effectiveness in meeting the requirements of the New Zealand Framework.

J. Learning and Training Pathways

J.1. Overarching Role and Principles for a Doctor in Training

This has been an area of prolonged contention, which has mostly revolved around aspects of training environments: what specialities and attachments are compulsory; the length of time in each; and when they may occur. The Working Party considered the key question of what will make a Doctor in Training well-prepared for the future workforce, which led to the endorsement of an overarching principle and a consequential set of principles to underpin the potential learning and teaching pathways.

All parties continue to hear about the generic inadequacies of those entering the Workforce (irrespective of the validity of the evidence for the use of 'inadequate'). Noting the unintended negative stereotyping, members are likely to resonate with comments such as junior doctors:

- are inadequately oriented into the 'system' and hence take considerable time to adapt to/ become familiar with it;
- are working in roles (for at least part of their jobs) for which they do not need a medical degree;
- are not making decisions and are waiting to be told 'what to do' from other health professionals (medical and others);
- are dissatisfied with their work and current training;
- often feel exhausted and undervalued.

This Workstream should bring a fresh and independent perspective to the major perceived problems and consider a key overarching principle that will enhance the capability of a Doctor in Training at any stage of training and prepare them for specialty training and future workforce. This cannot be separated from a consideration of the environments in which Doctors in Training are to be working and learning.

J.1.1. Proposed Overarching Principle

A Doctor in Training 'well-prepared for the medical workforce' learns through being continually challenged to solve clinical problems, and taking responsibility for patient care. The challenge is to create the environment whereby a Doctor in Training works to his/her capacity and is stimulated to move forward in responsibility and learning, while balancing this with safeguarding patient safety. To achieve this requires the opportunity to:

- take graded responsibility for assessing undifferentiated patients and those with a change in condition, making diagnoses, recommending tests, and proposing and implementing management plans;

- engage with patients with respect to preventive health measures and chronic disease management;
- make decisions for which they are accountable; and
- work in conducive environments, being one that extends Doctors in Training from a ‘comfort zone’ to enforce learning and self-reflection, yet has adequate supervision and support in place for each stage of training appropriate to their Category and which ensures patient safety.

The Working Party sees the pathway to achieving the correct balance between encouraging learning and ensuring patient safety is to create a system whereby expected competencies are well stated and agreed to, and assessments of an individual’s capabilities against these competencies are reliable and valid. For these reasons, the process of determining and agreeing to the expected competencies at each Waypoint should be robust and inclusive.

J.1.2. Consequential Set of Principles underpinning Pathways

The Working Party endorsed the following set of Principles to underpin the Doctors’ in Training Learning and Training Pathways, noting that Doctors in Training are adult learners.

- The years to entry to a vocational training programme incorporate well-developed learning and training pathways, and are part of a continuum of lifelong learning.
- There must be significant periods of apprenticeship-style of learning in a range of clinical settings.
- The pathways adopt and reflect the Principles of Adult Learning
 - choice and options should be allowed
 - the predominant mode of learning is enhanced by both experiences and reflection
 - facilitated workplace learning provides a balance of service provision and learning and reflection.
- The competencies are achievable in a range of settings.
- What the Doctor in Training does, and how they learn in the attachment, is likely to be more important than the type of discipline.
- There needs to be a core of learning experiences in settings with sufficient numbers and variety of undifferentiated patients.
- Flexibility is essential to allow for part-time work and study, time-out or time-off, without penalty.
- In-depth prolonged exposure within a health care team in a specific setting is preferable to short and frequent exposures.

- Options should be offered to cater for career interests, training needs, and to maintain a work /life balance.
- Pathways should allow for Doctors in Training to continue engaging with the full breadth of medicine they have experienced as an undergraduate, including general practice, population/public health medicine, education and research.
- Pathways should allow Doctors in Training to combine some specialty elements with generalist elements.
- A minimum time should be spent in any one 'learning setting' to achieve the depth of experience needed. At present this is 3 months but arguably might be 4 months. Notwithstanding this, as long as the Doctor in Training meets the required competencies, there should be flexibility to individualise work experience to local situations.
- A minimum number of total 'learning experiences' should be required before a Doctor in Training can meet the competencies needed to pass Waypoint 3.
- All Doctors in Training are encouraged to continue in the New Zealand Education Prevocational Framework until they are in a College learning pathway, or to complete appropriate professional development.
- The learning pathways should be cognisant of the workforce issues prevailing at the time, which may limit some pathways from time to time
- All pathways for Doctors In Training are equal in standing, and this should be reflected in the individual's choice of learning experiences

The proposed structure and pathways should also take cognisance of international developments that are occurring in the prevocational years, especially in Australia, given the reciprocity of registration that exists.

Before passing Waypoint 3 and commencing vocational training, student doctors and Doctors in Training will need to have compulsory core experiences in a range of settings and cover a range of patient care aspects.

Experience with range of patient care

As satisfactory performance with one type of clinical scenario does not necessarily imply transference to another, experience with the types of patients needs to include:

- those with acute and emergency problems;
- those with sub-acute and chronic problems;
- those with 'medical' and 'surgical' problems;
- persons at various stages throughout the lifespan.

Experience in range of training settings

Both to foster workforce recruitment, and because satisfactory performance in one context does not imply this in another, the range of training settings needs to include:

- Primary or Integrated care or Community/ Ambulatory care;
- Secondary care/ Regional care;
- Tertiary care (including subspecialties).

Explanatory notes

1. It is anticipated that time spent in Primary, Integrated or Community/ Ambulatory care could expose the Doctor in Training to a range of scopes of medicine including emergencies, acute medicine, surgery or women and child's health (with many undifferentiated patients), psychiatry, rehabilitation and aged care, chronic disease management and preventative care, and minor illnesses and procedures.
2. It is anticipated that time spent in Secondary care/ Regional care could expose Doctors in Training to a similar range as noted for 1.
3. Time spent in Tertiary care should enable a Doctor in Training to choose complementary options that uphold the principles.
4. There should be flexibility to allow a Doctor in Training to choose Learning and Training Pathways that enable them to move between DHBs and/ or PHOs. This would require some change in the 'employee' provision of the Doctor in Training to give the desired balance of between learning needs and service provision.

It is also essential that student doctors and Doctors in Training experience health care delivery provided on a 24/7 basis.

Experiences of Population Health and educational and research posts should also be available as options in the new training framework.

There are a number of Doctors in Training who wish to pursue a career in academic medicine and who wish to receive formal postgraduate qualifications. Currently, this is a lengthy process, as the New Zealand educational environment doesn't easily allow or encourage formal postgraduate study during the Doctors in Training period. There should be a minimum compulsory component to be completed to achieve Registration. Then they would be expected to choose options that would lead to a postgraduate qualification. It is anticipated that those choosing this pathway would predominantly choose options that combined opportunities in academic medicine and formal education programmes.

Consideration should also be given the study leave that may be needed for Doctors in Training to complete the requisite assessments.

Once the new framework has been endorsed, consideration needs to be given to an Evaluation Model that will review/evaluate the implementation in the early years. This will need to incorporate a review and effectiveness of the Prevocational Training Framework, the Assessment System and the Governance model to support both. Ongoing development and review will also be necessary to reflect developments in medical education and the changing needs of the healthcare system.

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L. Acknowledgements

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Appendix 1a Common symptoms and presenting complaints (adults)

This list includes acute and chronic conditions. Emergencies are in Appendix 4.

The list has been compiled by University of Auckland⁹

| Symptom/Presentation | Waypoint 1 Entry to Cat 1 | Waypoint 2 End of Cat 1 Entry to Cat 2 | Waypoint 3 End of Cat 2 Entry to Cat 3 | Vocational End of Cat 3 Entry to Cat 4 |
|--------------------------------|------------------------------|--|--|--|
| Abdominal mass | 2 | 3 | 4 | 5 |
| Abdominal pain | 2 | 3 | 4 | 5 |
| Abnormal vaginal bleeding | 2 | 3 | 4 | 5 |
| Abuse | | | | |
| - child | 1 | 2 | 2 | 4 |
| - domestic | 1 | 2 | 2 | 4 |
| - elder | 1 | 2 | 2 | 4 |
| Amennorrhoea | 2 | 3 | 3 | 4 |
| Anxiety | 2 | 3 | 3 | 5 |
| Altered level of consciousness | 2 | 3 | 4 | 5 |
| Chest pain | 2 | 3 | 4 | 5 |
| Confusion | 2 | 3 | 4 | 5 |
| Constipation | 2 | 3 | 4 | 5 |
| Contraceptive advice | 2 | 3 | 3 | 5 |
| Cough | 2 | 3 | 3 | 5 |
| Decreased urine output | 2 | 3 | 4 | 5 |
| Depression | 2 | 3 | 4 | 5 |

| Symptom/Presentation | Waypoint 1 Entry to Cat 1 | Waypoint 2 End of Cat 1 Entry to Cat 2 | Waypoint 3 End of Cat 2 Entry to Cat 3 | Vocational End of Cat 3 Entry to Cat 4 |
|--|------------------------------|--|--|--|
| Diarrhoea | 2 | 3 | 4 | 5 |
| Excessive daytime tiredness | 2 | 3 | 3 | 5 |
| Fall | 2 | 3 | 4 | 5 |
| Fatigue | 2 | 3 | 3 | 4 |
| Fever | 2 | 3 | 4 | 5 |
| GIT bleeding | 2 | 3 | 4 | 5 |
| Headache | 2 | 3 | 4 | 5 |
| Heart rate and rhythm problems | 2 | 3 | 4 | 5 |
| High blood pressure | 2 | 3 | 4 | 5 |
| Hypotension and shock | 2 | 3 | 4 | 5 |
| Incontinence | 2 | 3 | 4 | 5 |
| Insomnia | 2 | 3 | 4 | 5 |
| Jaundice | 2 | 3 | 4 | 5 |
| Limb pain | 2 | 3 | 4 | 5 |
| Nausea and vomiting | 2 | 3 | 4 | 5 |
| Neck mass | 2 | 3 | 4 | 4 |
| Pain (other than specifically mentioned) | 2 | 3 | 4 | 5 |
| Pregnancy and labour | 2 | 3 | 4 | 5 |
| Problems with lines, tubes, drains | 2 | 3 | 4 | 5 |
| Pronouncing death | 2 | 3 | 4 | 5 |
| Shortness of breath | 2 | 3 | 4 | 5 |
| Skin problems | 2 | 3 | 4 | 5 |
| Swellings – joints and soft tissues | 2 | 3 | 4 | 5 |

| Symptom/Presentation | Waypoint 1 Entry to Cat 1 | Waypoint 2 End of Cat 1 Entry to Cat 2 | Waypoint 3 End of Cat 2 Entry to Cat 3 | Vocational End of Cat 3 Entry to Cat 4 |
|------------------------------|------------------------------|--|--|--|
| Syncope | 2 | 3 | 4 | 5 |
| Thought disorder | 2 | 3 | 4 | 5 |
| Upper respiratory tract pain | 2 | 3 | 4 | 5 |
| Urinary symptoms | 2 | 3 | 4 | 5 |
| Vaginal or penile discharge | 2 | 3 | 4 | 5 |
| Weight change | 2 | 3 | 4 | 5 |

COMMON PROBLEMS & CONDITIONS (ACFJD, for comparison)

Doctors should be able to appropriately assess patients presenting with common, important conditions, including the accurate identification of symptoms, signs and/or problems and their differential diagnosis and then use that information to further manage the patient, consistent with their level of responsibility:

| | | |
|------------------------------------|-----------------------------------|---------------------------------|
| Abdominal pain | Domestic violence | Non-accidental injury |
| Asthma | Dysuria &/or frequent micturition | Non-specific febrile illness |
| Cough | Elder abuse | Pneumonia/respiratory infection |
| Addiction (smoking, alcohol, drug) | Envenomation | Poisoning |
| Anaphylaxis | Falls, especially in the elderly | Post-operative care |
| Bleeding in the 1st trimester | Functional decline or impairment | Psychosis |
| Breathlessness | Gastrointestinal bleeding | Pyelonephritis and UTIs |
| Cardiac Arrhythmias | Genetically determined conditions | Reduced urinary output |
| Chest pain | Headache | Renal failure |
| Child abuse | Heart failure | Septicaemia |
| Chronic Obst. Pulmonary Disease | Hypertension & hypotension | Sexually Transmitted Infections |
| Coma | Ischaemic heart disease | Seizure disorders |
| Cognitive or physical disability | Injury | Spinal disease |
| Constipation | Joint disorders | Stroke / TIA |
| Deliberate self-harm | Leg ulcers | Subarachnoid haemorrhage |
| Delirium | Limb ischaemia | Substance abuse |
| Dementia | Liver disease | Tiredness/Anaemia |

| | | |
|-----------------------------------|-----------------------|--------------------------|
| Depression and anxiety | Loss of consciousness | Upper airway obstruction |
| Diabetes: new cases/complications | Masses | Urinary Incontinence |
| Diarrhoea | Minor trauma | Weight gain |
| Disturbed or aggressive patient | Multiple trauma | Weight loss |

Examinable problems in the OSCE (Otago) for comparison

For patients presenting with any of the problems listed, students are expected to be able to:

- take a focused history
- perform an appropriate clinical examination
- formulate a differential diagnosis
- recommend appropriate investigations & treatment (including drugs)
- explain & discuss diagnosis, investigations & treatment with the patient

The level of competence is that of a *beginning trainee intern*

| Cardiovascular system | Respiratory system | Gastrointestinal system |
|------------------------------------|---------------------|-------------------------|
| Cardiac murmur | Chest pain | Abdominal distension |
| Chest pain | Cough | Abdominal mass |
| Hypertension | Cyanosis | Abdominal pain |
| Hypotension | Haemoptysis | Constipation |
| Leg pain | Shortness of breath | Diarrhoea |
| Leg swelling | Stridor | Dyspepsia |
| Oedema | Wheeze | Dysphagia |
| Palpitations/abnormal heart rhythm | | Enlarged liver |
| Shortness of breath | | Faecal incontinence |
| Syncope/blackout | | Haematemesis /melaena |
| | | Jaundice |
| | | Rectal bleeding |
| | | Vomiting |

| Renal/Urology | Gynaecology | Musculoskeletal system |
|--|--|--|
| Abdominal mass Abdominal pain Dysuria Urethral discharge Erectile dysfunction Frequency/nocturia Groin lump Haematuria Nocturnal enuresis Oedema Testicular pain Testicular/scrotal swelling Urinary incontinence Urinary hesitancy/retention | Abdominal/pelvic mass Abdominal/pelvic pain Abnormal vaginal bleeding Abnormal vaginal discharge Contraception Infertility Menstrual disturbance Urinary incontinence Cervical smear | Abnormal/unsteady gait Back/neck problems Joint problems hip knee hand upper limb foot and ankle Peripheral nerve problems |
| Neurology | Eyes/ ENT | Haematology/Oncology/ Infection |
| Abnormal gait Confusion/delirium Disturbed consciousness/coma Dizziness/vertigo Facial pain Headache Movement disorder/tremor Paraesthesia/numbness Seizure/blackout Speech disturbance Strabismus Visual disturbance | Earache Ear discharge Facial pain Hearing loss Hoarseness Nasal discharge Nasal obstruction Neck lump Red eye Sore throat Snoring Strabismus | Anaemia Bleeding Breast lump Enlarged spleen Enlarged liver Fever Lymphadenopathy Neck lump Pain Weight loss |

| | | |
|---|---|--|
| Weakness | Stridor Tinnitus Visual disturbance | |
| Endocrinology | Skin | Mental health |
| Diabetes Weight gain Weight loss Menstrual disturbances Polyuria Thyroid dysfunction | Itch Common rashes/eruptions Common skin lesions Skin ulcers | Alcohol/drug misuse Anxiety Self harm Deterioration in intellect Depression Hallucinations Sleep disturbance |
| Obstetrics | Growth & development | Preventive health care |
| Normal pregnancy Unplanned pregnancy Abdominal pain in pregnancy Bleeding in pregnancy Normal labour Premature labour Delay in labour Postpartum haemorrhage Normal puerperium Puerperal fever Neonatal examination | Developmental assessment of a child Failure to thrive in a child Short stature in a child | Childhood immunisations Counselling on health threatening behaviours Screening for disease Contraception |

Appendix 1b Paediatric symptoms and presentations

List compiled by University of Auckland¹⁰

| Specific symptom | Waypoint 1 Entry to Cat 1 | Waypoint 2 End of Cat 1 Entry to Cat 2 | Waypoint 3 End of Cat 2 Entry to Cat 3 | Vocational End of Cat 3 Entry to Cat 4 |
|--|------------------------------|--|--|--|
| Abnormal behaviour in child or adolescent – Sleep, Eating, Fatigue, Poor school progress, Absenteeism | 1 | 2 | 3 | 5 |
| Abnormal development in infant – Hearing, Vision, Delayed speech, Poor school progress | 1 | 2 | 3 | 5 |
| Abnormal growth in child – Obesity – Failure to thrive, abnormal puberty | 1 2 | 1 2 | 2 3 | 5 5 |
| Abnormal gait in child | 2 | 2 | 3 | 5 |
| Abnormal movements in infant or child | 2 | 3 | 3 | 5 |
| Acute/ chronic abdominal pain in child or adolescent | 2 | 2 | 3 | 5 |
| Abdominal or groin mass in child or adolescent | 2 | 3 | 4 | 5 |
| Altered level of consciousness in infant or child | 2 | 3 | 4 | 5 |
| Breathing difficulty in infant or child | 2 | 3 | 4 | 5 |
| Disorder of elimination in infant or child | 2 | 2 | 3 | 5 |
| Easy bruising in infant or child | 1 | 2 | 3 | 5 |
| Febrile infant or child | 2 | 3 | 4 | 5 |

| Specific symptom | Waypoint 1 Entry to Cat 1 | Waypoint 2 End of Cat 1 Entry to Cat 2 | Waypoint 3 End of Cat 2 Entry to Cat 3 | Vocational End of Cat 3 Entry to Cat 4 |
|--|------------------------------|--|--|--|
| Generalised swelling in a child | 1 | 2 | 3 | 5 |
| Headache in child or adolescent | 2 | 3 | 3 | 5 |
| Heart murmur in child | 2 | 2 | 3 | 5 |
| Infant 6 week check – immunisations et al | 2 | 2 | 4 | 5 |
| Irritable child | 2 | 2 | 4 | 5 |
| Jaundice in infant or child | 2 | 3 | 3 | 5 |
| Non-accidental injury | 2 | 2 | 3 | 5 |
| Pallor in infant or child | 2 | 2 | 3 | 5 |
| Rash in infant or child | 2 | 3 | 4 | 5 |
| Swollen tender joints in child | 2 | 2 | 3 | 5 |
| Unusual appearance in infant or child | 2 | 2 | 3 | 5 |
| Vomiting and or diarrhoea in infant or child | 2 | 3 | 4 | 5 |

Appendix 2: Common problems and their interpretation

List compiled by University of Auckland

| Problem and interpretations | Waypoint 1 Entry to Cat 1 | Waypoint 2 End of Cat 1 Entry to Cat 2 | Waypoint 3 End of Cat 2 Entry to Cat 3 | Vocational End of Cat 3 Entry to Cat 4 |
|---|------------------------------|--|--|---|
| Abnormal cervical smear results – interpretation and referral | 2 | 3 | 4 | 5 |
| Acid base problems | 2 | 3 | 3 | 5 |
| Calcium problems | 2 | 3 | 3 | 5 |
| Coagulation problems | 2 | 3 | 3 | 5 |
| Glucose problems | 2 | 3 | 4 | 5 |
| Interpretation of ECGs | 2 | 3 | 4 | 5 |
| Interpretation of plain radiology (CXR, AXR) | 2 | 3 | 4 | 5 |
| Potassium problems | 2 | 3 | 3 | 5 |
| Reduced GFR | 2 | 3 | 3 | 5 |
| Sodium problems | 2 | 3 | 3 | 5 |
| Transfusion problems | 1 | 2 | 2 | 5 |

Appendix 3: Procedural Skills

A procedural skill is regarded as something that would be performed as part of investigation / therapy, rather than a physical examination. The letter 'c' indicates a level of competence in a controlled setting e.g. clinical skills laboratory, or using models. There will always be dissension regarding the categorisation of skills into levels; this provides a starting point for discussion.

List compiled by University of Auckland

| Procedural Skills ¹¹ | Waypoint 1 Entry to Cat 1 | Waypoint 2 End of Cat 1 Entry to Cat 2 | Waypoint 3 End of Cat 2 Entry to Cat 3 | Vocational End of Cat 3 Entry to Cat 4 |
|---|------------------------------|--|--|--|
| Advanced cardiac life support | | | | |
| – Airway assessment and management | 3c 3 | 4c 4c | 4 4 | 4 4 |
| – Bag and mask ventilation of unintubated patient | 2c | 4c | 4c | 4 |
| – Use of laryngeal mask | 2 | 4c | 4c | 3 |
| – Intubation | 3c | 4c | 4c | 5 |
| – CPR (adult) | 1 | 2 | 4c | 3 |
| – CPR (child) | | | | |
| Ankle brachial BP index | 2c | 3c | 3 | 4 |
| Anterior nasal pack insertion | 1 | 1 | 2 | 3 |
| Anterior rhinoscopy | 2 | 2 | 3 | 5 |
| Apply liquid nitrogen | 1 | 2 | 3 | 4 |
| Arterial blood gas | 2 | 3 | 5 | 5 |
| Aspiration of pneumothorax | 1 | 1 | 1 | 3 |
| Auditory canal irrigation | 1 | 1 | 1 | 1 |

| Procedural Skills¹¹ | Waypoint 1 Entry to Cat 1 | Waypoint 2 End of Cat 1 Entry to Cat 2 | Waypoint 3 End of Cat 2 Entry to Cat 3 | Vocational End of Cat 3 Entry to Cat 4 |
|---------------------------------------|--------------------------------------|---|---|---|
| Bandaging a limb | 1 | 2 | 4 | 5 |
| Blood culture | 3 | 5 | 5 | 5 |
| Blood glucose determination | 3 | 5 | 5 | 5 |
| Bone marrow aspirate/ biopsy | 1 | 1 | 1 | 3 |
| Central venous line insertion | 1 | 1 | 1 | 2 |
| Cervical collar application | 2 | 3c | 3 | 4 |
| Cervical smear | 3c | 3 | 3 | 5 |
| Diagnostic abdominal paracentesis | 1 | 1 | 1 | 5 |
| ECG | 3 | 5 | 5 | 5 |
| Endocervical swabs | 3c | 3 | 4 | 5 |
| Fluorescein (cornea) | 1 | 2 | 2 | 5 |
| Foreign body removal – eye | 1 | 2 | 2 | 3 |
| Injection (adult) | | | | |
| – Intramuscular | 3 | 4 | 5 | 5 |
| – Intradermal | 1 | 2 | 3 | 3 |
| – Subcutaneous | 3 | 4 | 5 | 5 |
| – Intravenous drug administration | 1 | 2 | | |
| Injection (child) | 1 | 1 | | |
| Insertion urinary catheter | | | | |
| – female | 2c | 3 | 4 | 5 |
| – male | 2c | 3 | 4 | 5 |
| Intercostal tube | | | | |
| – removal | 2 | 3c | 3 2 | 4 3 |

| Procedural Skills¹¹ | Waypoint 1 Entry to Cat 1 | Waypoint 2 End of Cat 1 Entry to Cat 2 | Waypoint 3 End of Cat 2 Entry to Cat 3 | Vocational End of Cat 3 Entry to Cat 4 |
|---|--------------------------------------|---|---|---|
| – insertion | 1 | 1 | | |
| IV cannulation | | | | |
| – Adult | 3 | 5 | 5 | 5 |
| – Child | 1 | 2 | 2 | 5 |
| IV infusion setup | 2 | 4 | 5 | 5 |
| Joint aspiration | 1 | 1 | 1 / 2c | 4 |
| Joint relocation | 1 | 1 | 1 | 3 |
| Lumbar puncture | 2c | 3c | 3 | 5 |
| Metered-Dose Inhaler (MDI) | | | | |
| – Adult | 2 | 3 | 3 | 4 |
| – Child | 1 | 2 | 2 | 4 |
| Nasogastric tube insertion | 2c | 3c | 4 | 5 |
| Ophthalmic | | | | |
| – Eye drop administration | 3 | 3 | 4 | 5 |
| – Eye bandage application | 2 | 2 | 2 | 4 |
| – Eye irrigation | 2 | 2 | 2 | 4 |
| – Eyelid eversion | 2 | 2 | 2 | 5 |
| Plaster cast/splint limb immobilisation | 2c | 2 | 2 | 4 |
| Pleural aspiration | 1 | 3c | 2 | 5 |
| Point-of-care urinalysis | | | | |
| – Dipstick testing | 3 | 5 | 5 | 5 |
| – Urine pregnancy test | 3 | 3 | 5 | 5 |
| Pulse oximetry | | | 5 | 5 |

| Procedural Skills ¹¹ | Waypoint 1 Entry to Cat 1 | Waypoint 2 End of Cat 1 Entry to Cat 2 | Waypoint 3 End of Cat 2 Entry to Cat 3 | Vocational End of Cat 3 Entry to Cat 4 |
|---------------------------------|------------------------------|--|--|--|
| – Adult | 4 | 5 | 3 | 4 |
| – Child | 1 | 2 | | |
| Sigmoidoscopy | 1 | 1 | 1 | 2 |
| Surgical | | | | |
| – Sterile trolley preparation | 2 | 3 | 4 | 5 |
| – Scrub, gown and glove | 2 | 2 | 2 | 3 |
| – Knots | 2 | 3 | 3 | 4 |
| – Wound suturing | 2 | 3 | 3 | 5 |
| – Suture removal | 3 | 4 | 5 | 5 |
| Skin lesion excision | 1 | 1 | 1 | 3 |
| Slit lamp examination | 2 | 2 | 1 | 1 |
| Swab of skin area | 2 | 3 | 5 | 5 |
| Throat swab (child and adult) | 2 | 3 | 5 | 5 |
| Tympanometry (child and adult) | 1 | 2 | 2 | 4 |
| Use of non-invasive ventilation | 1 | 1 | 2 | 3 |
| Urethral swab | 1 | 1 | 4 | 5 |
| Venous blood sampling | | | | |
| – Adult | 3 | 5 | 5 | 5 |
| – Child | 1 | 2 | 2 | 5 |
| Wound care – clean and dress | 2 | 3 | 3 | 5 |

ACFJD List of Skills and Procedures

General

Measurement

Blood pressure measurement

Pulse oximetry reading

Temperature measurement

Intravenous

Venepuncture

Intravenous cannulation

Intravenous infusion set up

Intravenous drug administration

Intravenous fluid & electrolyte therapy

Diagnostic

Blood sugar estimation

Blood culture

Wound swab

Respiratory

Oxygen therapy

Nebuliser/inhaler therapy

Therapeutics

Anticoagulant prescription/monitoring

Antibiotic prescription/monitoring

Insulin prescription/monitoring

Injections

Intramuscular injections

Subcutaneous injections

Joint aspiration or injection (ADV.)

CARDIOPULMONARY

12 lead electrocardiogram

Arterial blood gas sampling

Peak flow measurement

Spirometry

Pleural effusion/pneumothorax aspiration

Central venous line insertion (ADV.)

GASTROINTESTINAL

Nasogastric tube insertion

Rectal examination

Faecal occult blood analysis

Anoscopy/proctoscopy (ADV.)

Abdominal paracentesis (ADV.)

NEUROLOGICAL

Glasgow Coma Score estimation

Neck stiffness testing

Focal neurological sign identification

Papilloedema identification (ADV.)

Lumbar puncture (ADV.)

MENTAL HEALTH

Mini-mental state examination

Psychiatric Mental State Examination

Suicide risk assessment

Alcohol withdrawal scale use

Application of Mental Health Schedule

WOMEN'S HEALTH

Fundal height assessment

Foetal heart sound detection

Urine pregnancy testing

Speculum examination

Endocervical swab / PAP smear (ADV.)

Gynaecological pelvic examination (ADV.)

CHILD HEALTH

Infant respiratory distress assessment

Infant/child dehydration assessment

Apgar score estimation

Newborn examination (ADV.)

Neonatal CPR (ADV.)

SURGICAL

Scrub, gown & glove

Assisting in the operating theatre

Surgical knots & simple wound suturing

Local anaesthesia

Simple skin lesion excision

Suture removal

Complex wound suturing (ADV.)

EAR, NOSE & THROAT

Throat swab

Anterior rhinoscopy

Anterior nasal pack insertion

Auroscopy/otoscopy

External auditory canal irrigation

Ext. aud. canal ear wick insertion (ADV.)

OPHTHALMIC

Visual field assessment

Visual acuity assessment

Direct ophthalmoscopy

Eye drop administration

Eye bandage application

Eye irrigation

Eyelid eversion

Corneal foreign body removal

Intraocular pressure estimation (ADV.)

Slit lamp examination (ADV.)

UROGENITAL

Bladder catheterisation (M&F)

Urine dipstick testing

Urethral swab

TRAUMA

Primary trauma survey

In-line immobilisation of cervical spine

Cervical collar application
Pressure haemostasis
Volume resuscitation
Peripheral neurovascular assessment
Plaster cast/splint limb immobilisation
Joint relocation
Secondary trauma survey (ADV.)
Intercostal catheter insertion (ADV.)

Appendix 4 Specific Emergencies

List compiled by University of Auckland from various sources.

| Specific Emergencies | Waypoint 1 Entry to Cat 1 | Waypoint 2 End of Cat 1 Entry to Cat 2 | Waypoint 3 End of Cat 2 Entry to Cat 3 | Vocational End of Cat 3 Entry to Cat 4 |
|---|------------------------------|--|--|--|
| Acute abdominal pain | 2 | 3 | 3 | 5 |
| Acute chest pain | 2 | 3 | 4 | 5 |
| Acute paralysis | 2 | 3 | 3 | 4 |
| Anaphylaxis | 2 | 3 | 3 | 5 |
| Arrhythmias (brady and tachy) | 2 | 2 | 3 | 5 |
| Cardiac arrest | 2 | 3 | 3 | 5 |
| Collapse/ coma | 2 | 3 | 3 | 5 |
| Confused/ agitated/ combative patient | 1 | 2 | 3 | 5 |
| Epistaxis | 2 | 2 | 3 | 3 |
| Haematemesis (major) | 2 | 3 | 3 | 4 |
| Haemoptysis (major) | 2 | 2 | 3 | 4 |
| Hypercapnic respiratory failure | 2 | 2 | 3 | 4 |
| Hypoxic respiratory failure | 2 | 3 | 3 | 4 |
| Needlestick injuries (NB should never manage alone) | 2 | 2 | 2 | 2 |
| Painful /red eye | 2 | 2 | 2 | 3 |
| Poisoning/ overdose (accidental and deliberate) | 2 | 3 | 3 | 4 |
| Rectal bleeding (major) | 2 | 3 | 3 | 4 |

| Specific Emergencies | Waypoint 1 Entry to Cat 1 | Waypoint 2 End of Cat 1 Entry to Cat 2 | Waypoint 3 End of Cat 2 Entry to Cat 3 | Vocational End of Cat 3 Entry to Cat 4 |
|--|--------------------------------------|---|---|---|
| Seizures | 2 | 2 | 3 | 5 |
| Severe burns | 2 | 2 | 2 | 3 |
| Severe trauma | 2 | 2 | 3 | 3 |
| Shock (hypovolaemic, cardiogenic) | 2 | 3 | 3 | 4 |
| Stridor/ large airway obstruction | 2 | 2 | 2 | 3 |
| Sudden hearing loss | 2 | 2 | 3 | 4 |
| Sudden loss of vision | 2 | 2 | 3 | 4 |
| Sudden onset severe headache | 2 | 3 | 3 | 3 |
| Suicidal patient/ deliberate self harm | 2 | 2 | 3 | 4 |
| Threatened limb | 2 | 3 | 3 | 3 |
| Vaginal bleeding (major) | 2 | 3 | 3 | 4 |

Appendix 5: Major features of assessment methods

The Working Party acknowledges the following publication in the completion of the assessment section.

Wilkinson TJ, Wade WB. A selection of tools for an integrated assessment programme within postgraduate education – their purposes and characteristics. 2008 (in press). 25pp.

mini-CEX

The mini-CEX is a 15-30 minute observed snapshot of a doctor/patient interaction. It is conducted within actual patient care settings using real patients but has a structured marking sheet that covers pre-defined generic areas. Validity derives from using authentic interactions and reliability is achieved by ensuring a sufficient number of encounters are aggregated.

It is designed to assess clinical skills attitudes and behaviours. The dimensions that could be assessed within each encounter are:

- Medical interviewing skills
- Physical examination skills
- Consideration for patient/ professionalism
- Clinical judgement
- Counselling and communication skills
- Organisation/ efficiency
- Overall clinical competence

Advantages and disadvantages

It samples encounters from “real-life” patients in “real-life” settings. Reliability and validity are achieved if scores from a sufficient variety of encounters and of assessors are collated. Standardisation between sites can be achieved with examiner training and collating scores from several encounters.

Suggested use

Results from at least six encounters per year should be collated, with several different assessors used across the encounters. Each encounter should represent a different clinical problem so that a representative range is covered by the end of a year. Its formative value comes from the immediate feedback that can be provided after each encounter by the assessor rating the trainee. Trainers and trainees then identify and agree strengths, areas for development and an action plan for each encounter.

Estimated time

20 minutes (15 minutes observation and 5 minutes feedback) for each encounter.

Case based discussion (CBD)

The trainee selects two case records from patients they have recently been seen and in whose notes they have made an entry. The assessor selects one of these for the case-based discussion.

Trainees regularly present and discuss their cases with more experienced colleagues throughout their training, though rarely are those conversations documented. The aim of the CBD is to enable an assessor to provide systematic assessment and structured feedback, and to assess clinical decision-making and the application or use of medical knowledge in the care of the trainee’s own patients. It enables discussion of the ethical and legal framework of practice, and it allows trainees to discuss why they acted as they did. It can be used to assess management skills, decision-making, risk appraisal, application of knowledge, and/or record keeping.

Advantages and disadvantages

It is the closest assessment of true unobserved performance. It can provide feedback on clinical reasoning.

Suggested use

The trainee chooses the timing, the cases and the assessor, but the direct supervising consultant should be one of the observers for each clinical placement. The discussion will start from and be centred on the trainee's record in the notes and is designed to assess clinical decision-making and the application or use of medical knowledge in the care of the trainee's own patients. It should not be used as a viva that tests unrelated facts theories or philosophies. Results from at least six encounters per year should be collated.

Estimated time

20 minutes (15 minutes observation and 5 minutes feedback) for each encounter.

Multisource feedback

This is the systematic collection and feedback of data on an individual's performance, acquired from a number of stakeholders. In the past, this has sometimes been referred to as the 360-degree assessment. The areas assessed are often related to professional skills and behaviours.

It can be used to assess professional skills and behaviours such as inter-personal skills, ethical behaviour, team-working skills, collegiality, and communication skills. Depending on which raters are chosen, it can be used to assess clinical skills to a limited extent.

Advantages and disadvantages

It can be used to assess actual behaviours within the workplace that are difficult to assess within formal assessment conditions. It can be used to assess skills and behaviours that can sometimes be concealed within a formal assessment.

Suggested use

The trainee nominates his or her assessors (usually 10-20 in total who collectively can comment on the range of a trainee's abilities), who may include supervising consultants, registrars, nurses, allied health professionals, and clerical staff. A third party, or the trainee, then sends a questionnaire to each of the nominated assessors, who are asked to complete Likert scale ratings on specified areas. The collated results, without details that could identify individual assessors, are provided to the trainee. Sometimes these ratings are compared with the trainee's self-assessment. The trainee and educational supervisor agree strengths and key areas for development from the collated feedback. Some forms allow the use of free text comments, which can also be fed back to the trainee verbatim, once rendered anonymous. Good practice

would be to require free text comments if any ratings are below a pre-set threshold. In this way, the trainee can receive specific feedback about potentially serious deficits.

Directly Observed Procedural Skills (DOPS)

DOPS is designed to assess procedural skills essential to the provision of good clinical care. It has similarities to the mini-CEX (see above) but is specifically used to assess procedural skills (Wilkinson & Wade 2005).

These are two components of the assessment – an assessment of generic aspects of the procedure, and an assessment of the specialty-specific aspects of the procedure being observed.

The dimensions assessed within each encounter include:

- Indications for procedure
- Obtaining informed consent
- Appropriate analgesia or safe sedation
- Technical ability
- Professionalism and consideration for patient during the procedure
- Clinical judgement
- Awareness and management of complications

Advantages and disadvantages

It samples encounters from “real-life” patients in “real-life” settings. Reliability and validity are achieved if scores from a number of assessors are collated. Standardisation between sites can be achieved with assessor training and collating scores from several encounters.

Suggested use

Trainees should be asked to undertake six observed encounters during the year with a minimum of two observers in total. Each DOPS should represent a different procedure and trainees should sample from each of the core procedures identified in the relevant curriculum. Results from

at least six encounters per year should be collected and recorded. Its formative value comes from the immediate feedback that can be provided after each encounter by the assessor rating the trainee. Trainers and trainees then identify and agree strengths, areas for development and an action plan for each encounter.

Estimated time

This varies but should include the time taken for the procedure plus 5 minutes for feedback.

Supervisor Report Forms

On its own, this is not a very reliable assessment tool (Wilkinson and Wade, 2007). However, it has value as a tool for:

- giving feedback;
- giving a profile of performance;
- allowing timely interaction between learner and supervisor;
- flagging minor/ major concerns
- supervisors signalling standards achieved.

It can be a powerful guide to learning, and is useful to inform overall decision-making that includes other assessment tools. Furthermore, it is an assessment tool with which many supervisors are familiar. The University of Auckland asks supervisors to note if there are any Ft P issues with the learner, and this works well (also enables a colleague in a leadership role to follow up on any issues).

A supervisor report form can be designed such that supervisors are not actually passing or failing a learner; rather they are required to complete a profile of performance, to which an academic department/governing body applies agreed rules to determine the actual grade.