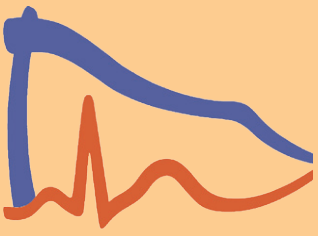
THE VICTORIAN DOCTORS IN TRAINING MANAGERS GUIDE



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Postgraduate Medical Council of Victoria Inc.

VICTORIAN DOCTORS IN TRAINING MANAGERS GUIDE

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FOREWORD

The Postgraduate Medical Council of Victoria Inc (PMCV) is an Incorporated Association established in August 1999 to support prevocational doctors in Victoria.

Mission:

PMCV is the lead organisation in Victoria that supports state and national initiatives in relation to prevocational medical officer (JMO) training.

PMCV supports the development of a high quality doctors-in-training workforce by providing a range of programs and services that support effective training outcomes, and promote safe patient care.

The PMCV has supported the Doctors in Training Managers of Victorian health services since 1999 and established a formal link to this group in 2001 when the HMO Managers subcommittee was established. Since then the subcommittee has not only provided an important networking vehicle for Doctors in Training Managers but has developed consistency around matching processes and dates and has been involved in a number of projects and consultations.

Medical Workforce Units (MWUs) within health services provide the leadership and coordination of the rostering and human resource functions that assist the junior medical staff (JMS) to deliver high quality and safe patient care.

We trust that the Guide will be useful to all Victorian Doctors in Training Managers, particularly those new to the role and will also support other staff in their role of managing and supporting the doctors-in-training workforce in Victoria.

Acknowledgment

The PMCV is grateful to HETI, NSW, for allowing the PMCV to adapt the *JMO Managers Guide, 2013.*

Victorian Working Group

The Victorian adaption of the JMO Managers Guide, NSW, was undertaken by:

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SECTION 1 DOCTORS-IN-TRAINING (DITS) MANAGEMENT

The Doctors in Training Manager role at a glance

Ask any experienced Doctors in Training Manager what they do and they will generally reply "everything". This response reflects both the diversity of the role and responsibilities and the context and location of health service within which they work.

Many Doctors in Training Managers bring to the role a deep commitment to making a difference to the working lives of junior doctors.

The Doctors in Training Manager role can range from managing a small cohort of junior doctors in a rural hospital, (often in addition to a number of other responsibilities), through to having responsibility for the entire junior medical workforce across a large metropolitan network.

The variation in roles and responsibilities may also depend on the other support structures and staffing arrangements within the facility or health service. So although not all Doctors in Training Managers will be responsible for all of the following, roles and responsibilities may include:

- Oversight of doctors in training in a hospital, facility or network including education and accreditation with external bodies (PMCV, Colleges)
- Recruitment of doctors in training
- Orientation – commencement of year, mid-year and change of rotations
- Term allocations
- Rostering
- Creation and co-ordination of secondment agreements with rotating health services including invoice management
- Leave management
- Human resource functions related to payroll
- Performance management, including support of trainees in difficulty
- Organisation of the prevocational trainee education program
- Preparation and support of accreditation processes
- Managing grievances and complaints involving junior doctors
- Liaison with external organisations in relation to doctors in training, on behalf of the facility (such as PMCV, Colleges, Department of Immigration and Border Security, AHPRA, other health services).

Prevocational training

To the new Doctors in Training Manager unfamiliar with the medical training continuum, the structures, requirements and associated terminology can appear very complex and at times, confusing. This section focuses on the prevocational training period.

Prevocational training refers to the period immediately following medical school undertaken prior to a doctor entering specialist (vocational) training. During the first year, postgraduate year one (PGY1) doctors (also known as interns) are provisionally registered with Australian Health Practitioner Regulation Agency (AHPRA) and are only permitted to work in accredited training facilities and in accredited rotations.

At the end of the successful completion of 12 months of supervised training, or internship, the year one prevocational trainee is recommended by a facility to AHPRA for general registration. (See Section 8 of this Guide for details)

In Victoria PGY2 positions are generally available in General, Medical, Surgical or Critical Care streams.

Whilst most PGY2 doctors may enter vocational training programs at the commencement of the PGY3 year, others may complete further generalist years, undertake academic studies or research prior to entering a vocational training program.

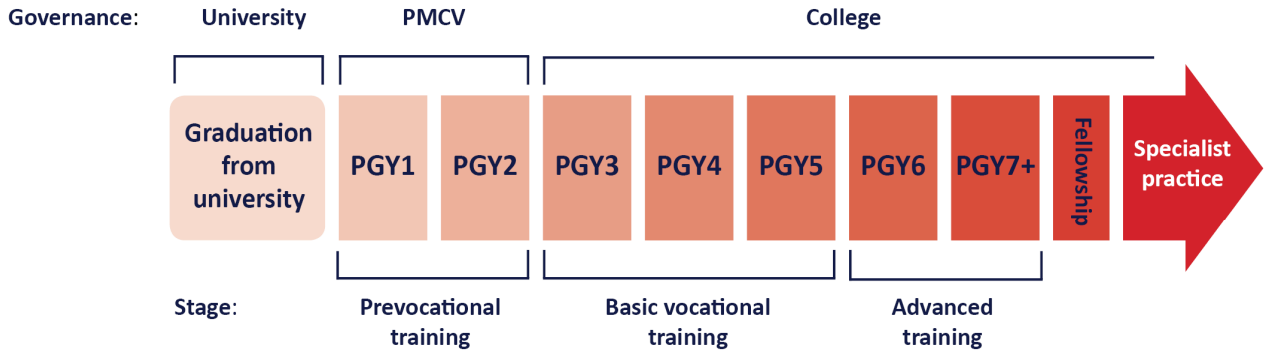
The essential elements of the prevocational training program are:

- Patient safety – the program creates a supervised environment in which prevocational trainees are able to make the transition from medical student to medical practice in ways that are safe for patients.
- Learning by doing – the majority of learning during the prevocational training period is by doing. The apprenticeship model is central to this and supplemented by a range of formal educational activities.
- Trainee welfare – the program ensures through appropriate structures that prevocational trainees are safe and supported in their work. Doctors in Training Managers have a central role with regards to this.
- Learning culture – the program promotes the values of self-directed lifelong learning by all of its participants – both supervisors and trainees – thereby promoting and contributing to the learning culture of the health care system.

SECTION 2 MEDICAL EDUCATION AND TRAINING

Training pathways at a glance

Diagram1: Medical training continuum



Medical Training Continuum - Overview of training pathways. This is indicative only - training pathways can vary from speciality to speciality. For information about specific training programs, refer to the relevant College website.

The role of the Australian Medical Council (AMC)

The governance arrangements involved in medical education and training within Australia can seem quite complex, with multiple organisations and structures involved. This section provides a brief overview, with a focus on the prevocational medical training period.

Training for medical practice is a lengthy process, commencing with a university based degree of four or five years. Many medical degree programs are now undertaken on a postgraduate basis, with applicants having completed a basic degree prior to entering a medical program. In Victoria there are four medical schools offering a medical degree. A comparison is provided in Table 1 below.

Table 1: Victorian medical schools and offerings

University	Degree	Duration	Entrance
Deakin University	Bachelor of Medicine Bachelor of Surgery (MBBS)	4 years	Graduate entry
Monash University	Bachelor of Medicine and Bachelor of Surgery MBBS (Honours) MBBS (Honours)	5 years 4 years	Entry post Year 12 Graduate entry
Notre Dame Sydney (Melbourne Clinical School)	Bachelor of Medicine/Bachelor of Surgery (MBBS)	4 years	Graduate entry
University of Melbourne	Doctor of Medicine (MD)	4 years	Graduate entry

All medical school programs within Australia must comply with the standards set by the Australian Medical Council (AMC), which is responsible for accrediting medical schools. Further information: Australian Medical Council, Assessing Basic Medical Education. Available at: http://www.amc.org.au/accreditation/primary-medical-education/schools [accessed March 2015].

The purpose of AMC accreditation is to ensure that medical courses produce graduates competent to practice safely and effectively under supervision as interns in Australia and New Zealand, with an appropriate foundation for lifelong learning and for further training in any branch of medicine. Upon completion of the university-based program, medical graduates are eligible for provisional registration with the Australian Health Practitioner Regulation Agency (AHPRA). During the year of provisional registration (internship), PGY1 doctors are only permitted to work in facilities and terms accredited through their state based postgraduate medical council (or equivalent organisation). Following the successful completion of the first postgraduate year, prevocational trainees obtain general registration with AHPRA and most go on to complete a further prevocational training year. In Victoria, the

Postgraduate Medical Council of Victoria Inc (PMCV) has responsibility for setting accreditation standards and accrediting facilities for both years of the prevocational training period. (Refer Section 6 of the Guide)

AHPRA and the AMC finalised a national framework for medical internship, which took effect from 1 January 2014. This framework includes a national registration standard on *Granting general registration to Australian and New Zealand medical graduates on completion of internship.* Medical Board of Australia website Available at:
http://www.medicalboard.gov.au/Registration-Standards.aspx [accessed March 2015]

National standards, guidelines and forms on intern training have also been developed to support the National Internship Training Framework (NITF). Australian Medical Council website. Available at: http://www.amc.org.au/accreditation/prevoc-standards [accessed March 2015]

In the new national framework from 1 January 2014, the AMC has taken on responsibility for reviewing the bodies that accredit intern training programs on behalf of AHPRA. These reviews focus on their intern training accreditation role. They assess the performance of intern training accreditation authorities against the requirements in *Intern training – Domains for assessing accreditation authorities.* The PMCV has been granted initial approval as an authority authorised to accredit intern posts in Victoria and a full review of the PMCV by the AMC was completed in 2015. Further information on prevocational accreditation standards and processes is available from the Australian Medical Council website at: http://www.amc.org.au/accreditation/prevoc-standards [accessed March 2015]

Although prevocational trainees are generally employed within the public sector (state or territory health departments), and predominantly work within the public hospital system, they may also complete rotations in accredited terms in other settings, including community health, general practice and more recently, private hospitals. Whilst undertaking a term external to the parent health service, the prevocational trainee remains an employee of the parent health service. (See Section 4 of this Guide for details).

Most doctors in training complete between one and three years in general rotations before entering a vocational training program. Vocational or specialty training generally takes between three and six years. Medical Colleges are responsible for specialty training, both setting the curriculum, training program and examination requirements for candidates and oversight of continuing professional development of College fellows. The Committee of Presidents of Medical Colleges (CPMC) is the unifying and support structure for the medical colleges in Australia. From the CPMC website, you can access the College websites. Available at: http://cpmc.edu.au/ [accessed September 2014].

The AMC also has responsibility for accreditation of providers of specialist medical training and their specialty training programs that lead to qualifications for practice in recognised medical specialties. Further information: Australian Medical Council website, Assessing Specialist medical education and training. Available at: http://www.amc.org.au/accreditation/medical-education [accessed March 2015].

How junior doctors learn

Doctors in Training Managers with previous experience of other public sector professional or employment groups will notice some important differences with respect to prevocational trainees, some of which have implications for the way in which junior doctors work and are employed.

In the first instance, prevocational trainees are just that – trainees and although there have been some significant changes to the medical training paradigm in recent years, medical training during the prevocational period is still largely predicated on the apprenticeship model. Doctors in their Intern and/or PGY2 year learn by doing. So whilst some of their training will be supplemented by formal educational activities (see later section on the formal education program) much of what a junior doctor learns will be on the basis of the clinical exposure they get whilst caring for patients during their rotations under the supervision of consultant medical staff and other doctors. Junior doctors in their first year of training must complete core terms as required by their registration. (Refer Section 8 of the Guide)

Interns (or PGY1s) are provisionally registered with AHPRA and having graduated from medical school, have the basic knowledge and skills to work as junior doctors. However there is a clear expectation that during the course of the prevocational training period they will develop and consolidate the knowledge, skills and behaviours required of medical practitioners, gradually moving toward more independent

medical practice. This has important implications for the way in which doctors in training work and are assessed. Implicit in this is the expectation that prevocational trainees at the completion of the PGY1 year will be quite different in terms of knowledge and skills acquisition compared to interns at the commencement of the year. The buffer for this variation in practice across the year is an appropriate level of supervision.

Terms are accredited on the basis of the skill mix of the medical workforce and levels of supervision available to support doctors in training throughout this period. As the year progresses, the prevocational trainee will gain clinical experience and require progressively less direct supervision. It is also understood that it will be many years of medical practice before a doctor is ready to practice completely independently. It should also be noted that junior doctors are engaged by a health service/facility on the basis of contracts whilst they complete their prevocational and vocational training. This has implications not just for recruitment (covered in Section 5) but also means that the junior doctor workforce as a whole can be quite mobile, with large cohorts changing hospitals and locations as they access the various terms required of their chosen vocational training program.

Sometimes the interface between trainee education and employee service commitments can become a point of tension. Experienced Doctors in Training Managers will work with junior doctors to create a positive training environment that places the delivery of safe patient care at the centre. The tensions between Doctors in Training Managers and junior medical staff were identified during the course of a project in 2009-2010 and a document "*Best Practice Guidelines: Improving interactions between MWU and JMS"* was developed. Further information: PMCV website. Available at: http://www.pmcv.com.au/medical-administrators/current-projects [accessed September 2014].

Australian Curriculum Framework for Junior Doctors (ACF)

The learning outcomes required of prevocational trainees are described in the Australian Curriculum Framework for Junior Doctors (ACF).

The ACF is built around three learning areas: clinical management, communication and professionalism. These areas are subdivided into categories, each of which is further subdivided into learning topics. Within each learning topic, the ACF describes the workplace performance outcomes that prevocational trainees are expected to acquire. The ACF is about more than what doctors actually know; it is about what they actually do at work. Further information: Confederation of Postgraduate Medical Education Councils website. Available at: http://www.cpmec.org.au/Page/acfjd-project [accessed September 2014]

Specific intern requirements

AHPRA requires that interns undertake at least 47 weeks of general clinical experience providing opportunities for the newly qualified medical graduate to apply, consolidate and expand clinical knowledge and skills while taking increasing responsibility for safe high quality patient care.

The general clinical experience is achieved by completing a series of supervised terms. Under the terms of the provisional registration with AHPRA, prevocational trainees are required to perform satisfactorily under supervision in the following terms:

- At least 10 weeks in a term that provides experience in medicine
- At least 10 weeks in a term that provides experience in surgery
- At least 8 weeks in a term that provides experience in emergency medical care
- Other accredited rotations that provide opportunities for wide clinical experience in hospital, general practice and community settings.
- All five terms must be completed satisfactorily for the intern to be eligible to apply for General Registration.

The specific requirements for these terms are reflected in the national internship framework and specific documents, including *Intern Training - Guidelines for terms.* Further information: Australian Medical Council website. Available at: http://www.amc.org.au/accreditation/prevoc-standards [accessed September 2014]

Assessment processes for prevocational trainees

During the first two years, term supervisors assess prevocational trainees with regards to performance under three domains of the Australian Curriculum Framework for Junior Doctors – clinical management, communication and professionalism. Doctors in Training Managers are frequently involved with other health service staff in setting up the administrative processes underpinning assessment of prevocational trainees, in addition to monitoring the performance and progression of trainees.

This section provides an overview of prevocational trainee assessment processes to assist in fulfilling these responsibilities.

The purposes of assessment are as follows:

- Assessment should provide trainees with feedback about their performance that will help their development as doctors. This is the **formative assessment** purpose and with respect to the mid-term assessment is referred to as appraisal. Appraisal should help trainees identify their strengths and weaknesses, and give them ideas about how to improve.
- Assessment should provide evidence that trainees are achieving the competencies required for their future responsibilities as doctors. This is a **summative assessment** process and provides evidence for certification and registration. A good assessment system should assure the community that doctors are meeting certain standards of practice and competence before advancing to higher levels of responsibility.
- Assessment should **identify underperforming trainees** so that appropriate remedial action can be taken early. In some cases this may involve the provision of additional supervision or support activities. In more serious cases of underperformance, the trainee is prevented from advancing to the next stage of training before remediation. This is the safety purpose, protecting both patients and trainees.

In the case of PGY1 trainees, the satisfactory completion of rotations during internship is the basis on which the intern training programs/health services (usually through the Supervisor of Intern Training (SIT)/Director of Clinical Training (DCT) and Director of Medical Services (DMS) provide a recommendation to the Medical Board of Australia (MBA) for progression from provisional to general registration.

Term supervisors (TS) should meet with prevocational trainees at the commencement of the rotation to provide an orientation to the term in addition to discussing the appraisal and assessment processes. Term supervisors should meet with trainees in about week 5 to discuss the mid-term appraisal and then at the end of term, to complete the end of term assessment.

Doctors in Training Managers who are responsible for the administrative processes supporting the assessment of prevocational trainees will likely have systems in place that ensure that trainees are provided with the forms in a timely manner in addition to being able to collate and monitor forms as they are returned.

Tips: Supporting assessment processes:

- Group email to prevocational trainees to remind them of the requirements for mid-term assessment (MTA) and end of term assessment (ETA).
- Group email term supervisors to remind them re requirements for MTA and ETA (sent by nominated health service person).
- Remind PGY1s that they need signed forms to be submitted for recommendation for general registration with AHPRA.
- Encourage PGY2s to get forms signed as useful for future College requirements and recognition for prior learning (RPL).
- Encourage prevocational trainees to make an appointment with their term supervisor well beforehand to discuss midterm appraisal and end of term assessment.
- Ensure health services keep their own copy of signed assessment forms. Many health services actually keep the original document, not the copy - the doctor can keep a copy.

Orientation program

Facility Orientation

Just as with other employees, all prevocational trainees are expected to receive an appropriate orientation to:

(1) the facility within which they work at the commencement of employment, and
(2) the specific unit or rotation at the commencement of each term.

These requirements are reinforced through the provisions of the PMCV accreditation standards. Along with the Medical Education Unit staff, the Doctors in Training Managers are likely to be heavily involved in both organising and participating in the orientation program for junior doctors at the commencement of the clinical year. This also extends to managing rosters and term changeover to optimise attendance.

The orientation program for interns is held just prior to the formal commencement of the clinical year and may be of one to five days duration depending on the training site. It is a major undertaking for any prevocational medical training facility. The orientation program covers a range of topics that are aimed at assisting the prevocational trainee's transition to working as a junior doctor. Most programs cover the following four themes:

- General information about the facility and its rotation sites as it relates to all employees. This includes mandatory training, important general policies and procedures, human resource matters, IT systems, and usually a tour of the hospital.
- Specific information related to the role as a junior doctor. This might include responsibilities of junior doctors, important clinical policies and procedures, multidisciplinary care, diagnostic test ordering, education and training as a junior doctor, assessment procedures, medico-legal matters and so on.
- Clinical and procedural skills training and verification. All orientation programs incorporate some practical training sessions, sometimes with additional skills verification activities, covering topics such as basic and advanced life support, venipuncture, cannulation, scrubbing and safe prescribing.
- Shadowing/Ward attachment with the outgoing junior doctor. Many health services offer a shadowing program so that the incoming prevocational trainees are attached to the outgoing junior doctor on the term that they are rotated to for their first term. This provides an opportunity for an effective clinical handover in addition to a more extended term orientation.

The orientation period will provide you with the opportunity to meet prevocational trainees attached to your training program. Those Doctors in Training Managers from smaller rotation sites relying on the larger parent health service to host the program are advised to attend relevant sessions of the orientation program.

The PMCV has developed a set of guidelines to guide the development of facility orientation programs. PMCV website. Available at: http://www.pmcv.com.au/resources/guidelines-alphabetical [accessed September 2014]

Rotation (Secondment) sites orientation program

In addition to the main orientation program held at the commencement of the clinical year by the parent facility, most rotation sites will hold a half-day orientation at the commencement of each term. This orientation program should supplement the main orientation provided to PGY1 trainees and delivers information specific to the facility, highlighting local policies and procedures, access to IT systems, diagnostics (particularly after hours) and clinical services. It may also include a tour of the hospital.

Many Doctors in Training Managers will also be involved in organising the orientation program attended by Residents (PGY2, 3, 3+) and Registrars. This program is normally abbreviated, supplements or replaces the general staff orientation program and provides information required by junior doctors of all classifications to fulfil their responsibilities.

Term orientation

Term orientation is an important component of the prevocational training program. It is the responsibility of the term supervisor to provide an orientation to the term for prevocational trainees. Whilst junior doctors appreciate the participation of senior doctors and particularly the term supervisor in term orientation, registrars, nursing staff and allied health staff, might deliver some aspects of the orientation. This also provides an opportunity for the prevocational trainee to get to know and be inducted by members of the team that they will closely work with for the duration of the rotation.

Doctors in Training Managers, working with the DCT/SIT/MEO and others, may be involved in implementing systems and processes that support effective term orientation. These include:

- Ensuring that there is a term description for every prevocational term with current information reviewed by the term supervisor on a regular basis and made available to the prevocational trainee prior to the commencement of term *(see Junior Doctor Term Description Guidelines)*. PMCV website. Available at: http://www.pmcv.com.au/resources/guidelines-alphabetical [accessed March 2015].
- Having systems in place that remind term supervisors and other clinical staff of term changeover dates and the requirement for term orientation.
- Reviewing rosters covering the term changeover period in order to optimise term orientation and effective clinical handover.

ROVER

In recent years, some prevocational trainees developed a resource to assist their colleagues with term orientation. The ROVER Form is a template for collecting information about the specific practical day-to-day responsibilities involved in a particular rotation. It is designed to supplement information provided in the term description and the orientation by the term supervisor. The ROVER template can be found on the PMCV website. Available at: http://www.pmcv.com.au/resources/guidelines-alphabetical [accessed September 2014].

Some Doctors in Training Managers and DCTs/SITs have led very innovative approaches to orientation, in addition to other prevocational training activities. For example, one facility developed a peer led orientation program, called Code Red, whereby prevocational trainees at the end of their first year provide much of the orientation to incoming trainees.

The JMO Forum, the quarterly medical educators workshops and the PMCV's annual Symposium, provides those working with prevocational trainees opportunities to showcase innovative approaches.

Formal education program

Whilst the focus of prevocational training is learning by doing, the formal facility education program supplements unit based activities and ensures that all prevocational trainees have an opportunity to cover important clinical topics, pitched at their level. The education program is developed by each facility normally with feedback provided by those involved in program development (such as trainees, MEOs, Doctors in Training Managers, DMS etc).

The development of the formal education program is one of the flagships of a prevocational medical training site. Whilst the DCT/SIT will ultimately be responsible for the formal education program, as the Doctors in Training Manager you will undoubtedly have a role in providing support for development and implementation.

As the Doctors in Training Manager, you will also have a critical role in encouraging and supporting attendance. Expecting and encouraging prevocational trainees to attend formal education sessions provides an important lesson in exposing them to the discipline of setting aside time in the context of clinical demands for their own professional development and learning – this is a lesson in life-long learning.

Of course, rostering practices underpin attendance and participation. In addition to the obvious educational benefits, the formal education program also offers an opportunity for prevocational trainees to come together as a group away from the clinical environment. It may provide you with an opportunity to informally catch up with them on a regular basis, even if you are only able to attend for a few minutes at the beginning of the session or during the break. As the Doctors in Training Manager you can use this

as an opportunity to make important announcements, provide reminders of significant events and so on. It should be noted though, that this is quarantined time for medical education activities and therefore the time should not be used for non-clinical topics.

You may also be involved in setting up systems to evaluate the formal education program, often with the assistance of the DCT/SIT. This is usually achieved through the distribution of evaluation forms at the conclusion of each formal education session asking prevocational trainees to evaluate that session in terms of relevance of content and delivery. The information contained in these forms is then collated and provided to the relevant health services committee.

Useful Resources

Burnand, J (Ed). *Becoming a Doctor: surviving and thriving in the early postgraduate years*. Sydney, Elsevier 2007.

Australian Curriculum Framework, CPMEC website: http://www.cpmec.org.au/Page/acfjd-project

Australian Medical Council, National Internship Training Framework, AMC website: http://www.amc.org.au/accreditation/prevoc-standards

ROVER template, PMCV website: http://www.pmcv.com.au/resources/guidelines-alphabetical

Guidelines for the Orientation of Junior Doctors, PMCV website: http://www.pmcv.com.au/resources/guidelines-alphabetical

Best Practice Guidelines: Improving Interactions between MWU and JMS, PMCV website: http://www.pmcv.com.au/resources/guidelines-alphabetical

SECTION 3 MANAGING JUNIOR DOCTORS

Working with doctors

As a Doctor in Training Manager, many of your professional interactions are likely to be with doctors. Whilst you will obviously have regular contact with junior doctors, you will also likely have frequent contact with senior doctors, including the DMS, the DCT/DME and term supervisors. Effective Doctors in Training Managers work to establish collaborative relationships (refer Section 7 of the Guide) with doctors and appreciate that sometimes doctors and managers may have different perspectives.

Despite an increasing recognition of the importance of team work within the healthcare setting, medical training at the university level largely teaches doctors to be individualistic, with a focus on the doctor having primary responsibility for patient care. Whilst junior doctors will be very closely supervised during the prevocational training period, postgraduate medical training, particularly vocational training is concentrated on doctors taking increasing responsibility for clinical care under gradually decreasing levels of supervision.

Medical training is highly competitive and at times stressful. Junior doctors are on a very steep learning curve, particularly in the immediate postgraduate period. They must adapt to working in increasingly complex healthcare environments whilst frequently changing rotations. With every change of term they must adapt to working with a new team (not just their medical supervisors but also with respect to the other healthcare team members such as medical staff nursing, allied health and ward administrative staff).

Postgraduate medical training is a very significant undertaking involving a high level of commitment, long hours of study, the ability to successfully pass a number of barrier exams, all whilst working (usually) full time. Rotations provide opportunities for junior doctors to experience different clinical specialties, get to know the senior doctors in those specialties and make important decisions regarding future specialty or career pathway. As a result, junior doctors, even during the prevocational training period, can be very focused upon working toward their particular training goal or specialty. This can sometimes become a point of tension as their training needs are from time to time prioritised over other work obligations.

Effective Doctors in Training Managers who recognise these different perspectives and work to establish cooperative and supportive relationships with prevocational trainees are able to have a significant impact upon the way in which doctors interact within the organisation.

Welfare and support

The prevocational trainee period represents a significant touch-point in the medical career, as they make the transition from medical student to medical practitioner. Whilst most prevocational trainees enjoy the challenge, many also report that at times it can be stressful.

The reasons for this can be numerous and include:

- Loss of a structured learning environment coupled with increased demands on knowledge and performance.
- Structured working hours (i.e. a roster).
- New responsibilities and confrontations with life and death experiences.
- Unprecedented levels of administrative duties that may conflict with the trainee's self-image as a professional clinician.
- Frequent changes in work environment, patients, colleagues and bosses.

Given the regular contact that they have with prevocational trainees, Doctors in Training Managers are well positioned to provide support to them. This can be a fundamental component to the role and one that many Doctors in Training Managers report as being the source, when done well, of considerable professional satisfaction. Implicit in this is a supportive but firm approach in managing prevocational trainees.

The way in which Doctors in Training Managers work with trainees can have a major impact on the morale of the junior doctor group. This might range from having an open door policy, arranging regular face-to-face meetings, promoting a culture of cooperative working relationships, a can do attitude and a positive approach to resolving issues; this approach is highly valued by junior doctors.

The fact that the Doctors in Training Managers sit somewhat to the side of the medical hierarchy means that many junior doctors may be more willing to confide in the Doctors in Training Manager (rather than a more senior doctor) about their concerns and anxieties.

Doctors in Training Managers are often very adept at picking up those junior doctors who may be struggling and may be involved in managing trainees in difficulty, often with the support and assistance of others. Some resources and references that Doctors in Training Managers may find useful are included at the end of this section.

Performance management

Doctors in Training Managers are often responsible for first line management of performance issues involving prevocational trainees, sometimes in collaboration with clinical unit heads. This can include ensuring that prevocational trainees meet their obligations with respect to public sector employment policies and related human resource matters, such as turning up for work on time, submitting appropriate leave forms, responding to a complaint from a nurse, completing discharge summaries and so on.

Doctors in Training Managers will be involved in developing and supporting systems that provide prevocational trainees with regular feedback, both informal and formal about their performance.

All public health organisations have well-established policies and procedures with regards to the performance management of employees and these should be followed. You will undoubtedly seek assistance when required from the DMS, DME/DCT, clinical Head of Department, HR and a range of others depending on the context of the specific issue.

Trainee in difficulty

As the Doctors in Training Manager you may often be the first to recognise that a prevocational trainee is experiencing difficulties.

Whilst the way in which a prevocational trainee in difficulty may present might vary, all require appropriate support and timely intervention. Generally, the DME/DCT and Doctors in Training Manager will be involved at an early stage.

Many Doctors in Training Managers report that dealing with trainees who are experiencing difficulties is one of the most challenging aspects of their work. The reasons for this are numerous and include the following:

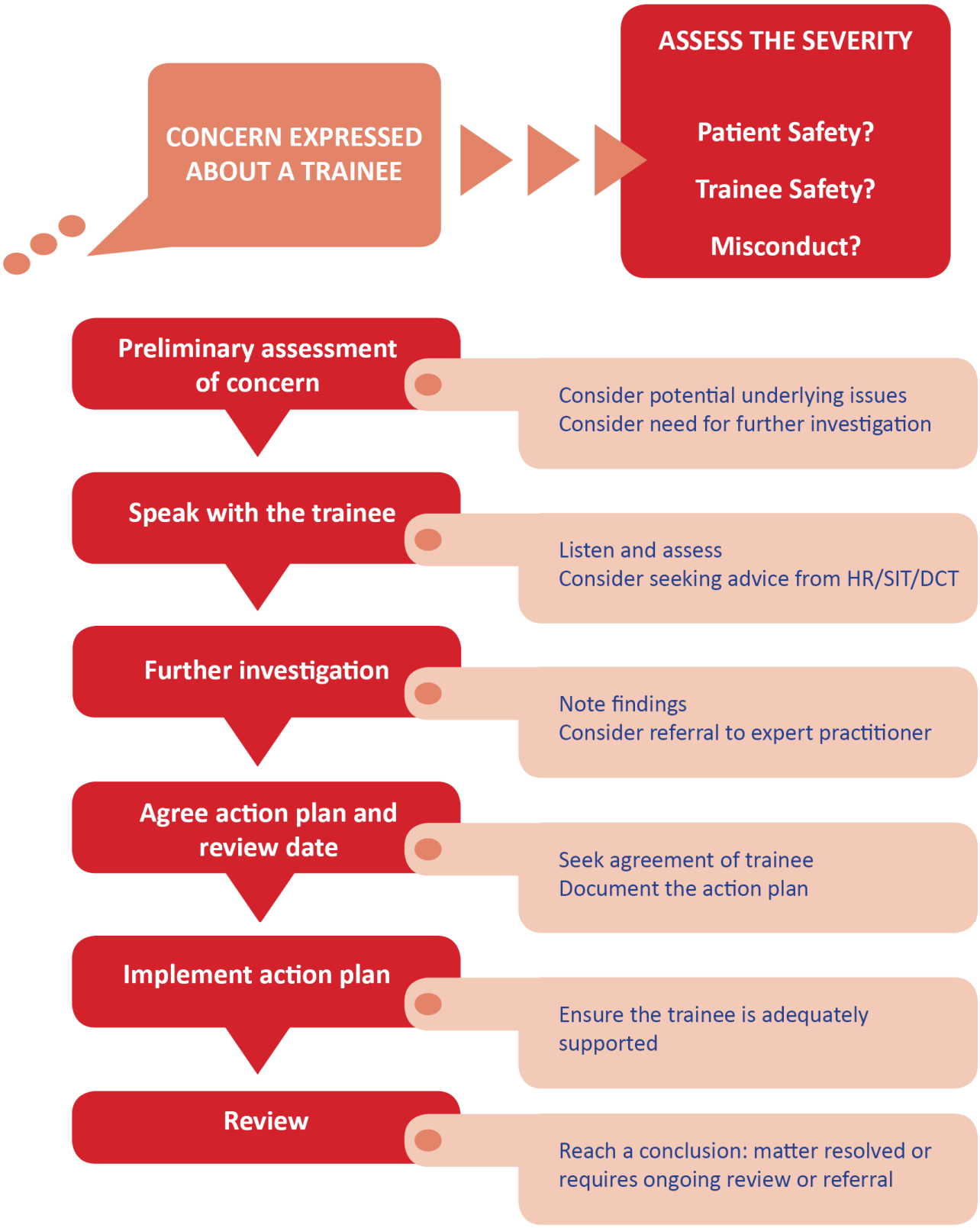
- The legal and industrial frameworks are complex and there are multiple public sector policies to consider.
- Those involved must negotiate the interface between the roles of the prevocational doctor as both trainee and employee.
- Working with prevocational trainees experiencing difficulties can be demanding, particularly those who have problematic attitudes and behaviours. Effective communication skills are required.

Employers have a legal responsibility to ensure that industrial conditions and legislated requirements pertaining to employment are upheld. This includes responsibility for managing performance and disciplinary matters, and ensuring that performance issues are responded to in a timely, fair and objective way.

Every public health organisation has processes for identifying, investigating, managing and supporting prevocational trainees who are experiencing difficulties. The SIT/DCT has a central role in responding to prevocational trainees and they will often involve the Doctors in Training Manager. Some situations will additionally require assistance from medical administration or human resources.

The following management overview is taken from "*Trainee in difficulty – A management guide for DME/DCTs"* developed by HETI, NSW, 2012.

Trainee in difficulty: Management Outline



Early signs of a trainee in difficulty

- The disappearing act
- Low work rate
- Ward rage
- Rigidity
- Bypass syndrome
- Career problems
- Insight failure

Adapted from Paice, E. *The role of education and training*. in Cox J, King J, Hutchinson A, editors. "Understanding doctors' performance". Oxford: Radcliffe Publishing. 2006.

Trainee in difficulty – what are the potential underlying issues? (trainee, supervisor, system)

Work Environment

- Unfamiliar discipline of being a hospital employee, not a student
- Junior status: having to respond to the immediate demands of other staff
- Frequent transitions to new work environments
- Interpersonal conflict within the team
- Excessive workload
- Inadequate support for medical and administrative tasks
- Inadequate supervision and support
- Inadequate role definition/orientation
- Bullying or harassment
- Sexual harassment

Lifestyle Issues

- Ill health
- Poor general health
- Fatigue
- Unhealthy lifestyle – poor nutrition, lack of exercise, lack of relaxation and recreation.

Competence

- Deficient knowledge
- Poor communication
- Poor time management
- Poor record-keeping or documentation

Extrinsic factors

- Relationship issues
- Accommodation and transport difficulties
- Pregnancy and parenting
- Financial issues
- Visas and migration issues
- Language and cultural issues.

Psychological issues

- Heightened stress reaction or burnout
- Lack of self confidence
  - Highly self-critical
  - Perfectionist or obsessive tendencies
  - Heightened distress over patient death
  - Detachment, loss of empathy

- Poor attitude
- Lack of insight
- Lack of motivation
- Emerging or existent mental illness (anxiety, depression, bipolar disorder, anorexia)
- Alcohol or drug abuse
- Difficult personality traits

Source: *Trainee in difficulty. A management guide for Directors of Prevocational Education and Training.* 2nd Edition. Sydney: HETI, 2012.

Key messages

- Most trainees in difficulty can be assisted, over time, to become competent clinicians. A supportive approach, with common sense interventions, coordinated and monitored by the DME/DCT, usually leads to a satisfying result for the trainees and their clinical supervisors. The Intern training assessment pro-forma developed by the Australian Medical Council includes an *Improving Performance Action Plan* (IPAP), to guide clinical intervention where problems are identified. Further information: AMC website. Available at: http://www.amc.org.au/joomla-files/images/intern-training/intern-training-term-assessment-form-2014-09-24-colour.pdf [accessed September 2015].

- "You cannot unknow what you know"– do not accept someone telling you something "off the record."

- Any risks to patient safety, risk to trainee safety or allegations of criminal conduct require immediate action and referral.

- All prevocational trainees should be encouraged to have their own general practitioner and should seek early advice from their GP in the event of emerging health issues. Consider facilitating GP contact for trainees rotating to remote and rural areas, where they may not be able to consult their own GP easily.

- There are other individuals within any healthcare organisation who have particular expertise in dealing with these matters.

- There are numerous external resources that can be accessed to assist a trainee in difficulty (e.g. Victorian Doctors Health Program, AMA Peer Support, Employee Assistance Programs).

- The Doctors in Training Manager is often the first to notice that something is amiss. Some trainees experiencing difficulties may be at risk of self-harm and need timely escalation to expert health practitioners such as a general practitioner or mental health clinician. As the Doctors in Training Manager, you will need to adopt an attitude of early referral to the DME/DCT or the DMS if you are concerned about a trainee.

Key Principles:

1. Patient safety should always be the primary consideration.
2. Prevocational trainees require supervision and support.
3. Prevention, early recognition and early intervention are the preferred approach.

Dealing with grievances and complaints

Given their regular contact with prevocational trainees, it is not surprising that Doctors in Training Managers report that dealing with grievances and complaints can sometimes occupy a significant proportion of their time. The circumstances and context can vary from involving an issue of an incorrect pay, interpersonal tensions between a prevocational trainee and another doctor or nurse on the team, through to more complex issues, such as an allegation of bullying.

All public health organisations have clearly documented grievance policies and managers should be well aware of their relevant organisational grievance policy and follow these.

The vast majority of issues or complaints from prevocational trainees that cross your desk are likely to be able to be resolved without the requirement for escalation or significant interventions by adopting a supportive and fair, but firm approach.

It is worth remembering that responding professionally to situations in the workplace where one might justifiably feel upset, irritated or angry is an important learning point for prevocational trainees. Sometimes just having someone to listen to their side of the story or concerns is enough. By giving them the opportunity to debrief and express frustration they will then be able to work constructively towards a resolution.

The obvious exceptions to this are significant grievances or complaints that involve patient or junior doctor safety or serious allegations involving other staff. These matters can be very complex to investigate and manage. The Doctors in Training Manager should be alert to the requirement for timely referral and escalation to the SIT/DCT, medical administration or the Human Resources department of their organisation.

Useful Resources

beyondblue, various resources on depression, anxiety, mental health, suicide prevention, perinatal depression, and more. Available at: http://www.beyondblue.org.au/resources [accessed 29 January 2015]

Cox J, King J, Hutchinson A, McAvoy P, editors. *Understanding doctors performance.* Oxford: Radcliffe Publishing, 2006.

Firth-cozens J, Morrison LA, "Sources of stress and ways of coping in junior house officers", *Stress Medicine* 1989; 5 121–126.

Paice E, Rutter H, Wetherell M, et al." Stressful incidents, stress and coping strategies in the pre-registration house officer year", *Medical Education* 2002; 36: 56–65.

Markwell AB, Wainer Z. "The health and wellbeing of junior doctors: insights from a national survey". *Medical Journal of Australia* 2009; 191: 441–444.

Health Education and Training Institute. *The Superguide: a handbook on supervising doctors in training.* Sydney, HETI, 2013. Available at: http://www.heti.nsw.gov.au/Global/allied-health/The-Superguide.pdf

Health Education and Training Institute, *Trainee in difficulty. A management guide for Directors of Prevocational Education and Training*, 2nd Edition, Sydney, 2012. Available at: http://www.heti.nsw.gov.au/Global/Prevocational/trainee-in-difficulty-2nd.pdf

Postgraduate Medical Council of Victoria (PMCV) Inc. The PMCV has collated a list of resources covering support services within and outside of health services, links to useful resources (on issues such as resilience, fatigue), and key online help telephone numbers and links to websites which have fact sheets, vignettes and useful strategies. This document is available from the JMO Forum section of the PMCV website. Available at: http://www.pmcv.com.au/jmo-welfare-a-support/jmo-resources/junior-doctor-welfare-support-services [accessed April 2015]

Royal College of Physicians, UK. *Survive your first night shift*. Available at: https://www.rcplondon.ac.uk/education-practice/advice/how-survive-your-first-night-shift [accessed 2 February 2015]

Victorian Doctors Health Program (VDHP). Further information from VDHP website: Available at: http://www.vdhp.org.au/website/home.html

SECTION 4 TERM ALLOCATIONS AND ROSTERING

Term Dates

The term (or rotation) dates for doctors in training can be found on the PMCV website. Available at: http://www.pmcv.com.au/medical-administrators/term-dates [accessed September 2015]

The dates are prepared by the PMCV in consultation with the HMO Managers subcommittee and published on the PMCV website when finalised.

In relation to registrar start dates there is a national agreement that these will commence on the first Monday in February of each year.

53 Week Year

Every 6.5 years a calendar which begins on the same day in the same month must include a 53 week year. This accounts for the extra day in every calendar year (and 2 extra days in a leap year. There are 365 days per year or 366 in a leap year, and yet 52 weeks = 52 x 7 = 364 days.) If uncorrected the intern and HMO start dates get earlier and earlier each year until they slip over into the preceding month. The last 53 week year was in 2009 and the next is due in 2016.

The impact on health services will be on:

- HR – contracts for interns and HMO's must reflect the actual start and finish dates and not the number of weeks (or all current Doctors in Training could leave one week before your new doctors commence).
- Budgeting – the interns and JMOs and all staff paid on a weekly, fortnightly or four weekly cycle will end up being paid an extra week for that year. It will not affect staff paid on a nominated day each month, or those paid an annual salary, however that salary is divided.
- Term planning – the 2016 intern year (5 terms per year) will contain terms of 10, 10, 11, 10 and 12 weeks. The HMO year (4 terms per year) will have terms of 13, 13, 13 and 14 weeks.
- Finance departments – adjustments to the amount of salary packaging per week need to be made to keep the total packaged under the salary packaging allowable level.

Recruitment dates

The PMCV prepares in conjunction with the HMO Managers subcommittee, the key recruitment dates for each of the medical matches (Intern Match, HMO Match, BPT Match). These dates reflect the opening and closing of the matching process, the period in which a facility will conduct their interview and/or selection process, and the date when the matching results will be released. Further information. PMCV Computer Matching website. Available at: http://www.computermatching.pmcv.com.au/ (Refer to Section 5 for more detailed information on Computer Matching)

Term allocations

Similar to rostering dealt with later in this section, the interface between trainee and employer is no more keenly felt than when it comes to annual term or rotation allocations. This is reflected in the amount of time that (if it falls under your area of responsibility) you will spend engaged in sorting out both!

On one hand you will have a responsibility to the organisation to ensure that all units and rotations (including nights and weekends) are adequately staffed with appropriately skilled JMO's. On the other, you will be trying to juggle the specific training and other requirements of your doctors in training.

Intern Allocations

During the first twelve months of training, the prevocational trainee is required to complete a number of rotations (currently five terms of between ten to twelve weeks duration combining to provide a minimum of 47 weeks clinical experience), with mandated terms in medicine, surgery and emergency medicine. Most healthcare services or facilities have a number of available terms beyond the mandated requirements. Most prevocational trainees will be able to undertake terms across a range of specialty areas in a variety of settings.

In addition to mandated requirements there are a number of other factors to consider in the allocation of intern terms. These include: individual trainee preferences; capacity to undertake a term in a rural setting; timing of a particular term in relation to annual leave requests; prerequisite requirements for college training programs; and so on. Individual trainee preferences are particularly important in the second postgraduate year where a trainee may not only want to undertake particular terms but may well want the timing of those terms to be at the commencement of the year, well ahead of the next recruitment cycle. Given all of these considerations it is no wonder that term allocations can sometimes be very complex, but there are a number of ways to approach this task.

Intern rotation planners can be created as "whole" rosters for the entire year, as each intern has specific core requirements to be met. The planner can be sent to the matched interns to select a preferred roster rather than to build the roster from preferred core terms. The pre-developed rosters need to have an allocation of two weeks annual leave within the year, keeping in mind that all intern positions finish three weeks before PGY2 positions commence in Victoria, and so all interns are given their additional three weeks of annual leave before they commence the PGY2 year.

Many Doctors in Training Managers allocate the annual leave within the year during the Emergency Medicine term, as the requirement for Emergency Medicine experience is eight weeks and not ten weeks as with the other core term requirements. Another alternative is to allocate intern annual leave in a relieving term (if you have relief terms in the intern rotation planner). When you allocate the annual leave component, you need to ensure that the core training requirements and total weeks of experience will not be compromised; it is important not to create a situation where the intern will only have the ability to work 47 weeks in a year (by allocating the entire five week annual leave entitlement in the employment year) as there does need to be some flexibility to allow for sick leave without having to make time up at the end of the year to meet the time pre-requisite.

Towards the latter end of the clinical year, as the Doctors in Training Manager, you may also have the challenging task of assigning prevocational trainees to the terms for the following year often with the assistance of the Director of Physician or Surgical Training. This is usually done immediately following the recruitment period.

Whilst you may be put under pressure by some individual trainees to provide terms to meet college entry prerequisites, this must only be done where a fair and equitable term allocation can still be made for all the prevocational trainees. The principles of fairness and equity of access are important here and should underpin whatever approach is taken. This includes a fair and equitable division of the less sought after terms (which may include night duty, rural and relief terms). All Doctors in Training should expect some portion of their annual allocation of terms to include "service" terms and if explained upfront when preferences are sought, should not pose an insurmountable problem.

PGY2 Allocations

When allocating terms for PGY2 and above, you need to be aware of the training program requirements for the areas of interest for the Doctor's in Training. Some Doctor's in Training will have signed up for training programs with a College in their PGY2 year, and need to meet certain requirements in their training program to complete the training. One example of this is the Royal Australasian College of Physicians (RACP); another may be the GP training Colleges: The Royal Australian College of General Practitioners (RACGP) or the Australian College of Rural and Remote Medicine (ACRRM). It is important to familiarize yourself with the different Specialist Training College requirements for entry into training programs and to keep up to date with the requirements as changes occur often and may not always be communicated.

Most Doctors in Training Managers start the rotation allocation process early (particularly in the bigger sites) and may seek the assistance of others – (for example the Director of Physician Training or Pre-SET Supervisor, or perhaps a senior Registrar) to develop annual rotation planners or rosters. Sometimes the Doctor in Training Manager and their team develop the annual rotation allocation plan and then seek input to ensure training requirements are met from the DPE / Surgical Supervisor(s). Some form a small subcommittee of junior doctors to help. Others send out a term allocation preference list (which may also request additional information required to build the annual rotation planner such as annual leave preferences or conference leave requests) giving prevocational trainees the opportunity to list their preferences. For the intern year, this is often done as soon as medical graduates are allocated places in the intern training program/parent health service. For PGY2s this is done toward the end of the intern year. Managers will need to work with others in the health service to ensure alignment and coordination of rotations, whilst also keeping in mind the organisational requirements and the ability to provide safe patient care.

When designing a rotation planner for the year, it is important to consider a number of factors that can affect staffing throughout the year. Some examples of things to consider include:

- Examination dates for pre-Specialist College entry (many doctors in training may request examination leave to prepare for and attend these examinations; it is a good idea NOT to allocate any annual leave during these times if known prior to rotation planning). The RACS examinations, for example, are currently held twice each year, and planning for examination leave during the examination period may impact on your ability to provide annual leave during this time.
- Course dates (once again, trainees may request conference leave to attend preparation courses prior to examinations; the dates for these courses are usually available in October/November the year before they are due to be held)
- Conference dates (many trainees will request conference leave to attend conferences which may or may not be required by an Advanced Trainee training program) Where possible, try to avoid allocation of annual leave around known conference dates if you expect that attendance requests might be high as this can impact on the organisational ability to cover service delivery and patient care. Conferences may not be attended by Doctor's in Training but will often be attended by VMO's or Full time Consultants in a particular area. This can leave a gap in 1) supervision of Doctor's in Training and 2) impact on service provision for patients still requiring care during the conference period. Knowledge of all course, conference and examination dates is important prior to creating an annual rotation plan.
- Six month rotations; some doctors in training will request a six month rotation during their PGY2 or PGY3 year, with the other six months being taken as a 'break' whilst they either travel or work out what direction they want their career to take; some will not advise upfront of this intention, but may resign from their position before the end of their appointment, (remember, many doctors in training have been at University for a number of years and may want a break before they decide to focus on their advanced training options). Be mindful of the potential for early resignations when planning annual rotations. It is wise to leave some capacity for backfill in the second six months of any yearly planner to assist if early resignations do occur.
- Preferred terms: There are many ways to allocate preferences to build an annual rotation planner; you can allocate annual leave preferences first, followed by preferred terms and then fill up the gaps with less desirable terms; you can allocate preferred terms first then proceed to allocate leave in relieving terms; you can allocate less desired terms first and then fill the gaps with preferred terms and annual leave requests; whichever allocation method is used, fairness and equity as well as preferences and training requirements (for the entire cohort, not just individual doctors in training) must be kept in mind.

Tips: Rostering:
Once term allocations have been completed, it is useful to maintain two spreadsheets, the first cut by rotations (to ensure that there are no vacant terms) and the second by individual prevocational trainee (to ensure that each junior doctor has an appropriate range of terms).

Why term allocations are important (from an educational perspective)

The prevocational education and training program for interns (PGY1) and HMO2's (PGY2) provides the foundation of a skilled medical workforce with a broad range of training experiences across specialties and in different contexts, including tertiary, outer metropolitan and rural hospitals, general practice and community settings.

From a medical education and training perspective, term allocations provide the opportunity for trainees to gain important clinical experience within a clinical specialty. This can provide them with a sense of what the specialty (and the training program for that specialty) might be like, through their work with consultants and vocational trainees. Experience in a particular specialty can have a very significant impact in making career choices, by seeking greater clarity about which specialty they would like to pursue, and just as importantly, which ones they don't.

From a service provision point of view, you as the Doctors in Training Manager will be concerned about ensuring that all terms across your facility and those you have rotational agreements with are adequately staffed with junior doctors with the appropriate seniority and skill mix.

From the prevocational trainee point of view, having the opportunity to complete a particular term can be very important. Put simply, term allocations can have a very significant impact on a doctors-in-training choice of career and their ability to meet the pre-requisites for entry into many Specialist training programs. As the numbers of trainees in the system increases and with it, competition for training places, the decisions around term allocations are likely to become more contentious. Doctors in Training Managers should have transparent systems in place for allocating terms, based on the principles of fairness and equity of access.

Rostering

Rostering of junior medical staff is a complex business.

Doctors in Training Managers who work in large metropolitan networks or facilities will often have responsibility for coordinating, in consultation with the various clinical departments, over 50 different rosters involving junior medical staff. Even Doctors in Training Managers responsible for much smaller cohorts of junior medical staff, will find that they spend a significant amount of their time managing rosters and associated tasks.

The remainder of this section highlights some particular considerations with regards to rostering of prevocational trainees, particularly as it relates to their education and training. Doctors in Training Managers should refer to relevant industrial instruments (for Doctor's in Training this is the *AMA Victoria – Doctors in Training Agreement 2013*) and individual Health Service policy (if available) for specific information on rostering practices.

At the commencement of their medical careers, prevocational trainees may have had little experience with working on a roster. Working after hours, weekends, evenings and nights can be a new experience. Many junior doctors report that the work they undertake outside of normal hours, where supervision arrangements and skill mix of staff may differ from that available during business hours can be stressful. Rosters that give consideration to the skill mix and appropriate supervision are particularly important in this context.

Experienced Doctors in Training Managers will also confirm that as increasing numbers of prevocational trainees are entering the system, rostering templates for this cohort are changing.

One of the most significant changes, at least in the larger centres, is the reduction in rostered overtime hours with a simultaneous increase in the number of ordinary hours worked outside of the traditional business hours for an individual Doctor in Training.

When developing rosters for prevocational trainees in this context, access to the formal education program and other teaching opportunities (which for medical staff continue to be held predominantly in normal hours) needs to be taken into consideration.

Junior doctors adjusting to working shifts, particularly night shifts, require support. In recognition of this, the Royal College of Physicians in the UK developed a guide for junior doctors that provides useful advice to doctors working night shifts. A link to this document is included in the resources section at the end of this section.

Daily Duty rosters (outlining the expected duties whilst allocated to a particular rotation) are a useful tool for both the Doctor in Training and the Doctors in Training Manager and the Medical Workforce Unit staff. A duty roster outlines daily duty requirements including attendance at outpatient clinics, the operating theatre and education or training as well as ward work and afterhours and weekend work. It outlines clearly where a Doctor in Training should be at any given time, and their rostered hours for any given week (including rostered overtime). This is an important tool for assisting with budgetary preparation and monitoring of expenditure associated with unrostered overtime. For Registrars, *the AMA Victoria - Doctors in Training Agreement 2013* requires that 'blocks of training time must be identified in the roster" (Clause 11.24.4 (b).

An example of a daily duty roster is included in Appendix 4 of this Guide.

Overarching principles to guide rostering:

Patient Centre Care - delivering services to patients is the first consideration. There are a number of principles that can be used to guide rostering:

Principle 1: Rosters must ensure that there is sufficient and appropriately skilled staff rostered to work, in order to provide appropriate patient care and to meet anticipated service demands.

Principle 2: Rosters must conform to relevant regulatory frameworks, including antidiscrimination, occupational health and safety legislation, industrial awards, and local Healthcare Service policies.

Principle 3: Rostering processes should ensure staff are rostered fairly, while still providing appropriate flexibility to facilitate meeting unit staffing needs.

Principle 4: Rosters must make appropriate provision for adequate staff supervision, training and clinical handover.

Principle 5: The organisation must have appropriate governance structures in place to oversee roster planning, creation, approval, monitoring and reporting.

Principle 6: Rostering practices are based on co-operation between rostering managers and staff, in order to promote fairness in rostering and to deliver appropriate care to patients.

Principle 7: Rostered hours should reflect the time it takes to complete the required work.

Roster template build and development of rostering measures of success

- Develop roster template in line with full-time equivalent (FTE), budget allocated and agreed skill requirements with approved staffing profile
- Roster templates must be responsive to known workload variations, service provision, seasonal fluctuations and special events
- Factor OH&S and industrial Award provisions
- Consider leave planning when developing roster templates e.g. maximum number of staff on leave at one time

- Determine roster structure e.g. shift work, staggered shifts, on call
- Ensure locally developed rostering rules are incorporated into the roster template including temporary individual Roster arrangements
- Ensure adequate time for patient handover is built into shifts
- Ensure adequate supervision is available for staff
- Determine the number, classifications and skills of staff required per shift
- Build in training and education requirements and provide cover where necessary
- Develop and agree on roster measures of success.

Staffing availability

- Ensure there is a process for review and approval of the following:
    - Staff roster requests and temporary individual roster arrangements
    - Annual leave requests and leave schedule
    - High leave balances
- Identify part-time staff available for additional shifts to assist with vacancy management.

Roster creation

- Ensure all approved individual roster arrangements, roster requests and leave are entered into roster
- Allocate staff to remaining shifts according to roster template build requirements and staffing availability
- Fill vacancies according to locally developed vacancy management processes.

Approved roster for publishing

Prior to sign off ensure all appropriate steps in the roster process have been completed and agreed roster measures of success have been met

- Ensure local processes are in place for sign off and approval prior to publishing roster
- Following approval, publish roster according to industrial Award requirements

Ensure rosters are updated daily to record time worked, unplanned leave, shift swaps and any other changes to the published roster.

An example of a yearly rotation and annual leave planner is included in Appendix 1.

An example of a weekly rotation and annual leave planner is included in Appendix 2.

An example of a unit roster is included in Appendix 3.

Budget and finance management

Many Doctors in Training Managers have responsibility for managing budgets and finances relating to the junior medical workforce. This extends to managing rosters and medical overtime in ways that are cost effective and within budget. Doctors in Training Managers undertake this work in collaboration with clinical units, finance and other key individuals within the organisation. As a Doctor's in Training Manager you should be familiar with the financial reporting systems within your facility, and the budgetary imperatives that need to be met.

Many Doctors in Training Managers are also responsible for implementing policies and processes around rosters and overtime, particularly unrostered overtime, in addition to monitoring the compliance of junior doctors with requirements. Central to this is the development of clear communication with junior doctors regarding their responsibilities in meeting obligations regarding rosters and overtime, including timesheets and approval processes.

Each health service needs to have a policy in place regarding the approval process for claiming of unrostered overtime. The policy should be mindful of the requirements in the *AMA Victoria Doctor's in Training Agreement 2013* regarding unrostered overtime (refer Section 32.3.2 of the Doctor's in Training Agreement).

Many health services are able to provide assistance to new Doctors in Training Managers in roster redesign to reduce rostered and unrostered overtime costs. PMCV is able to provide an up to date list of Doctors in Training Managers who may be able to assist with this process.

Monitoring prevocational trainee's workload

Doctors in Training Managers frequently have responsibility for setting up systems to monitor trainee workload. This may range from monitoring rostered and unrostered overtime, call backs for those rostered to be oncall through to patient loads on individual teams. A number of factors may impact upon workload at the level of the individual trainee. These can include the following:

- Rosters (ordinary hours)
- Rostered overtime
- Unrostered overtime
- Patient numbers and clinical complexity
- Registrar or Consultant rosters (as Doctor's in Training are generally assigned to a number of senior medical staff within a given specialty, changes to senior medical staff rosters or senior medical staff leave and cover arrangements can significantly impact on individual junior doctor workload).
- Numbers and skill mix of other junior doctors in the term, including leave arrangements
- Seasonal fluctuations in patient numbers in some terms
- Individual trainee progress or performance issues (particularly at the commencement of the year, trainees may take longer to complete tasks compared with the end of the year).

Systems that monitor workload should be in place and significant issues escalated to the relevant individual. Depending on the organisational context this may be the Clinical Head of Department, the Supervisor of Training or the Chief Medical Officer/Director of Medical Services. In some instances, there may be a Senior Registrar in the facility who can act as a resource to assist with solving these issues before they escalate.

Supporting effective clinical handover

Doctors in Training Managers are well positioned to support effective clinical handover practices in their facilities or networks and have an important role in developing systems that support effective clinical handover and many will be familiar with the range of tools and resources developed to support effective clinical handover practices for junior doctors and actively promote them amongst their junior doctor cohort.

In view of the critical importance of effective clinical handover practices to safe patient care, a considerable amount of work has been undertaken to develop appropriate systems and handover tools. There are three key elements that have been identified to help improve DiTs handover:

a) A communication framework for prevocational doctors (ISBAR),
b) Senior leadership (i.e. registrar, consultant, VMOs, senior nurses) handover, and
c) Shift to shift handover.

Given the nature of their roster and rotation arrangements, prevocational trainees need to develop and engage in effective clinical handover practices as a critical component of their work, appropriately supervised and supported by more senior medical staff.

At the end of handover, the prevocational doctor, be it at the end of a shift or at the end of the term, should have a clear understanding of:

- Sick, deteriorating and unstable patients
- Outstanding actions, procedures, test or results to be reviewed
- Other important factors that will impact work on the following shift.

Doctors in Training Managers can also assist effective clinical handover in the following ways:

- Development of roster templates that facilitate time for handover – this implies that there is provision for rostered shift overlap and that punctuality with start and end times of shifts with junior doctors is reinforced.
- Incorporate requirement and responsibility for clinical handover into junior doctor position descriptions and term descriptions.
- With respect to the end of term changeover, coordinate with secondment hospitals to ensure that rostering practices are aligned to maximise opportunities for incoming and outgoing junior doctors to provide clinical handover of patients, (in addition to other considerations such as time to travel, management of fatigue and so on). The HMO Managers subcommittee have developed a document in an attempt to formalise and standardise the day and date of the end of rotation for junior medical staff (JMS) who move between home and rotation or secondment hospitals during an employment year. A copy of the *Rotation Start and End Guideline* can be found on the PMCV website. Available at: http://www.pmcv.com.au/medical-administrators/current-projects [accessed 19 April 2015]
- Participate (with other relevant staff) in auditing and monitoring of clinical handover practices within your facility.

The Australian Commission on Safety and Quality in Healthcare developed the *OSSIE Guide to Clinical Handover Improvement* to assist with the design, implementation and evaluation of clinical handover. A copy can be accessed at the ACSQH website. Available at:
http://www.safetyandquality.gov.au/our-work/clinical-communications/clinical-handover/ossie-guide/
[accessed April 2015)]

ISBAR

ISBAR is a communication strategy to enhance structured communication and referral between healthcare professionals and health care teams. ISBAR stands for:

- Identify - self and others
- Situation - state the purpose of the call / contact and is it urgent?
- Background - tell the story
- Assessment - your interpretation of the situation and degree of certainty
- Request - state what you want from the other person.

Further information including tutorials and information sheets can be found on the VMIA website. Available at:
https://www.vmia.vic.gov.au/risk/risk-tools/isbar [accessed September 2015]

Useful Resources

AMA Victoria, Victorian Public Health Sector (AMA Victoria) - Doctors In Training (Single Interest Employers) Enterprise Agreement 2013.
https://amavic.com.au/page/Doctors_in_Training/DiT_Agreement_2013-2017/ [accessed September 2015]

NSW Department of Health, *Improving JMO clinical handover at all shift changes – implementation toolkit*, 2010. Available at: http://www.aci.health.nsw.gov.au/__data/assets/pdf_file/0020/235145/jmo-handover-toolkit.pdf [accessed April 2015].

NSW Health, *Rostering Resource Manual*, Version 2, August 2014
Available at: http://www.health.nsw.gov.au/Performance/rostering/Publications/rostering-resource-manual.pdf [accessed November 2015].

AMA National Code of Practice - Hours of Work, Shiftwork and Rostering for Hospital Doctors. February 2005. Available at: https://ama.com.au/article/national-code-practice-hours-work-shiftwork-and-rostering-hospital-doctors [accessed April 2015].

Royal College of Physicians, UK. *Working the night shift: preparation, survival and recovery. A guide for junior doctors.* 2006. Available at: https://www.rcplondon.ac.uk/sites/default/files/documents/working-the-nightshift-booklet.pdf [accessed April 2015].

Victorian Department of Health, Accreditation resource which comprises a list of policies, guidelines and tools that can assist Victorian health services in identifying evidence to demonstrate how you meet the National Safety and Quality Health Service Standards - Standard 6 - Clinical Handover, August 2012, http://docs.health.vic.gov.au/docs/doc/Standard-6-Clinical-Handover [accessed April 2015]

Financial Management Education Program offered in NSW. Available at: http://www.heti.nsw.gov.au/programs/financial-management-education-program/ [accessed 2 February 2015]

SECTION 5 RECRUITMENT AND SELECTION

Overview

Prevocational junior doctors are employed by health services within Victoria on contracts, which generally are one year in duration and have a start and end date aligned with the clinical year. Some rural/regional health services may offer a two year employment contract. All intern positions are allocated via the PMCV Intern Computer Match. The majority of Victorian HMO2 positions are allocated via the PMCV HMO Computer Match, however rural and regional health services can recruit directly to fill some or all of their HMO2 positions provided they complete the exemption form and return to CMS Manager. The opening and closing dates of the Intern Match are set nationally. The dates of the HMO recruitment period are set by the PMCV in consultation with Victorian health services. Schedules of dates are distributed to the Victorian health service managers early in the year and are published on the PMCV Computer Matching website for each respective match. Available at:
http://computermatching.pmcv.com.au

Junior doctors at the vocational training level apply for positions directly with health services, often in parallel with application for candidacy or training positions with a specialist college. Exceptions to this are Radiology Registrars and Basic Physician Trainees which are allocated using the PMCV Computer Matching Service. Many, but not all of the junior medical positions at PGY3 level and above are accredited for vocational training with the relevant specialty college. In some cases, the college may allocate a particular trainee to a specific training post but generally vocational trainees will make direct application to the hospital or facility for a training position. There may also be a number of other streamed and non-streamed positions at the PGY3+ level to fill in addition to the accredited training positions. A small number of these PGY3+ streamed positions are available via the PMCV HMO Computer Match.

The specific dates for the commencement of the clinical year (currently early to mid-January for Interns and the first Monday in February for most PGY2 and above doctors) and term rotation dates are published on the PMCV website. Available at: http://www.pmcv.com.au/medical-administrators/term-dates [accessed September 2015]

Appointments of junior doctors at all stages of the training continuum are generally aligned with these dates.

Preparing for the general recruitment period

Experienced Doctors in Training Managers will tell you that the period May through to October represents a very busy six months of the year. Some Doctors in Training Managers, particularly at the larger facilities, will deal with thousands of applications during this period. Given the complexity of the task, a systematic approach to the recruitment period, often working in collaboration with others (clinical Heads of Department, medical administration and the human resources department) is required.

Preparation for the recruitment period usually begins several months before the positions are advertised. In the first instance, many Doctors in Training Managers will be responsible for confirming the budgeted FTE (including at what level) of all junior medical staff and seeking approval for the proposed recruitment action. At facilities that have 500 plus junior medical staff, this can take some time and preparations are best commenced early.

The box below contains a number of core tasks that are required to be completed in the lead up to the recruitment period. Doctors in Training Managers should be aware that changes may occur from year to year and that relevant policies should be accessed to ensure up to date procedures are being implemented.

State-wide Secondment Agreement

Health Services have individually developed various contractual instruments in an attempt to document all facets of the arrangements relating to the rotation of Doctors in Training. As the matter is complex a working group was convened to consider a number of matters including payment methods, administrative responsibilities and requirements and on-costs. The Secondment Agreement has a specific focus on award entitlements and includes clauses for items including Annual Leave Penalties, Maternity Leave and Continuing Medical Education (CME) obligations. It is recommended that the draft secondment agreement be used as the basis for negotiations between hospitals.
Further information: DHHS website. Available at: http://docs2.health.vic.gov.au/docs/doc/Doctors-in-training-Draft-Secondment-Agreement [accessed November 2015]

Tips: Preparations for the annual recruitment period:

- Refer to recruitment policies to ensure currency of understanding and compliance
- Review recruitment systems and processes within the Medical Workforce Unit to maximise efficiency
- Check budgeted FTE and obtain approvals
- Review position descriptions or ask the relevant unit clinical staff to do this
- Prepare advertisements – check currency, particularly with regard to contact information
- Work with clinical Heads of Department/HR/Medical Administration and other relevant people as required
- Organise selection panels and interview rooms (if applicable)
- Book senior medical staff for selection panels early
- Consider office requirements for recruitment period and plan ahead (for example, stationary orders and diary management)
- Prepare recruitment packs (these might include letter templates, forms and hospital information).

English language requirement

The English language requirements set out below are correct at time of publication but are subject to change and should be checked regularly. More information on the English Language *Skills Registration Standard* on the Medical Board of Australia website. Available at: http://www.medicalboard.gov.au/Registration-Standards.aspx [accessed April 2015]

All internationally qualified doctors who apply for AHPRA registration, or applicants who complete their medical degree in Australia but did not complete their secondary education in English MUST be able to demonstrate English language skills at IELTS (International English Language Testing System) Academic level 7 or equivalent, and achieve the minimum score in each component (reading, writing, comprehension and spelling) in the IELTS academic module or the OET (Occupational English Test), with a minimum score of B in each of the four components (listening, reading, writing, speaking) prior to their AHPRA registration application being approved.

From 1 July 2015, additional tests have been approved including the PTE Academic with a minimum overall score of 65 and a minimum score of 65 in each of the four communicative skills (listening, reading, writing and speaking), and the TOEFL iBT with a minimum total score of 94 and the achievement of a minimum score in each section of the test, listening, reading, writing, and speaking. The Board will also accept the successful completion of the NZREX, or the successful completion of the PLAB test.

Each applicant must provide evidence of having satisfactorily completed the English language requirements within the two years prior to their application for registration being submitted; if the test date is more than two years prior to the application for registration, it will not be counted as current.

If a doctor has been working continuously since their initial registration with AHPRA and has an IELTS or OET older than two years old (say for example they are coming to work from a different hospital and still have Limited Registration), they should not be required to resubmit the IELTS or OET results, as their work has been continuous.

Tip: Applicants satisfying the English language requirement:

It is important to remind international students who have graduated from an Australian University medical degree that they will be required to submit a current IELTS or OET to be granted provisional registration, and that the minimum score in each component is 7.0 or above (for IELTS) and B or above (for OET); **the English Language requirements for medical registration are higher than the English Language requirements to enter University as a student.**

Criminal History Checks

The Medical Board of Australia has the power to check the criminal history of registered medical practitioners. Medical practitioners will be required, at annual renewal (section 109 of the National Law), and at any time during the registration period (section 130 of the National Law) to advise the Board of any charges for offences punishable by 12 months imprisonment or more, and any convictions or findings of guilt for offences punishable by imprisonment.

Before making a decision about an application for renewal of registration, or at any time during the registration period, the Board may check a registrant's criminal history. The Board can do so by obtaining a written report from CrimTrac, a police commissioner or an entity in a jurisdiction outside Australia that keeps records about the criminal history of persons in that jurisdiction. It has this power under sections 79 and 135 of the National Law.

The Board's Criminal history registration standard sets out the factors that the Board will consider when it decides whether a medical practitioner's criminal history is relevant to the practice of medicine. The *Registration Standard: Criminal History* applies to all applicants for registration and all registered health practitioners and sets out the requirements In deciding whether a medical practitioner's criminal history is relevant to the practice of medicine.

From 4 February 2015, a new process commenced for checking criminal history outside of Australia. This new approach requires certain applicants and registered practitioners to apply for an international criminal history check from an approved supplier. All new applicants seeking registration in Australia are required to apply for an International criminal check if they declare they have a criminal history outside Australia and have lived primarily based on one or more countries outside Australia for 6 consecutive months or longer, when aged 18 years or more. Further information from AHPRA website. Available at: http://www.ahpra.gov.au/Registration/Registration-Process/Criminal-history-checks/International-Criminal-History.aspx [accessed August 2015]

Visa requirement (457)

A Temporary Work (Skilled) visa (subclass 457), or "457 visa", lets a skilled worker travel to Australia to work in their nominated occupation for their approved sponsor for up to four years. The following information is correct at time of publication and should be checked regularly.

To be eligible for this visa, the skilled worker MUST have a sponsor (who has an approved sponsorship agreement with the Department of Immigration and Border Protection) who agrees to employ them. This visa allows the sponsored employee to work in Australia for up to four years, bring their family with them to work or study in Australia and travel into and out of Australia as often as they want to in the four year period.

Sponsor obligations for a 457 visa

The granting of a sponsorship agreement to an organisation brings with it certain obligations that the employer must uphold. These obligations include:

- Cooperation with inspectors from the Department of Immigration and Border Protection
- Ensuring equivalent terms and conditions of employment
- Maintenance of records
- Provision of records and information to the Minister if and when requested to do so
- Advise the Department of Immigration and Border Protection when certain events occur
- Ensure the visa holder participates in the nominated occupation, program or activity
- Not recover from, transfer or change certain costs to another person
- Pay travel costs to enable sponsored people to leave Australia
- Pay costs to remove unlawful non-citizens
- Provide training to Australians and permanent residents

Further information relating to sponsor obligations is available on the Department of Immigration and Border Protection website. Available at: http://www.immi.gov.au/Visas/Pages/457.aspx [accessed August 2015]

Employee obligations

The employee also has obligations that they must meet with regard to being granted a 457 visa. These obligations include:

- Reporting any changes in their circumstances to the Department of Immigration and Border Protection
- Meeting the employment conditions of their visa, and
- Continuing to meet the health insurance requirements of being a 457 visa holder

Medical Practitioners must work in their nominated occupation but they can work for employers other than their sponsor or an associated entity of their sponsor.

457 visa applications are made online and comprise three components:

1) The sponsorship application
   The sponsorship application is made every three-six years (depending on how long the Department of Immigration and Border Protection grant the sponsorship agreement for); this document needs to be lodged on behalf of the organisation about six weeks prior to your current sponsorship agreement ending.
2) The nomination.
   The nomination for an individual needs to be lodged for each employee you want to sponsor.
   Approval of the nomination is relatively quick; you will be sent an approval notification for the nomination by the Department of Immigration and Border Protection; this in turn gets sent to the nominee as some of the approval numbers are required for them to lodge their application with the Department of Immigration and Border Protection.
3) The nominee needs to submit their application once the organisational nomination has been approved.
   This stage can take **one-two months to be processed**, and relies on the applicant providing ALL information required at once.

Tip: Ready decision applications:
The Department of Immigration and Border Protection request that applications be made once all other processes (such as medical registration) have been completed; they request 'decision ready' applications only be submitted. If applications are incomplete, the Department of Immigration will request that the documents be uploaded preferably through the applicants ImmiAccount; emails to the 457 email address: e457@immi.gov.au take longer to be accessed and forwarded to the correct case manager (up to two weeks).

Visa requirement (402)

The Training and Research visa (subclass 402) is for people wanting to come to Australia on a temporary basis to participate in occupational training, to observe or participate in research as a visiting academic, or to participate in a professional development program.

The 402 visa has three streams:

- Occupational Trainee stream
- Professional Development stream, and
- Research stream.

To apply for the Occupational Training or Research streams, you can be inside or outside of Australia when your application is lodged.

When applying for the Professional Development stream, the applicant MUST BE OUTSIDE OF AUSTRALIA when they apply and when the visa is granted. The sponsor can lodge the application on behalf of the person applying for the Professional Development stream.

Further information is available from the Department of Immigration and Border Protection website on subclass 402 visa. Available at: http://www.immi.gov.au/visas/Pages/402.aspx [accessed April 2015]

Other visas

Some other visa types can be used to employ Doctors in Training, but for the vast majority of cases either the 457 visa or the 402 visa will meet the organisational requirements. One other visa that can provide short term employment opportunities without sponsor obligations is the Working Holiday subclass 417 visa. This visa has some specific limitations but may assist in short term employment for certain doctors if they meet the requirements of the visa. Further information is available from the Department of Immigration and Border Protection website on subclass 417 visa. Available at: http://www.immi.gov.au/Visas/Pages/417.aspx

How does computer matching work?

Computer matching is purely an algorithmic process which matches the preferences of both candidates and health services. Health services only have candidates removed from their preference lists when a permanent match has been made to a hospital at a higher priority of that candidate. A candidate will be appointed to the highest available hospital/health service on their *Candidate's Priority List* that includes them within the quota boundary of the hospital preference list at any time during the matching procedure. Further information on the computer matching algorithm can be found on the Computer Matching Website. Available at: http://computermatching.pmcv.com.au/public/about/matchingprocess.cfm [accessed April 2015]
Once a health service is notified by PMCV of the medical graduates who have been matched to positions at their health service/intern training program, the relevant Doctors in Training Manager will need to undertake the necessary pre-employment checks, clearances, generation of contracts and associated paper work.

Medical graduate recruitment (Intern recruitment)

This section provides information on the processes managed by PMCV in relation to medical graduate recruitment for intern positions. The PMCV administers the Intern Match on behalf of the Victorian Department of Health and Human Services and all accredited intern posts are allocated via computer matching. The employing facility is supported by a Training & Development grant provided by the Department of Health and Human Services for each accredited intern post.

Final year medical graduates are invited to apply for intern positions within the Victorian system about seven months prior to the commencement of the clinical year. A schedule of dates is released early in the year. Eligible candidates must register for the Intern Match via the computer matching website. Candidates are asked to provide personal details, to nominate two referees, upload a standardised CV and nominate a minimum of one hospital preference. In addition to registering in the Intern Match, candidates must also fulfil health service application requirements which are normally described on individual hospital websites. Hospitals may ask for a variety of information to be provided to them directly e.g. cover letters addressing the selection criteria, and character references. The PMCV publishes a *Hospital Directory* annually which provides candidates with information regarding all of the health services /intern training programs participating in the Intern Match and their individual application requirements.

Candidates rank hospitals that they are willing to work at (by submitting an electronic *Candidate Priority List*) and hospitals rank candidates that they are willing to employ (by submitting an electronic *Hospital Nomination Form)*. Both lists should be in strictly in preferential order.

HMO and Resident recruitment and transition

Different facilities offer different streams of disciplines, such as General, Medical, Surgical, Critical Care and GP training. HMO training assists doctors in deciding their future career path while working under the guidance of more senior medical staff and consultants.

Most PGY2/HMO2 positions in Victoria are allocated via the HMO Match. However some rural health services will recruit to these positions directly. The HMO Match is mainly for HMO2 positions, higher level posts (HMO3 and above) are generally allocated directly by health services.

The PMCV publishes a *Hospital Directory* each year which contains information from Victorian health services which offer HMO2/3 training positions via the HMO Match. Further details, including the application process, can be found on the PMCV Computer Matching website. Available at: http://computermatching.pmcv.com.au/

The PMCV has also published a document to assist health services develop professional development programs for the safe transition from internship to PGY2, which covers principles on organisational and unit orientation, unit based position descriptions/learning objectives, unit handbooks and feedback on performance. The Guideline, *Supporting Safe Transition from Intern to PGY2: Professional Development Guideline for Health Services*, is available from the resources section of the PMCV website. Available at: http://www.pmcv.com.au/resources/guidelines-alphabetical [accessed 2 February 2015].

Basic Physician Training (BPT) recruitment

Recruitment for Basic Physician Training positions is conducted via the BPT Match. Details including the Schedule of Dates, Eligibility Criteria, Referee Nomination Process, CV Process and Notification of Match Results can be found on the PMCV Computer Matching website. Available at: http://computermatching.pmcv.com.au/

Defence Force Doctors

As part of a health services recruitment process, it may be useful to ask a candidate if they are a defence force member as this will affect how a doctor is paid. You should receive a letter from the Defence Force with instructions. Further information about pay rates and allowances. Defence jobs website. Available at: http://www.defencejobs.gov.au/army/jobs/MedicalOfficer/PayAndAllowances/ [accessed November 2015]

Contact: Lynette Vernell, Resident Medical Officer (RMO) Administrator, Defence Pay Accounting, Department of defence.
Email: DEFPAC.RMO@defnece.gov.au or telephone: +61 3 92827457.

Department of Health and Human Services

On 1 January 2015, the Victorian Government restructured the health department and established the Department of Health & Human Services (DHHS) to integrate health and human services policies, programs and services to improve the wellbeing of all Victorians. The new DHHS brings together the former Department of Health, former Department of Human Services and Sport and Recreation Victoria.

Health.vic.gov.au provides information about planning, policy development, funding and regulation of health services and activities that promote and protect Victoria's health. This includes delivery of mental health and aged care services in Victoria.

Further information is available at: http://www.health.vic.gov.au/ [accessed 2 February 2015]

Training and Development Grant

The Training and Development (T&D) Grant provides subsidies for prevocational medical positions in public hospitals and health services for postgraduate years one and two to contribute to the cost of teaching, training and research.

Positions have been targeted to areas and disciplines of high need. Clinical training has also been supported in an expanded range of settings, such as general practices and areas within hospitals that traditionally have not been used for clinical training of early medical graduates. The Department of Health and Human Services includes information about the Training and Development Grant in the annual *Victorian Health Policy and Funding Guidelines*. Further information from DHHS website. Available at: http://www.health.vic.gov.au/pfg/operations.htm [accessed November 2015]

Medical specialist training

Both the Victorian and Commonwealth Governments offer funding to expand and support medical specialist training. The Strengthening Medical Specialist Training (SMST) program was introduced in 2008 to provide support for health services to increase the number of accredited specialist training positions in areas of identified workforce shortage. Since 2008, funding has been provided for 892 specialty training posts in 36 specialty areas. An evaluation of the program conducted in 2013, determined that the SMST program had met its objective to build specialist training capacity across a number of specialties state wide. From 2015, the Victorian Government continues its investment in medical specialist training through the Victorian Medical Specialist Training program. Applications will continue to be coordinated by health services. For further information contact: workforce@health.vic.gov.au.

Further information is available from the: DHHS website:
Available at: http://health.vic.gov.au/workforce/learning/medical.htm [accessed 2 February 2015]

Victoria's Health Workforce Knowledge Bank

Victoria's Health Workforce Knowledge Bank is an interactive online repository for data about the health workforce in Victoria.

Current data contained on this site relates primarily to Victoria's nine clinical training networks (CTNs). The CTNs drive local workforce development initiatives for the benefit of their membership, which comprises clinical education stakeholders across the health, education and government sectors.

Knowledge Bank has been developed to assist health workforce stakeholders to better plan, understand and lead the development of strategic initiatives that support workforce development at all stages of health careers.

The Workforce Knowledge Bank Portal is at: http://www.vicknowledgebank.net.au/ [accessed 2 February 2015]

Credentialing and scope of practice of medical practitioners

The Department of Health and Human Services has convened a Clinical Engagement Advisory Group (CEAG) to advise on the projects and the implementation of the credentialing and scope of practice policy. The CEAG is an expert advisory group that has representatives from across the health sector and the department. The policy currently applies to all senior medical staff appointed to a health service. The policy was initially implemented in July 2007 and was updated in February 2009 and 2011.

The Victorian Department has developed, *Credentialing and defining the scope of clinical practice for medical practitioners* in Victorian health services – a policy handbook and a toolkit that has been developed to assist with credentially and defining the scope of clinical practice process. Available at: http://www.health.vic.gov.au/clinicalengagement/credentialling/index.htm [accessed 2 February 2015]

Useful Resources

Medical Graduate Recruitment in Victoria, PMCV Computer Matching Service, Available at: www.computermatching.pmcv.com.au [accessed April 2015]

SECTION 6 ACCREDITATION

Overview

The Australian Health Practitioner Regulation Authority (AHPRA) in granting provisional registration to doctors in their first postgraduate year has a requirement that interns can only work in terms or rotations accredited by an accredited intern training accreditation authority (normally a postgraduate medical council or equivalent body).

In Victoria, the PMCV has the delegated responsibility for accrediting facilities and posts for prevocational year one training posts (from the Medical Board of Australia/AHPRA) and for review of prevocational year two training posts (from Victorian Department of Health and Human Services).

Accreditation of prevocational medical training programs and posts is a process undertaken by an accreditation authority (PMCV) that establishes and monitors standards to ensure high quality clinical training for junior doctors (interns and PGY2s). This comprises of:

- Quality assurance, involving facility self-evaluation and external peer review of compliance with the standards, and remediation following review (conditions);
- Quality improvement involving peer review with a focus on excellence identifying commendations (best practice) and recommendations for improvement; and
- Continuous improvement involving ongoing monitoring by the facility itself as well as regular formal reviews by the accreditation authority.

The duration of accreditation decisions is based on the assessment process and recommendations assist the facility to improve the education and training of junior doctors[1] and to provide the best possible environment for the training of junior doctors.

The PMCV Accreditation Guide is a useful resource. PMCV website. Available at: http://www.pmcv.com.au/resources/guidelines-alphabetical [accessed November 2015}

Victorian Accreditation Standards

The PMCV accreditation standards have been developed with reference to the Australian Medical Council's (AMC) National Intern Training Framework (NITF). All facilities that provide intern training must comply with the AMC requirements.

The accreditation standards assess the performance of the facility training program in the following domains:

- Governance (i.e. organisational structure, program management, educational expertise, support of medical education,)
- Organisational purpose
- The program structure (i.e. intern and/or PGY2 program, flexible training)
- Training program - teaching and learning (i.e. clinical and non-clinical teaching activities, educational opportunities and dedicated teaching and training time)
- Assessment of learning (i.e. assessment approach, feedback and performance review, assessor training)
- Monitoring and evaluation (i.e. monitoring, review and modifications to programs following feedback)
- Implementing the education and training framework (i.e. appointment to program and allocation to roster, Doctor's in Training welfare and support, Doctor's in Training involvement in governance of training, communication processes and resolution of training problems and disputes)

[1] *PMCV Duration of Accreditation, Applications, Communication and Monitoring Guidelines*, available on PMCV website (www.pmcv.com.au)

- Implementing the training framework - delivery of educational resources (i.e. supervisors and supervision, clinical experience and facilities)

The PMCV Accreditation Submission including Standards, includes a Checklist of the evidence to be provided with a facility submission for accreditation. Further information: PMCV website available at: http://www.pmcv.com.au/accreditation

Accreditation process

Accreditation of prevocational medical training programs and posts is a quality assurance process to ensure high quality clinical training for junior doctors and is essentially undertaken by peer review whereby a team, usually comprising a senior clinician and/or a medical administrator, a prevocational trainee and a medical educator or Doctors in Training Manager visit the facility to assess the training provided to junior doctors against the accreditation standards.

The process commences with a self-assessment conducted by the facility several months prior to the survey visit. Staff responsible for prevocational training at the facility complete the self-assessment section of the report, and collate evidence to support the self-assessment. This report is sent back to the Accreditation Manager, who then assembles a team to conduct the site visit (usually lasting between 1–3 days depending on the number of sites to be visited). The team meets via teleconference prior to the visit to review the documentation and to identify any issues that may require exploration at the visit.

At the survey visit, the survey team interview key staff involved in prevocational training – trainees, term supervisors, the Supervisor of Intern Training/Director of Clinical Training, Doctors in Training Managers, executive staff and others in addition to reviewing the documentation provided by the facility in order to make an assessment against the standards. A tour of the facility is also normally conducted. Debriefing occurs at the end of the visit and the survey team provides feedback on their observations and general findings. The facility is encouraged to respond to issues raised at the debriefing.

The survey team then completes a report that is subsequently forwarded to the Accreditation subcommittee of the PMCV. The findings of the survey visit (not the recommendations or outcomes) are sent to the facility for review of "errors of fact".

The final report will be considered by the Accreditation subcommittee which may include accreditation consideration and recommendations for improvement of junior doctor training, the duration of accreditation and a list of all intern and PGY2 posts accredited. The report will then be sent to the facility and a response is sought to the consideration and recommendations in the survey report within a given time frame.

Following the visit, an email link to a questionnaire is sent for the facility to provide feedback on the performance of the survey team. As the Doctors in Training Manager you will often be involved in both the preparation and conduct of the survey. The rest of this section provides further information to assist you in preparing and participating in the accreditation process.

The whole accreditation process usually takes 4-6 months.

Preparing for the survey

The survey process relies on the provision of evidence across all accreditation standards with particular attention on the structures and processes in place to support prevocational training. As the Doctors in Training Manager, working with the medical education team and Director of Clinical Training/Supervisor of Intern Training, you may be responsible for ensuring that many of these structures are in place.

You should be familiar with the content and structure of the accreditation standards, particularly with respect to the specific requirements, guidelines and evidence requirements. You will note that significant emphasis is placed on monitoring, collecting evidence, evaluation and continuous improvement. Whilst not all of the requirements in the standards, or the evidence needed may necessarily fall to your

responsibility, it is very likely that you will be involved in at least assisting the facility to prepare for the survey visit.

Experienced Doctors in Training Managers who have been through the survey process suggest that collecting information or evidence as you go (particularly in the twelve months prior to survey), makes the job of completing the self-assessment report and producing the evidence in the lead-up to the survey much easier. It can also be very useful to participate as a surveyor on a visit to another facility prior to going through your own facility's survey process. By being familiar with the standards at an early point in time, you will be guided as to what information to collect and file.

It is useful to maintain a hard copy master file (or ensure that the Chair/secretariat does) of the meetings of the committees that plan, implement and review the intern/PGY2 training program. The file should contain not just agendas, minutes and action plans but also correspondence and any reports that are tabled. Keeping master files may save considerable time in preparing for the survey and generally also provide a good record of activities pertaining to prevocational education and training that are being undertaken mid survey cycle when it comes to filling in the detail of the self-assessment report.

The self-assessment report is completed a couple of months prior to survey. It asks for details around how the facility believes it has progressed against the standards and criteria (including the specific requirements and guidelines) in the period since the previous survey. It also includes a section to report on previous recommendations and how these have been addressed.

The self-assessment report is often the first contact the surveyors have with your facility. Therefore the information contained in the survey self-assessment helps form the surveyor's opinions even before the first day of the survey visit.

In completing the survey self-assessment, if that responsibility falls to you, engage the support of others (e.g. Director of Medical Services/Director of Clinical Training, Medical Education Officer and so on). The self-assessment material is required back at PMCV at least 2 months prior to survey so aim to start the process at least two months prior to that. As each facility is different it is important to identify early who has overall responsibility for preparing the pre-survey report and who will be called upon to provide the relevant evidence.

Your main contact for any enquiries is the PMCV Accreditation Manager who will assist you to effectively and efficiently complete all required documentation etc.

Tips: Preparing for PMCV survey visit:

- Review and become familiar with the PMCV accreditation standards
- Consider becoming a surveyor and doing a survey visit to another facility prior to your own survey
- Understand which parts of the standards you may be responsible for in your facility and collect evidence as you go/ Check which evidence is to be collected and by whom
- Start preparations early
- Establish a master file of all documents for survey visit – if using electronic storage, ensure all relevant staff can access and know where to find documents
- Once the date(s) of the survey visit are known, arrange for meeting times with key staff
- Any issues – speak with PMCV Accreditation Manager/ your health service's DMS/DCT

What to expect during the survey visit

Generally speaking by the time of the survey visit, most of the hard work from your point of view will be complete. The self-assessment report has been finalised and the evidence folders are ready for the survey team.

During the survey visit, the survey team will meet with prevocational trainees, term supervisors, the hospital Executive/senior staff, and members of medical administration, the Doctor in Training and medical education teams. They will also review all the documentation that has been provided in addition to completing a tour of the hospital.

At the conclusion of the survey, the team will meet with the hospital executive and the DCT/SIT for a formal debrief in order to provide a summary of their main findings. In some instances, depending on the facility, you as the Doctor in Training Manager may attend. Debriefing provides an opportunity for the survey team to deliver the findings, check any potential inaccuracies and summarise the main strengths and issues identified at survey. Whilst it is not the role of the survey team to make a recommendation of the accreditation outcome, it is their role to alert the hospital to any major problems. Given that the report is presented to the Accreditation subcommittee prior to it being forwarded to the hospital, it may be two to three months following the survey visit before the hospital or facility receives the report. Clearly if there are significant concerns identified the hospital will likely want to address these (or at least start to) prior to receiving the formal report.

Post survey

The survey report will contain a number of recommendations and may also include conditions for accreditation. If significant concerns have arisen the facility may be required to address these within a timeframe set out in the correspondence from the Accreditation subcommittee. As the Doctors in Training Manager you may be involved in responding to the conditions and recommendations, though this responsibility generally falls to the Director of Medical Services, with the assistance of the Supervisor of Intern Training/Director of Clinical Training.

Appeals

A facility may appeal against the accreditation status awarded by Council following a survey visit. The PMCV Appeals Policy can be accessed from the resources section of the PMCV website available at: www.pmcv.com.au/resources/alphabetical-listings [accessed August 2015]

Reporting changes between survey visits

It is important for a facility to notify the Accreditation subcommittee of any changes to posts or rotations or key staff changes (e.g. resignation of DMS or Director of ED or Head of Unit) which may impact on the supervision and/or clinical learning of interns and PGY2s.

Facilities wishing to establish new intern or PGY2 posts (or make significant changes to existing terms) during the period between survey visits must submit an application addressing all the domains including supervision, clinical learning, assessment and support.

It is best to contact the PMCV Accreditation Manager in the first instance to discuss what you need to do. Note that all new posts and any significant changes to existing posts must be approved by the Accreditation subcommittee prior to implementation.

The *PMCV Duration of Accreditation, Applications, Communication and Monitoring Guidelines* on the PMCV website provide guidance for:

- Survey teams and the Accreditation subcommittee in recommending duration of accreditation following assessment of new prevocational medical training programs/posts, assessment for re-accreditation, and of major changes.
- Facilities on the accreditation application, assessment and monitoring processes; and
- The process followed for the communication of accreditation outcomes.

Further information. *Duration of Accreditation and Monitoring Guidelines.* PMCV website. Available at: http://www.pmcv.com.au/resources/guidelines-alphabetical [accessed November 2015]

College accreditation of training posts

Given that most Doctors in Training Managers are responsible for the management of other junior doctors, it is very likely that they will also become involved from time to time in College accreditation processes. The Australian Medical Council (AMC) is responsible for accrediting education and training providers of specialist medical training.

AHPRA delegates this function to the AMC who complete periodic surveys of Colleges to ensure that the standard of education and training and requirements for specialist medical training is at a particular level. Only Fellows of specialist medical colleges accredited by the AMC are eligible to be registered as specialists with AHPRA. As part of the requirements set down by the AMC, all Colleges are required to have processes in place whereby the College accredits training posts or facilities. There is variation in the way in which Colleges undertake this. Some accrediting posts, others facilities, but generally many of the same themes which are features of the prevocational accreditation standards are present in the College accreditation. Whilst as a Doctors in Training Manager you would not normally be involved in completing the pre-college assessment information, you might well be asked to provide some information.

You should also be aware of the training requirements as junior doctors will submit roster preferences to ensure they meet the College training requirements.

It is strongly suggested that each health service provide a list of who in the health service is available to discuss career options or personal issues. This would normally be the Supervisor of Intern Training or the Directors of Clinical Training (DCTs) of the specialties or heads of units. An example of how this information could be presented is set out in the table below.

Table: Key contacts

	Position	Name	Contact details
Interns	Supervisor of Intern Training		
HMO2/3 (Medical)	Director of Clinical Training		
HMO2/3 (Surgical)	Supervisor of Junior Surgical Training		
Emergency Medicine	Director of ED		
Basic Physician Trainees	Director of Physician Training		
Basic Surgical Trainees	Supervisor of Junior Surgical Training		
Advanced trainees (including all SET trainees)	Relevant Director of Training in other clinical units		
Medical Education	Director of Clinical Training / Head, Medical Education Unit		
International Medical Graduates	Medical Clinical Educator		
Medical Administration	Executive/Director of Medical Services		
Research	Head of Research		
Other:			

Useful Resources

PMCV accreditation standards, policies and guidelines. PMCV website: http://www.pmcv.com.au/ [accessed April 2015]

Committee of Presidents of the Medical Colleges is the unifying organisation of and support structure for the specialist Medical Colleges of Australia. CPMC website: http://cpmc.edu.au/ [accessed February 2015]

Information regarding College assessment processes can be obtained via the relevant College website. A list of College websites can be found on the PMCV website: http://www.pmcv.com.au/jmo-welfare-a-support/jmo-resources/specialty-training-in-australia [accessed August 2015]

Medical Training Review Panel, annual reports include a chapter on undergraduate, prevocational and vocational training. MTRP website: http://www.health.gov.au/internet/main/publishing.nsf/Content/work-pubs-mtrp [accessed February 2015]

SECTION 7 SUPPORT STRUCTURES

This section provides information on the support structures that may be available to you as the Doctors in Training Manager, with a focus on support and systems in place for the prevocational training period.

Medical administration

Although the governance and executive arrangements of facilities differ depending on location and context, many hospitals have retained a medical administration department with a Director of Medical Services (or equivalent) providing oversight of professional matters for senior and junior medical staff, often in addition to a number of other functions. Directors of Medical Services (DMS) are qualified medical practitioners, often with a specialist qualification in medical administration. As the Doctors in Training Manager it is most likely that you will be part of the medical administration unit (however named) within the health service.

Supervisor of Intern Training (SIT) / Directors of Clinical Training (DCTs)

Directors of Clinical Training (DCTs) /Directors of Prevocational Education and Training (DPET) are responsible for providing medical leadership and oversight of the prevocational training period in the facility in which they work. In fulfilling this role, the DCT/DPET is responsible for the education, training, supervision and welfare of junior doctors during the first two years of medical practice. As the Doctors in Training Manager you will likely work very closely with the DCT/DPET in providing support and management of prevocational trainees. PMCV has developed a position description for this role. PMCV website. Available at: http://www.pmcv.com.au/resources/guidelines-alphabetical [accessed November 2015]

Medical Education Officers (MEOs)

Most health services have appointed a MEO to facilitate the continuing education of interns, PGY2s and those PGY3s who are not yet in vocational training. They generally work with senior clinical staff who are responsible for the supervision and education of prevocational doctors. The MEO is unique to each setting and responsive to the needs of that setting. The PMCV has developed a position description for this role. PMCV website. Available at: http://www.pmcv.com.au/resources/guidelines-alphabetical [accessed November 2015]

Health Service HMO committee

Each health service with prevocational trainees is expected to have a mechanism or structures with the responsibility, authority, capacity and appropriate resources to direct the planning, implementation and review of the intern/PGY2 training program(s) and to set relevant policy and procedures. Normally a health service would establish a committee which includes JMO representatives to achieve this accreditation standard.

Health service RMO societies

Each health service will normally have a Resident Medical Officer (RMO) society which provides an opportunity to meet informally with your peers and likely organises a range of social events for a small membership fee. Members of the RMO Society may also be invited to provide representatives to formal health service committees.

Postgraduate Medical Council of Victoria (PMCV) Inc.

The PMCV was established as the lead organisation in Victoria to support state and national initiatives in relation to prevocational training in Victoria. The PMCV encourages participation of HMO Managers in its accreditation activity as a surveyor and in various subcommittees of Council and work groups as established.

Doctors in Training Managers meetings and networks

The PMCV sponsors quarterly meetings of Victorian HMO Managers. This provides opportunities for Doctors in Training Managers to meet to discuss issues of common interest and exchange information on a regular basis. Members are able to suggest items for discussion at the meeting and often guest speakers (e.g. MBA) or other health service representatives will present on a topic of interest.

Annual Prevocational Medical Education Forum

The Confederation of Postgraduate Medical Education Councils (CPMEC) facilitates the Annual Prevocational Medical Education Forum, which rotates between jurisdictions. This annual event brings together clinicians and educators to facilitate sharing of research, educational activities and discussion of important current issues in prevocational medical education. A core component of this forum is the involvement of junior doctors in the program and the facilitation of special interest group meetings including MEOs, DCTs, JMOs and medical administrators. Doctors in Training Managers are encouraged to identify a project (Individual health service or collaborative with other health services) for presentation at the Forum.

SECTION 8 REGISTRATION OF DOCTORS

Australian Health Practitioner Regulation Agency (AHPRA)

AHPRA is the organisation responsible for the implementation of the National Registration and Accreditation Scheme across Australia. They work with 14 National Health Practitioner Boards to ensure the registration and accreditation of Health Practitioners across Australia.

For Doctors in Training Managers, working with AHPRA and understanding their processes is imperative to ensure all Doctors in Training and other medical staff are appropriately registered to perform their work. From our perspective, registration is the most common interaction with AHPRA. A brief outline of the current types of registration at the time of publication is set out below but Managers are expected to keep abreast of current developments and changes to registration by regular viewing of the AHPRA website. Available at: https://www.ahpra.gov.au/Registration/Registration-Standards.aspx

Tips: Registration forms:

- Do not expect AHPRA to always advise health services of changes to registration.
- If you have downloaded and saved copy of an AHPRA form, before completing make sure you have the current version as the paperwork will not be accepted unless on the correct form.
- Review the MBA / AHPRA website regularly.
- It is a good idea to sign up for the newsletter published by AHPRA to ensure regular notification of updates or changes.

Types of Medical Registration

There are five main types of medical registration:

- General Registration
- Specialist Registration
- Provisional Registration
- Limited Registration and
- Non-practising Registration

General Registration

General registration is available to:

- Australian and New Zealand medical school graduates who have completed approved intern training, and
- medical practitioners who have previously held general registration and are seeking to return to practise
- international medical graduates who have completed the requirements of the competent authority pathway or the standard pathway

Specialist Registration

Specialist registration is available to medical practitioners who have been assessed by an AMC accredited specialist college as being eligible for fellowship. Fellowship is not a pre-requisite for specialist registration.

The Ministerial Council has approved a list of specialties, fields of specialty practice and specialist titles. Medical practitioners with the necessary qualifications in the approved specialties will be included on the Specialist Register and their specialist title will be protected by law.

Provisional Registration

Provisional registration applies to persons required to complete a period of approved supervised practice to become eligible for general registration. Persons are qualified to apply for provisional registration if they are:

A) Australian or New Zealand trained medical graduates

Australian and New Zealand medical school graduates must apply for provisional registration to undertake a period of approved intern training to become eligible for general registration.

Interns are only permitted to work in accredited intern positions. They are not permitted to undertake any clinical work outside their allocated intern position.

The intern must satisfactorily complete a pre-determined clinical experience to become eligible for General medical registration; this includes

- A term of at least eight weeks that provides experience in emergency medical care
- A term of at least ten (10) weeks that provides experience in medicine
- A term of at least ten (10) weeks that provides experience in surgery, and
- A range of other approved terms to make up 12 months (minimum 47 weeks full-time equivalent experience)

After successful completion of intern training, those holding provisional registration are eligible to apply for general registration. (NOTE: General Registration does not get awarded automatically; the provisional registrant must APPLY for general registration.)

The Review of Medical Intern training commissioned by the Health Council of Australia Governments (COAG) to examine the current model of internship and to consider potential reforms to support medical graduate transition to practice has just been released. A Work Group is to be established to provide advise on the feasibility, priority and sequencing of the Review recommendations.
Further information: COAH Health Council website. Available at:
http://www.coaghealthcouncil.gov.au/MedicalInternReview [accessed November 2015]

B) Australian Medical Council Certificate Holders

Australian Medical Council (AMC) certificate holders are eligible to apply for provisional registration so they can undertake a 12-month period of approved supervised practice to meet the requirements for general registration. Alternatively, they can undertake some or all of the supervised practice while holding limited registration for postgraduate training or supervised practice.

The AMC certificate is awarded to international medical graduates who have successfully completed all components of the AMC examinations or the AMC CAT MCQ and workplace based assessment (standard pathway).

The AMC certificate holder must satisfactorily complete a pre-determined clinical experience to become eligible for General medical registration; this includes

- A term of at least eight weeks that provides experience in emergency medical care
- A term of at least ten (10) weeks that provides experience in medicine
- A term of at least ten (10) weeks that provides experience in surgery, and
- A range of other approved terms to make up 12 months (minimum 47 weeks full-time equivalent experience)

C) Overseas trained medical graduates applying for medical registration via the Competent Authority Pathway

Applicants who meet the eligibility requirements for the competent authority pathway are eligible to apply for provisional registration so they can undertake a 12-month period of approved supervised practice to meet the requirements for general registration.

IMGs who hold a primary medical degree from a medical school listed in the current *International Medical Education Directory (IMED) of the Foundation for Advancement of International Medical Education and Research (FAIMER),* and who have completed training or assessment with a Board approved competent authority may apply for provisional registration via the Competent Authority Pathway. Further information: FAIMER website. Available at: http://www.faimer.org/resources/imed.html [accessed September 2015]

The Board approved competent authorities are:

- General Medical Council (United Kingdom—for the PLAB examination or for graduates of GMC-accredited medical courses in the United Kingdom)
- Medical Council of Canada (LMCC)
- Educational Commission for Foreign Medical Graduates of the United States (USMLE)
- Medical Council of New Zealand (NZREX)
- Medical Council of Ireland (graduates of medical courses in Ireland accredited by the Medical Council of Ireland).

Following satisfactory completion of a 12 month period of supervised practice (minimum 47 weeks of full time service), Competent Authority Pathway registrants may be eligible to apply for general registration with the Board. http://www.medicalboard.gov.au/Registration/International-Medical-Graduates/Competent-Authority-Pathway.aspx [accessed November 2015]

Tip:
Overseas trained doctors or IMG's (International Medical Graduates) who qualify for provisional/general registration via the Competent Authority Pathway are NOT eligible to apply for limited registration.

Interns transitioning from provisional to general registration

The intern year commences early January each year. Around November of that year, AHPRA requires the completion of an intern certificate for each intern undergoing internship in a Victorian health service/intern training program. The '*Certificate of completion of an accredited internship'* must be completed and signed off by the relevant authorised signatory (the Director of Training Director of Medical Services or other person of a comparable level of seniority who has been authorised by the Healthcare Service), checked for accuracy by the intern and submitted to AHPRA (usually by the first week of December).

The intern must provide evidence as required in the Registration Standard (*Granting general registration as a medical practitioner to Australian and New Zealand medical graduates on completion of intern training).*

The intern must also **apply for** General Registration. Provisional registrants nearing completion of their internship are encouraged to apply for general registration early and on line to ensure a timely application process.

Tip: Interns transition to general registration:
Many interns are unsure of the process of needing to apply for general registration on completion of their internship; it is advisable to send an email to them reminding them that they need to complete an application to transition to general registration and that the process does not happen automatically.

Limited Registration

Limited registration is available to medical practitioners whose medical qualifications are from a medical school outside of Australia or New Zealand and who are not eligible to apply for Provisional Registration.

These medical schools must be listed in the current online version of the International Medical Education Directory (IMED) of the Foundation for Advancement of International Medical Education and Research. Approved courses of study means that the applicant must be able to demonstrate that they have completed a medical curriculum of at least four academic years, leading to an entitlement to registration in the country issuing the degree to practise clinical medicine.

There are four types of limited registration, granted for different purposes. These allow internationally qualified medical practitioners to provide medical services under supervision as set out below.

- Postgraduate training or supervised practice
- Area of Need
- Public Interest
- Teaching or Research

A) Postgraduate training or supervised practice

Typically, this type of registration is for International Medical Graduates (IMGs) who are undertaking supervised training in Australian hospitals or other health care facilities. Registrants may intend to return to their country of training after completing their training in Australia, or may propose to have their specialist qualifications assessed by an Australian specialist college. This is also a suitable type of registration for medical practitioners who are undertaking training so that they can sit the Australian Medical Council (AMC) examination.

Medical practitioners with this type of registration must comply with the AHPRA's registration standard on limited registration for postgraduate training or supervised practice that includes:

- compliance with a supervision plan
- compliance with a training plan
- authorising and facilitating the provision of regular reports from their supervisors to the Board about their safety and competence to practise
- satisfactory performance in the postgraduate training or supervised practice position
- if intending to practise medicine in Australia longer term, providing evidence to confirm satisfactory progress towards meeting the qualifications required for general registration or specialist registration

Medical practitioners with this type of registration are in one of three pathways to registration:

- Competent Authority Pathway (prior to 1 July 2014)
- Standard Pathway or
- Specialist Pathway

B) Area of Need

Medical practitioners with this type of registration are usually working under supervision in an area of medical workforce shortage. Usually, they are registered to practise in a rural or remote location. These practitioners have been assessed by the Board as having the necessary skills, training and experience to undertake this practice safely. The state or territory Minister for Health (or their delegate) must declare that the area in which the applicant will work is an 'area of need'.

Medical practitioners with this type of registration must comply with AHPRA's registration standard on limited registration for area of need that includes:

- compliance with a supervision plan
- compliance with a professional development plan
- authorising and facilitating the provision of regular reports from their supervisors to the Board about their safety and competence to practise
- satisfactory performance in the area of need

- if intending to practise medicine in Australia longer term, providing evidence to confirm the satisfactory progress towards meeting the qualifications required for general registration or specialist registration

Medical practitioners with this type of registration are in one of three pathways to registration:

- Competent Authority Pathway (prior to 1 July 2014)
- Standard Pathway or
- Specialist Pathway

C) Public Interest

Limited registration in the public interest is intended to be short-term, with a limited scope of practice. It applies to circumstances in which the Board deems there is a 'public interest' in registering a medical practitioner. Examples of when it might be in the public interest to register a medical practitioner who is not eligible for general or specialist registration might include natural disasters, pandemics or for an expert to demonstrate a new procedure.

All medical practitioners with limited registration in the public interest are required to have supervision. They are also required to:

- Perform satisfactorily in the position
- Authorise and facilitate the provision of regular reports from their supervisors to the Board about their safety and competence to practise

Limited registrants who are granted more than four weeks registration must also comply with a professional development plan.

This is **NOT** a suitable type of registration for medical practitioners who are working towards general or specialist registration. It is not an alternative to limited registration for area of need.

D) Teaching or Research

Medical practitioners with this type of registration will be likely to be working in a position that involves clinical teaching or research, for example, a university appointment. These practitioners can undertake a limited clinical practice that is relevant to their teaching or research role.
Medical practitioners with limited registration for teaching or research are required to:

- comply with a supervision plan if they are undertaking any clinical practice
- comply with a professional development plan
- authorise and facilitate the provision of regular reports from their supervisors to the Board about their safety and competence to practise
- perform satisfactorily in the teaching or research position and in any clinical practice undertaken

This is **NOT** a suitable type of registration for medical practitioners who are working towards general or specialist registration.

Non-Practising Registration

This type of registration may be suitable for medical practitioners who:

- have retired completely from medical practice,
- are having a temporary absence from practise (for example, on maternity or paternity leave) or
- who are not practising in Australia but are practising overseas.

Medical practitioners with non-practising registration must not:

- provide medical treatment or opinion about the physical or mental health of an individual
- prescribe or formally refer to other health practitioners.

Non-practising practitioners seeking to prescribe and/or refer to other health practitioners may apply for general or specialist registration and will need to meet the Board's registration standards for:

- continuing professional development
- recency of practice
- professional indemnity insurance arrangements
- criminal history

Other registration standards

Registration standards set out the requirements that applicants, registrants or students need to meet in order to be registered. The Medical Board of Australia has developed the following registration standards:

- Continuing Professional Development Registration Standard
- Criminal History Registration Standard
- English Language Skills Registration Standard
- Recency of Practice Registration Standard
- Professional Indemnity Insurance Registration Standard

A copy of these standards can be viewed at the MBA website:
http://www.medicalboard.gov.au/Registration-Standards.aspx [accessed 2 February 2015]

SECTION 9 PROVIDER AND PRESCRIBER NUMBERS

Applying for a Provider Number for a doctor

For a patient's medical care to be subsidised by Medicare, the treating health professional must have a current Medicare Provider Number appropriate for the location in which the service is provided. The service must be one that is subsidised by Medicare. Doctors also require a Provider Number to refer patients to specialist medical practitioners so that the patient can claim a Medicare rebate for the specialist service. Medicare Provider Numbers are issued by the Department of Human Services (Medicare Australia). Some restrictions apply to doctors' eligibility for a Medicare Provider Number.

A Medicare provider number uniquely identifies both you and the place you work. If you change work locations you are required to complete an *Application for an additional location Medicare provider number for a medical practitioner* form. You are not able to transfer a provider number from one address to another; each practice location requires a separate provider number. Prevocational doctors should apply for provider numbers as early as possible to ensure they have an active provider number for each location on commencement at that site.

Do not presume that the allocation of a provider number means Medicare benefits are payable for services provided. For interns, the vast majority of provider numbers only allow for referring or requesting services for patients.

A provider number consists of:

- six numbers referred to as the provider stem (e.g. 123456)
- an alpha or numeric character that identifies the practice location (e.g. 7)
- an alpha check digit (e.g. A)

Contact Medicare Australia for more information.
Ph: 132 150 (within Australia)
Email: medicare.prov@humanservices.gov.au
(Type 'Application for Medicare provider number' in the subject heading, and include which State or territory you'll be working in in the body of the email.)

The Medicare Australia site can be difficult to navigate; the following link connects directly to the application form for an ***initial*** provider number. The form contains fairly detailed explanations about what each applicant is required to provide in order to be issued with a provider number. Available at:

Further information, Medicare Australia. Available at:
http://www.humanservices.gov.au/health-professionals/forms/hw019 [accessed April 2015]

19AB exemptions

Eligibility to access Medicare benefits is determined by the *Health Insurance Act 1973* and related regulations. Section 19AB of the Act limits access to Medicare benefits for some people, including overseas trained doctors or foreign graduates of accredited medical schools. In order for these doctors to be able to bill for services, they must either:

1. become either Australian citizens or permanent residents; and
2. must obtain a recognised postgraduate qualification or be undertaking an approved program placement and registered in the program by Medicare Australia under section 3GA of the *Health Insurance Act 1973*.

What is a Prescriber Number and entitlements?

For a pharmacist to be able to provide prescription medications through the Pharmaceutical Benefits Scheme (PBS) (i.e. at a subsidised price), the prescribing doctor must have a valid Prescriber Number and quote this on the prescription. Prescriber Numbers are issued by Medicare Australia. All doctors registered in Australia are eligible for a Prescriber Number. Doctors only require one prescriber number that can be used at all locations. Further information, PBS website. Available at: http://www.pbs.gov.au/info/healthpro/explanatory-notes/section1/Section_1_2_Explanatory_Notes [accessed November 2015]

SECTION 10 ENJOYING THE DOCTORS IN TRAINING MANAGERS ROLE

Building and managing your team

Depending on the size and context of the facility, many Doctors in Training Managers are responsible for managing other staff within their team. As the Manager you will rely on the support of your direct report but will also work collaboratively with many others, including the SIT/DCT/DMS and in some cases with the Medical education Unit/ Medical Education Officer (MEO).

If your position has responsibility for managing a number of staff you will undoubtedly set up systems and processes to facilitate effective working relationships. Fostering collaborative relationships where all staff feel valued, with clear communication and regular team meetings will support this.

Given the nature of the work, many Managers promote a flexible approach where everyone in the Medical Workforce Unit team has an understanding of each other's roles and are therefore able to assist each other during the busy peak times, such as the orientation and recruitment period or provide cover during leave.

Some tips from Doctors in Training Managers for building and maintaining a cohesive team are included in the box below.

Tips from experienced HMO Managers:

- Always keep your sense of humour.
- Hold regular team meetings, especially during busy times.
- Maintain clear communication – be on the same page (this also helps keep any advice or information provided to trainees consistent).
- Consider flexible work arrangements to ensure coverage of unit across required hours.
- Look for opportunities for staff to develop skills (for example participate in or run projects, attend meetings or represent unit on wider committees).
- Consider activities (appropriate to the workplace) that will boost team morale – for example celebration of events with a morning tea or lunch get together.
- Make a point of thanking staff and recognising efforts.

Career planning (your own!)

Doctors in Training Managers come to the doctors-in-training role from a variety of backgrounds and professional experience. No matter what your pathway to the role, it is important that you are able to access professional support during the role and beyond.

Given the varied roles and responsibilities involved in being a Doctors in Training Manager (which are dependent on context and location, type of facility) your professional development needs may vary. It can also at times be challenging to make time for professional development activities but these are essential to sustaining enjoyment and further development within the role.

There are lots of professional development activities on offer. You can find out more by speaking with your local HR department. In addition, the PMCV offers support through the HMO Managers subcommittee and also convenes an annual Symposium on prevocational education and training forum each year which many HMO Managers attend. Further information can be found in the Education section of the PMCV website. Available at: pmcv.com.au

A national Prevocational Medical Education and Training Forum is held annually and normally one of the Special Interest Group meetings at this Forum is for Medical Administrators/Medical Workforce Managers. There is an opportunity to identify a project in advance and to submit a paper for presentation at the Forum. The Forum rotates between the states and territories. Further information on the annual Forum can be found on the CPMEC website: www.cpmec.org.au

You should have a performance review each year. This might be used as an opportunity to identify areas that you would like to work on and strategies to assist you in this.

Beyond the Doctors in Training Manager role

Many Doctors in Training Managers find that they gain a great deal of knowledge and skills during their time in the role and they find working with, managing and supporting junior doctors, particularly those in the very early postgraduate years very professionally satisfying. In addition the role of Doctor in Training Manager often brings with it opportunities to work and collaborate with others across the Victorian Health system in the medical education and training space.

Tips: Contributing to prevocational training:

- Undertake a quality improvement project in some aspect of junior doctor management or training: submit for conference presentation or poster or PMCV Research Grant funding.
- Presentation at national Prevocational Forum.
- Membership of a prevocational training committee.
- Surveyor for PMCV accreditation surveys.
- Committee membership at your local health service governance level.
- Committee membership (e.g. PMCV prevocational governance structures, participation in relevant work groups).

ACRONYMS

ACF	Australian Curriculum Framework for Junior Doctors
ACRRM	Australian College of Rural and Remote Medicine
ADO	Accrued Day Off
AHPRA	Australian Health Practitioner Regulation Agency
AMC	Australian Medical Council
AMC CAT MCQ	Australian Medical Council Computer Adaptive Test Multiple Choice Question
BPT	Basic Physician Training
CPMEC	Confederation of Postgraduate Medical Education Councils
CTN	Clinical Training Network
DCT	Director of Clinical Training
DHHS	Department of Health and Human Services (Victoria)
DIT	Doctor in Training
DME	Director Medical Education
DMS	Director Medical Services
DPET	Director of Prevocational Education and Training
ETA	End of Term Assessment
FAIMER	Foundation for Advancement of International Medical Education and Research
FTE	Full Time Equivalent
GMC	General Medical Council (United Kingdom)
GP	General Practitioner
HR	Human Resources
HETI	Health Education and Training Institute (NSW)
HMO	Hospital Medical Officer
IMED	International Medical Education Directory
IMG	International Medical Graduate
ITA	Intraining Assessment
JMO	Junior Medical Officer
JMS	Junior Medical Staff
LMCC	Medical Council Canada
MBA	Medical Board of Australia
MCE	Medical Clinical Educator
MEO	Medical Education Officer
MTA	Mid Term Assessment
MWU	Medical Workforce Unit
NITF	National Internship Training Framework
NZREX	Clinical examination for Registration with the Medical Council of New Zealand
PGY1	Postgraduate Year 1 (Intern / HMO1)
PGY2	Postgraduate Year 2 (HMO2)
PBS	Pharmaceutical Benefits Scheme
PLAB	Professional and Linguistic Assessments Board (United Kingdom)
PMCV	Postgraduate Medical Council of Victoria
RACP	Royal Australian College of Physicians
RACGP	Royal Australian College of General Practitioners
RCIT	Rural Community Intern Training program
RMO	Resident Medical Officer
SIT	Supervisor of Intern Training
SMST	Strengthening Medical Specialist Training
T&D	Training and Development e.g. T&D grant
TS	Term Supervisors
USMLE	Educational Commission for Foreign Medical Graduates of the United States
VMO	Visiting Medical Officer
VRMS	Victorian Rural Medical Scholarships Scheme
WBA	Workplace Based Assessment

APPENDIX 1 - SAMPLE YEARLY ROTATION AND ANNUAL LEAVE PLANNER

	Term 1	Term 2	Term 3	Term 4	Term 5
wk 3, 4	AED1	A-UROL 1	A-PSYCH1	ECHUCA1	A-MED ADMIT 2
wk 11,12	A-MED1A	AED1	A-UROL 1	A-PSYCH1	ECHUCA1
wk 20,21	A-SURG2	A-MED1A	AED1	A-UROL 1	A-PSYCH1
wk 1,2	AL	A-SURG2	A-MED1A	AED1	A-UROL 1
wk 19,20	A-UROL 1	AL	A-SURG2	A-MED1A	AED1
wk 5,6	AED2	A-SURG1A	AL	A-SURG2	A-MED1A
wk 13,14	A-MED1B	AED2	A-SURG1A	AL	A-SURG2
wk 23,24	SPINAL A	A-MED1B	AED2	A-SURG1A	AL
wk 9,10	AL	SPINAL A	A-MED1B	AED2	A-SURG1A
wk 11,12	A-SURG1A	AL	SPINAL A	A-MED1B	AED2
wk 7,8	AED3	A-SURG1B	AL	SPINAL A	A-MED1B
wk 15,16	A-MED2A	AED3	A-SURG1B	AL	SPINAL A
wk25,26	SPINAL B	A-MED2A	AED3	A-SURG1B	AL
wk35,36	MILDURA MED	SPINAL B	A-MED2A	AED3	A-ENT2
wk 45,46	A-SURG1B	MILDURA MED	SPINAL B	A-MED2A	AED3
wk9,10	AED4	A-SURG1C	MILDURA MED	SPINAL B	A-MED2A
wk17,18	A-MED2B	AED4	A-SURG1C	MILDURA MED	SPINAL B
wk27,28	ORTHO1	A-MED2B	AED4	A-SURG1C	MILDURA MED
wk37,38	A-GASTRO1	ORTHO1	A-MED2B	AED4	A-SURG1C
wk47,48	A-SURG1C	A-GASTRO1	ORTHO1	A-MED2B	AED4
wk1,2	AED5	A-SURG1D	A-GASTRO1	ORTHO1	A-MED2B
wk19,20	A-MED3A	AED5	A-SURG1D	A-GASTRO1	ORTHO1
wk21,22	ORTHO2	A-MED3A	AED5	A-SURG1D	A-GASTRO1
wk31,32	A-LTU1	ORTHO2	A-MED3A	AED5	A-SURG1D
wk49,50	A-SURG1D	A-LTU1	ORTHO2	A-MED3A	AED5
wk3,4	AED6	A-SURG3A	A-LTU1	ORTHO2	A-MED3A
wk17,18	A-MED3B	AED6	A-SURG3A	A-LTU1	ORTHO2
wk23,24	RADIOLOGY	A-MED3B	AED6	A-SURG3A	A-LTU1
wk 33,34	A-WD10A	RADIOLOGY	A-MED3B	AED6	A-SURG3A
wk41,42	A-SURG3A	A-WD10A	RADIOLOGY	A-MED3B	AED6
wk5,6	AED7	A-SURG3B	A-WD10A	RADIOLOGY	A-MED3B
wk15,16	A-MED4A	AED7	A-SURG3B	A-WD10A	RADIOLOGY
wk25,26	WARD12	A-MED4A	AED7	A-SURG3B	A-MED5B
wk35,36	A-ENT2	WARD12	A-MED4A	AED7	A-SURG3B
wk43,44	A-SURG3B	A-PSYCH1	WARD12	A-MED4A	AED7
wk7,8	AED8	A-SURG3C	A-TSC	WARD12	A-MED4A
wk13,14	A-MED4B	AED8	A-SURG3C	A-TSC	WARD12
wk27,28	ECHUCA2	A-MED4B	AED8	A-SURG3C	A-WD10A
wk37,38	A-STROKE 1	ECHUCA2	A-MED4B	AED8	A-SURG3C
wk35,36	A-SURG3C	A-STROKE 1	ECHUCA2	A-MED4B	AED8
wk 47,48	AED9	A-SURG4A	A-STROKE 1	ECHUCA2	A-MED4B
wk19,20	A-MED5A	AED9	A-SURG4A	A-STROKE 1	ECHUCA2
wk43,44	CARD SURG	A-MED5A	AED9	A-SURG4A	A-STROKE 1
wk45,46	A-STROKE 2	CARD SURG	A-MED5A	AED9	A-SURG4A
wk47,48	A-SURG4A	A-STROKE 2	CARD SURG	A-MED5A	AED9
wk 49,50	AED10	A-SURG4B	A-STROKE 2	CARD SURG	A-MED5A
wk 51,52	A-MED5B	AED10	A-SURG4B	A-STROKE 2	CARD SURG
wk41,42	VASC	A-MED5B	AED10	A-SURG4B	A-STROKE 2
wk39,40	A-TSC	VASC	A-MED5B	AED10	A-SURG4B
wk49,50	A-SURG4B	A-TSC	VASC	A-MED5B	AED10
wk43,44	MILDURA ED	A-ENT1	A-MED ADMIT 2	VASC	A-SURG1B
wk51,52	A-ENDO/RHEUM	MILDURA ED	A-ENT1	A-MED ADMIT 2	VASC
wk51,52	ORTHO5	A-ENDO/RHEUM	MILDURA ED	A-ENT1	A-TSC
wk1,2	A-WD10B	ORTHO5	A-ENDO/RHEUM	MILDURA ED	A-ENT1
wk41,42	A-ENT1	A-WD10B	ORTHO5	A-ENDO/RHEUM	MILDURA ED
wk47,48	ECHUCA1	A-ENT2	A-WD10B	ORTHO5	A-ENDO/RHEUM
wk45,46	A-MED ADMIT 2	ECHUCA1	A-ENT2	A-WD10B	ORTHO5
wk49,50	A-PSYCH1	A-MED ADMIT 2	ECHUCA1	A-ENT2	A-WD10B

APPENDIX 2 - SAMPLE WEEKLY ROTATION AND ANNUAL LEAVE PLANNER

WEEK1	WEEK2	WEEK3	WEEK4	WEEK5	WEEK6	WEEK7	WEEK8	WEEK9	WEEK10
AED1	AED1	AL	AL	AED1	AED1	AED1	AED1	AED1	AED1
A-MED1A	A-MED1A	A-MED1A	A-MED1A	A-MED1A	A-MED1A	A-MED1A	A-MED1A	A-MED1A	A-MED1A
A-SURG2	A-SURG2	A-SURG2	A-SURG2	A-SURG2	A-SURG2	A-SURG2	A-SURG2	A-SURG2	A-SURG2
AL	AL	AED1	AED1	AED2	AED2	AED3	AED3	AED4	AED4
A-UROL 1	A-UROL 1	A-UROL 1	A-UROL 1	A-UROL 1	A-UROL 1	A-UROL 1	A-UROL 1	A-UROL 1	A-UROL 1
AED2	AED2	AED2	AED2	AL	AL	AED2	AED2	AED2	AED2
A-MED1B	A-MED1B	A-MED1B	A-MED1B	A-MED1B	A-MED1B	A-MED1B	A-MED1B	A-MED1B	A-MED1B
SPINAL A	SPINAL A	SPINAL A	SPINAL A	SPINAL A	SPINAL A	SPINAL A	SPINAL A	SPINAL A	SPINAL A
AED5	AED5	AED6	AED6	AED7	AED7	AED8	AED8	AL	AL
A-SURG1A	A-SURG1A	A-SURG1A	A-SURG1A	A-SURG1A	A-SURG1A	A-SURG1A	A-SURG1A	A-SURG1A	A-SURG1A
AED3	AED3	AED3	AED3	AED3	AED3	AL	AL	AED3	AED3
A-MED2A	A-MED2A	A-MED2A	A-MED2A	A-MED2A	A-MED2A	A-MED2A	A-MED2A	A-MED2A	A-MED2A
SPINAL B	SPINAL B	SPINAL B	SPINAL B	SPINAL B	SPINAL B	SPINAL B	SPINAL B	SPINAL B	SPINAL B
MILDURA ME	MILDURA M	MILDURA	MILDURA	MILDURA	MILDURA	MILDURA	MILDURA	MILDURA	MILDURA
A-SURG1B	A-SURG1B	A-SURG1B	A-SURG1B	A-SURG1B	A-SURG1B	A-SURG1B	A-SURG1B	A-SURG1B	A-SURG1B
AED4	AED4	AED4	AED4	AED4	AED4	AED4	AED4	AL	AL
A-MED2B	A-MED2B	A-MED2B	A-MED2B	A-MED2B	A-MED2B	A-MED2B	A-MED2B	A-MED2B	A-MED2B
ORTHO1	ORTHO1	ORTHO1	ORTHO1	ORTHO1	ORTHO1	ORTHO1	ORTHO1	ORTHO1	ORTHO1
A-GASTRO1	A-GASTRO1	A-GASTRC	A-GASTRC	A-GASTRC	A-GASTRC	A-GASTRC	A-GASTRC	A-GASTRC	A-GASTRC
A-SURG1C	A-SURG1C	A-SURG1C	A-SURG1C	A-SURG1C	A-SURG1C	A-SURG1C	A-SURG1C	A-SURG1C	A-SURG1C
AL	AL	AED5	AED5	AED5	AED5	AED5	AED5	AED5	AED5
A-MED3A	A-MED3A	A-MED3A	A-MED3A	A-MED3A	A-MED3A	A-MED3A	A-MED3A	A-MED3A	A-MED3A
ORTHO2	ORTHO2	ORTHO2	ORTHO2	ORTHO2	ORTHO2	ORTHO2	ORTHO2	ORTHO2	ORTHO2
A-LTU1	A-LTU1	A-LTU1	A-LTU1	A-LTU1	A-LTU1	A-LTU1	A-LTU1	A-LTU1	A-LTU1
A-SURG1D	A-SURG1D	A-SURG1D	A-SURG1D	A-SURG1D	A-SURG1D	A-SURG1D	A-SURG1D	A-SURG1D	A-SURG1D
AED6	AED6	AL	AL	AED6	AED6	AED6	AED6	AED6	AED6
A-MED3B	A-MED3B	A-MED3B	A-MED3B	A-MED3B	A-MED3B	A-MED3B	A-MED3B	A-MED3B	A-MED3B
RADIOLOGY	RADIOLOGY	RADIOLOC	RADIOLOC	RADIOLOC	RADIOLOC	RADIOLOC	RADIOLOC	RADIOLOC	RADIOLOC
A-WD10A	A-WD10A	A-WD10A	A-WD10A	A-WD10A	A-WD10A	A-WD10A	A-WD10A	A-WD10A	A-WD10A
A-SURG3A	A-SURG3A	A-SURG3A	A-SURG3A	A-SURG3A	A-SURG3A	A-SURG3A	A-SURG3A	A-SURG3A	A-SURG3A
AED7	AED7	AED7	AED7	AL	AL	AED7	AED7	AED7	AED7
A-MED4A	A-MED4A	A-MED4A	A-MED4A	A-MED4A	A-MED4A	A-MED4A	A-MED4A	A-MED4A	A-MED4A
WARD12	WARD12	WARD12	WARD12	WARD12	WARD12	WARD12	WARD12	WARD12	WARD12
A-ENT2	A-ENT2	A-ENT2	A-ENT2	A-ENT2	A-ENT2	A-ENT2	A-ENT2	A-ENT2	A-ENT2
A-SURG3B	A-SURG3B	A-SURG3B	A-SURG3B	A-SURG3B	A-SURG3B	A-SURG3B	A-SURG3B	A-SURG3B	A-SURG3B
AED8	AED8	AED8	AED8	AED8	AED8	AL	AL	AED8	AED8
A-MED4B	A-MED4B	A-MED4B	A-MED4B	A-MED4B	A-MED4B	A-MED4B	A-MED4B	A-MED4B	A-MED4B
ECHUCA2	ECHUCA2	ECHUCA2	ECHUCA2	ECHUCA2	ECHUCA2	ECHUCA2	ECHUCA2	ECHUCA2	ECHUCA2
A-STROKE 1	A-STROKE 1	A-STROKE	A-STROKE	A-STROKE	A-STROKE	A-STROKE	A-STROKE	A-STROKE	A-STROKE
A-SURG3C	A-SURG3C	A-SURG3C	A-SURG3C	A-SURG3C	A-SURG3C	A-SURG3C	A-SURG3C	A-SURG3C	A-SURG3C
AED9	AED9	AED9	AED9	AED9	AED9	AED9	AED9	AED9	AED9
A-MED5A	A-MED5A	A-MED5A	A-MED5A	A-MED5A	A-MED5A	A-MED5A	A-MED5A	A-MED5A	A-MED5A
CARD SURG	CARD SURG	CARD SUR	CARD SUR	CARD SUR	CARD SUR	CARD SUR	CARD SUR	CARD SUR	CARD SUR
A-STROKE 2	A-STROKE 2	A-STROKE	A-STROKE	A-STROKE	A-STROKE	A-STROKE	A-STROKE	A-STROKE	A-STROKE
A-SURG4A	A-SURG4A	A-SURG4A	A-SURG4A	A-SURG4A	A-SURG4A	A-SURG4A	A-SURG4A	A-SURG4A	A-SURG4A
AED10	AED10	AED10	AED10	AED10	AED10	AED10	AED10	AED10	AED10
A-MED5B	A-MED5B	A-MED5B	A-MED5B	A-MED5B	A-MED5B	A-MED5B	A-MED5B	A-MED5B	A-MED5B
VASC	VASC	VASC	VASC	VASC	VASC	VASC	VASC	VASC	VASC
A-TSC	A-TSC	A-TSC	A-TSC	A-TSC	A-TSC	A-TSC	A-TSC	A-TSC	A-TSC
A-SURG4B	A-SURG4B	A-SURG4B	A-SURG4B	A-SURG4B	A-SURG4B	A-SURG4B	A-SURG4B	A-SURG4B	A-SURG4B
MILDURA ED	MILDURA ED	MILDURA	MILDURA	MILDURA	MILDURA	MILDURA	MILDURA	MILDURA	MILDURA
A-ENDO/RHE	A-ENDO/RH	A-ENDO/F	A-ENDO/F	A-ENDO/F	A-ENDO/F	A-ENDO/F	A-ENDO/F	A-ENDO/F	A-ENDO/F
ORTHO5	ORTHO5	ORTHO5	ORTHO5	ORTHO5	ORTHO5	ORTHO5	ORTHO5	ORTHO5	ORTHO5
AL	AL	A-WD10B	A-WD10B	A-WD10B	A-WD10B	A-WD10B	A-WD10B	A-WD10B	A-WD10B
A-ENT1	A-ENT1	A-ENT1	A-ENT1	A-ENT1	A-ENT1	A-ENT1	A-ENT1	A-ENT1	A-ENT1
ECHUCA1	ECHUCA1	ECHUCA1	ECHUCA1	ECHUCA1	ECHUCA1	ECHUCA1	ECHUCA1	ECHUCA1	ECHUCA1
A-MED ADM	A-MED ADM	A-MED AD	A-MED AD	A-MED AD	A-MED AD	A-MED AD	A-MED AD	A-MED AD	A-MED AD
A-PSYCH1	A-PSYCH1	A-PSYCH1	A-PSYCH1	A-PSYCH1	A-PSYCH1	A-PSYCH1	A-PSYCH1	A-PSYCH1	A-PSYCH1

Sample Weekly Rotation And Annual Leave Planner

WEEK11	WEEK12	WEEK13	WEEK14	WEEK15	WEEK16	WEEK17	WEEK18	WEEK19	WEEK20
A-UROL 1	A-UROL 1	A-UROL 1	A-UROL 1	A-UROL 1	A-UROL 1	A-UROL 1	A-UROL 1	A-UROL 1	A-UROL 1
AL	AL	AED1	AED1	AED1	AED1	AED1	AED1	AED1	AED1
A-MED1A	A-MED1A	A-MED1A	A-MED1A	A-MED1A	A-MED1A	A-MED1A	A-MED1A	A-MED1A	A-MED1A
A-SURG2	A-SURG2	A-SURG2	A-SURG2	A-SURG2	A-SURG2	A-SURG2	A-SURG2	A-SURG2	A-SURG2
AED1	AED1	AED2	AED2	AED3	AED3	AED4	AED4	AL	AL
A-SURG1A	A-SURG1A	A-SURG1A	A-SURG1A	A-SURG1A	A-SURG1A	A-SURG1A	A-SURG1A	A-SURG1A	A-SURG1A
AED2	AED2	AL	AL	AED2	AED2	AED2	AED2	AED2	AED2
A-MED1B	A-MED1B	A-MED1B	A-MED1B	A-MED1B	A-MED1B	A-MED1B	A-MED1B	A-MED1B	A-MED1B
SPINAL A	SPINAL A	SPINAL A	SPINAL A	SPINAL A	SPINAL A	SPINAL A	SPINAL A	SPINAL A	SPINAL A
AL	AL	AED8	AED8	AED7	AED7	AED6	AED6	AED5	AED5
A-SURG1B	A-SURG1B	A-SURG1B	A-SURG1B	A-SURG1B	A-SURG1B	A-SURG1B	A-SURG1B	A-SURG1B	A-SURG1B
AED3	AED3	AED3	AED3	AL	AL	AED3	AED3	AED3	AED3
A-MED2A	A-MED2A	A-MED2A	A-MED2A	A-MED2A	A-MED2A	A-MED2A	A-MED2A	A-MED2A	A-MED2A
SPINAL B	SPINAL B	SPINAL B	SPINAL B	SPINAL B	SPINAL B	SPINAL B	SPINAL B	SPINAL B	SPINAL B
MILDURA	MILDURA	MILDURA	MILDURA	MILDURA	MILDURA	MILDURA	MILDURA	MILDURA	MILDURA M
A-SURG1C	A-SURG1C	A-SURG1C	A-SURG1C	A-SURG1C	A-SURG1C	A-SURG1C	A-SURG1C	A-SURG1C	A-SURG1C
AED4	AED4	AED4	AED4	AED4	AED4	AL	AL	AED4	AED4
A-MED2B	A-MED2B	A-MED2B	A-MED2B	A-MED2B	A-MED2B	A-MED2B	A-MED2B	A-MED2B	A-MED2B
ORTHO1	ORTHO1	ORTHO1	ORTHO1	ORTHO1	ORTHO1	ORTHO1	ORTHO1	ORTHO1	ORTHO1
A-GASTRC	A-GASTRC	A-GASTRC	A-GASTRC	A-GASTRC	A-GASTRC	A-GASTRC	A-GASTRC	A-GASTRC	A-GASTRO1
A-SURG1D	A-SURG1D	A-SURG1D	A-SURG1D	A-SURG1D	A-SURG1D	A-SURG1D	A-SURG1D	A-SURG1D	A-SURG1D
AED5	AED5	AED5	AED5	AED5	AED5	AED5	AED5	AL	AL
A-MED3A	A-MED3A	A-MED3A	A-MED3A	A-MED3A	A-MED3A	A-MED3A	A-MED3A	A-MED3A	A-MED3A
ORTHO2	ORTHO2	ORTHO2	ORTHO2	ORTHO2	ORTHO2	ORTHO2	ORTHO2	ORTHO2	ORTHO2
A-LTU1	A-LTU1	A-LTU1	A-LTU1	A-LTU1	A-LTU1	A-LTU1	A-LTU1	A-LTU1	A-LTU1
A-SURG3A	A-SURG3A	A-SURG3A	A-SURG3A	A-SURG3A	A-SURG3A	A-SURG3A	A-SURG3A	A-SURG3A	A-SURG3A
AED6	AED6	AED6	AED6	AED6	AED6	AL	AL	AED6	AED6
A-MED3B	A-MED3B	A-MED3B	A-MED3B	A-MED3B	A-MED3B	A-MED3B	A-MED3B	A-MED3B	A-MED3B
RADIOLOC	RADIOLOC	RADIOLOC	RADIOLOC	RADIOLOC	RADIOLOC	RADIOLOC	RADIOLOC	RADIOLOC	RADIOLOGY
A-WD10A	A-WD10A	A-WD10A	A-WD10A	A-WD10A	A-WD10A	A-WD10A	A-WD10A	A-WD10A	A-WD10A
A-SURG3B	A-SURG3B	A-SURG3B	A-SURG3B	A-SURG3B	A-SURG3B	A-SURG3B	A-SURG3B	A-SURG3B	A-SURG3B
AED7	AED7	AED7	AED7	AL	AL	AED7	AED7	AED7	AED7
A-MED4A	A-MED4A	A-MED4A	A-MED4A	A-MED4A	A-MED4A	A-MED4A	A-MED4A	A-MED4A	A-MED4A
WARD12	WARD12	WARD12	WARD12	WARD12	WARD12	WARD12	WARD12	WARD12	WARD12
A-PSYCH1	A-PSYCH1	A-PSYCH1	A-PSYCH1	A-PSYCH1	A-PSYCH1	A-PSYCH1	A-PSYCH1	A-PSYCH1	A-PSYCH1
A-SURG3C	A-SURG3C	A-SURG3C	A-SURG3C	A-SURG3C	A-SURG3C	A-SURG3C	A-SURG3C	A-SURG3C	A-SURG3C
AED8	AED8	AL	AL	AED8	AED8	AED8	AED8	AED8	AED8
A-MED4B	A-MED4B	A-MED4B	A-MED4B	A-MED4B	A-MED4B	A-MED4B	A-MED4B	A-MED4B	A-MED4B
ECHUCA2	ECHUCA2	ECHUCA2	ECHUCA2	ECHUCA2	ECHUCA2	ECHUCA2	ECHUCA2	ECHUCA2	ECHUCA2
A-STROKE	A-STROKE	A-STROKE	A-STROKE	A-STROKE	A-STROKE	A-STROKE	A-STROKE	A-STROKE	A-STROKE 1
A-SURG4A	A-SURG4A	A-SURG4A	A-SURG4A	A-SURG4A	A-SURG4A	A-SURG4A	A-SURG4A	A-SURG4A	A-SURG4A
AED9	AED9	AED9	AED9	AED9	AED9	AED9	AED9	AL	AL
A-MED5A	A-MED5A	A-MED5A	A-MED5A	A-MED5A	A-MED5A	A-MED5A	A-MED5A	A-MED5A	A-MED5A
CARD SUR	CARD SUR	CARD SUR	CARD SUR	CARD SUR	CARD SUR	CARD SUR	CARD SUR	CARD SUR	CARD SURG
A-STROKE	A-STROKE	A-STROKE	A-STROKE	A-STROKE	A-STROKE	A-STROKE	A-STROKE	A-STROKE	A-STROKE 2
A-SURG4B	A-SURG4B	A-SURG4B	A-SURG4B	A-SURG4B	A-SURG4B	A-SURG4B	A-SURG4B	A-SURG4B	A-SURG4B
AED10	AED10	AED10	AED10	AED10	AED10	AED10	AED10	AED10	AED10
A-MED5B	A-MED5B	A-MED5B	A-MED5B	A-MED5B	A-MED5B	A-MED5B	A-MED5B	A-MED5B	A-MED5B
VASC	VASC	VASC	VASC	VASC	VASC	VASC	VASC	VASC	VASC
A-TSC	A-TSC	A-TSC	A-TSC	A-TSC	A-TSC	A-TSC	A-TSC	A-TSC	A-TSC
A-ENT1	A-ENT1	A-ENT1	A-ENT1	A-ENT1	A-ENT1	A-ENT1	A-ENT1	A-ENT1	A-ENT1
MILDURA	MILDURA	MILDURA	MILDURA	MILDURA	MILDURA	MILDURA	MILDURA	MILDURA	MILDURA EL
A-ENDO/R	A-ENDO/R	A-ENDO/R	A-ENDO/R	A-ENDO/R	A-ENDO/R	A-ENDO/R	A-ENDO/R	A-ENDO/R	A-ENDO/RH
ORTHO5	ORTHO5	ORTHO5	ORTHO5	ORTHO5	ORTHO5	ORTHO5	ORTHO5	ORTHO5	ORTHO5
A-WD10B	A-WD10B	A-WD10B	A-WD10B	A-WD10B	A-WD10B	A-WD10B	A-WD10B	A-WD10B	A-WD10B
A-ENT2	A-ENT2	A-ENT2	A-ENT2	A-ENT2	A-ENT2	A-ENT2	A-ENT2	A-ENT2	A-ENT2
ECHUCA1	ECHUCA1	ECHUCA1	ECHUCA1	ECHUCA1	ECHUCA1	ECHUCA1	ECHUCA1	ECHUCA1	ECHUCA1
A-MED AD	A-MED AD	A-MED AD	A-MED AD	A-MED AD	A-MED AD	A-MED AD	A-MED AD	A-MED AD	A-MED ADM

Sample Weekly Rotation And Annual Leave Planner

WEEK21	WEEK22	WEEK23	WEEK24	WEEK25	WEEK26	WEEK27	WEEK28	WEEK29	WEEK30
A-PSYCH1	A-PSYCH1	A-PSYCH1	A-PSYCH1	A-PSYCH1	A-PSYCH1	A-PSYCH1	A-PSYCH1	A-PSYCH1	A-PSYCH1
A-UROL 1	A-UROL 1	A-UROL 1	A-UROL 1	A-UROL 1	A-UROL 1	A-UROL 1	A-UROL 1	A-UROL 1	A-UROL 1
AL	AL	AED1	AED1	AED1	AED1	AED1	AED1	AED1	AED1
A-MED1A	A-MED1A	A-MED1A	A-MED1A	A-MED1A	A-MED1A	A-MED1A	A-MED1A	A-MED1A	A-MED1A
A-SURG2	A-SURG2	A-SURG2	A-SURG2	A-SURG2	A-SURG2	A-SURG2	A-SURG2	A-SURG2	A-SURG2
AED1	AED1	AED2	AED2	AED3	AED3	AED4	AED4	AL	AL
A-SURG1A	A-SURG1A	A-SURG1A	A-SURG1A	A-SURG1A	A-SURG1A	A-SURG1A	A-SURG1A	A-SURG1A	A-SURG1A
AED2	AED2	AL	AL	AED2	AED2	AED2	AED2	AED2	AED2
A-MED1B	A-MED1B	A-MED1B	A-MED1B	A-MED1B	A-MED1B	A-MED1B	A-MED1B	A-MED1B	A-MED1B
SPINAL A	SPINAL A	SPINAL A	SPINAL A	SPINAL A	SPINAL A	SPINAL A	SPINAL A	SPINAL A	SPINAL A
AED5	AED5	AED6	AED6	AED7	AED7	AED8	AED8	AL	AL
A-SURG1B	A-SURG1B	A-SURG1B	A-SURG1B	A-SURG1B	A-SURG1B	A-SURG1B	A-SURG1B	A-SURG1B	A-SURG1B
AED3	AED3	AED3	AED3	AL	AL	AED3	AED3	AED3	AED3
A-MED2A	A-MED2A	A-MED2A	A-MED2A	A-MED2A	A-MED2A	A-MED2A	A-MED2A	A-MED2A	A-MED2A
SPINAL B	SPINAL B	SPINAL B	SPINAL B	SPINAL B	SPINAL B	SPINAL B	SPINAL B	SPINAL B	SPINAL B
MILDURA	MILDURA	MILDURA	MILDURA	MILDURA	MILDURA	MILDURA	MILDURA	MILDURA	MILDURA
A-SURG1C	A-SURG1C	A-SURG1C	A-SURG1C	A-SURG1C	A-SURG1C	A-SURG1C	A-SURG1C	A-SURG1C	A-SURG1C
AED4	AED4	AED4	AED4	AED4	AED4	AL	AL	AED4	AED4
A-MED2B	A-MED2B	A-MED2B	A-MED2B	A-MED2B	A-MED2B	A-MED2B	A-MED2B	A-MED2B	A-MED2B
ORTHO1	ORTHO1	ORTHO1	ORTHO1	ORTHO1	ORTHO1	ORTHO1	ORTHO1	ORTHO1	ORTHO1
A-GASTRC	A-GASTRC	A-GASTRC	A-GASTRC	A-GASTRC	A-GASTRC	A-GASTRC	A-GASTRC	A-GASTRC	A-GASTRC
A-SURG1D	A-SURG1D	A-SURG1D	A-SURG1D	A-SURG1D	A-SURG1D	A-SURG1D	A-SURG1D	A-SURG1D	A-SURG1D
AL	AL	AED5	AED5	AED5	AED5	AED5	AED5	AED5	AED5
A-MED3A	A-MED3A	A-MED3A	A-MED3A	A-MED3A	A-MED3A	A-MED3A	A-MED3A	A-MED3A	A-MED3A
ORTHO2	ORTHO2	ORTHO2	ORTHO2	ORTHO2	ORTHO2	ORTHO2	ORTHO2	ORTHO2	ORTHO2
A-LTU1	A-LTU1	A-LTU1	A-LTU1	A-LTU1	A-LTU1	A-LTU1	A-LTU1	A-LTU1	A-LTU1
A-SURG3A	A-SURG3A	A-SURG3A	A-SURG3A	A-SURG3A	A-SURG3A	A-SURG3A	A-SURG3A	A-SURG3A	A-SURG3A
AED6	AED6	AL	AL	AED6	AED6	AED6	AED6	AED6	AED6
A-MED3B	A-MED3B	A-MED3B	A-MED3B	A-MED3B	A-MED3B	A-MED3B	A-MED3B	A-MED3B	A-MED3B
RADIOLOC	RADIOLOC	RADIOLOC	RADIOLOC	RADIOLOC	RADIOLOC	RADIOLOC	RADIOLOC	RADIOLOC	RADIOLOC
A-WD10A	A-WD10A	A-WD10A	A-WD10A	A-WD10A	A-WD10A	A-WD10A	A-WD10A	A-WD10A	A-WD10A
A-SURG3B	A-SURG3B	A-SURG3B	A-SURG3B	A-SURG3B	A-SURG3B	A-SURG3B	A-SURG3B	A-SURG3B	A-SURG3B
AED7	AED7	AED7	AED7	AL	AL	AED7	AED7	AED7	AED7
A-MED4A	A-MED4A	A-MED4A	A-MED4A	A-MED4A	A-MED4A	A-MED4A	A-MED4A	A-MED4A	A-MED4A
WARD12	WARD12	WARD12	WARD12	WARD12	WARD12	WARD12	WARD12	WARD12	WARD12
A-TSC	A-TSC	A-TSC	A-TSC	A-TSC	A-TSC	A-TSC	A-TSC	A-TSC	A-TSC
A-SURG3C	A-SURG3C	A-SURG3C	A-SURG3C	A-SURG3C	A-SURG3C	A-SURG3C	A-SURG3C	A-SURG3C	A-SURG3C
AED8	AED8	AED8	AED8	AED8	AED8	AL	AL	AED8	AED8
A-MED4B	A-MED4B	A-MED4B	A-MED4B	A-MED4B	A-MED4B	A-MED4B	A-MED4B	A-MED4B	A-MED4B
ECHUCA2	ECHUCA2	ECHUCA2	ECHUCA2	ECHUCA2	ECHUCA2	ECHUCA2	ECHUCA2	ECHUCA2	ECHUCA2
A-STROKE	A-STROKE	A-STROKE	A-STROKE	A-STROKE	A-STROKE	A-STROKE	A-STROKE	A-STROKE	A-STROKE
A-SURG4A	A-SURG4A	A-SURG4A	A-SURG4A	A-SURG4A	A-SURG4A	A-SURG4A	A-SURG4A	A-SURG4A	A-SURG4A
AED9	AED9	AED9	AED9	AED9	AED9	AED9	AED9	AED9	AED9
A-MED5A	A-MED5A	A-MED5A	A-MED5A	A-MED5A	A-MED5A	A-MED5A	A-MED5A	A-MED5A	A-MED5A
CARD SUR	CARD SUR	CARD SUR	CARD SUR	CARD SUR	CARD SUR	CARD SUR	CARD SUR	CARD SUR	CARD SUR
A-STROKE	A-STROKE	A-STROKE	A-STROKE	A-STROKE	A-STROKE	A-STROKE	A-STROKE	A-STROKE	A-STROKE
A-SURG4B	A-SURG4B	A-SURG4B	A-SURG4B	A-SURG4B	A-SURG4B	A-SURG4B	A-SURG4B	A-SURG4B	A-SURG4B
AED10	AED10	AED10	AED10	AED10	AED10	AED10	AED10	AED10	AED10
A-MED5B	A-MED5B	A-MED5B	A-MED5B	A-MED5B	A-MED5B	A-MED5B	A-MED5B	A-MED5B	A-MED5B
VASC	VASC	VASC	VASC	VASC	VASC	VASC	VASC	VASC	VASC
A-MED AD	A-MED AD	A-MED AD	A-MED AD	A-MED AD	A-MED AD	A-MED AD	A-MED AD	A-MED AD	A-MED AD
A-ENT1	A-ENT1	A-ENT1	A-ENT1	A-ENT1	A-ENT1	A-ENT1	A-ENT1	A-ENT1	A-ENT1
MILDURA	MILDURA	MILDURA	MILDURA	MILDURA	MILDURA	MILDURA	MILDURA	MILDURA	MILDURA
A-ENDO/F	A-ENDO/F	A-ENDO/F	A-ENDO/F	A-ENDO/F	A-ENDO/F	A-ENDO/F	A-ENDO/F	A-ENDO/F	A-ENDO/F
ORTHO5	ORTHO5	ORTHO5	ORTHO5	ORTHO5	ORTHO5	ORTHO5	ORTHO5	ORTHO5	ORTHO5
A-WD10B	A-WD10B	A-WD10B	A-WD10B	A-WD10B	A-WD10B	A-WD10B	A-WD10B	A-WD10B	A-WD10B
A-ENT2	A-ENT2	A-ENT2	A-ENT2	A-ENT2	A-ENT2	A-ENT2	A-ENT2	A-ENT2	A-ENT2
ECHUCA1	ECHUCA1	ECHUCA1	ECHUCA1	ECHUCA1	ECHUCA1	ECHUCA1	ECHUCA1	ECHUCA1	ECHUCA1

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WEEK31	WEEK32	WEEK33	WEEK34	WEEK35	WEEK36	WEEK37	WEEK38	WEEK39	WEEK40
ECHUCA1	ECHUCA1	ECHUCA1	ECHUCA1	ECHUCA1	ECHUCA1	ECHUCA1	ECHUCA1	ECHUCA1	ECHUCA1
A-PSYCH1	A-PSYCH1	A-PSYCH1	A-PSYCH1	A-PSYCH1	A-PSYCH1	A-PSYCH1	A-PSYCH1	A-PSYCH1	A-PSYCH1
A-UROL 1	A-UROL 1	A-UROL 1	A-UROL 1	A-UROL 1	A-UROL 1	A-UROL 1	A-UROL 1	A-UROL 1	A-UROL 1
AL	AL	AED1	AED1	AED1	AED1	AED1	AED1	AED1	AED1
A-MED1A	A-MED1A	A-MED1A	A-MED1A	A-MED1A	A-MED1A	A-MED1A	A-MED1A	A-MED1A	A-MED1A
A-SURG2	A-SURG2	A-SURG2	A-SURG2	A-SURG2	A-SURG2	A-SURG2	A-SURG2	A-SURG2	A-SURG2
AED1	AED1	AED2	AED2	AED3	AED3	AED4	AED4	AL	AL
A-SURG1A	A-SURG1A	A-SURG1A	A-SURG1A	A-SURG1A	A-SURG1A	A-SURG1A	A-SURG1A	A-SURG1A	A-SURG1A
AED2	AED2	AL	AL	AED2	AED2	AED2	AED2	AED2	AED2
A-MED1B	A-MED1B	A-MED1B	A-MED1B	A-MED1B	A-MED1B	A-MED1B	A-MED1B	A-MED1B	A-MED1B
SPINAL A	SPINAL A	SPINAL A	SPINAL A	SPINAL A	SPINAL A	SPINAL A	SPINAL A	SPINAL A	SPINAL A
AED5	AED5	AED6	AED6	AED7	AED7	AED8	AED8	AL	AL
A-SURG1B	A-SURG1B	A-SURG1B	A-SURG1B	A-SURG1B	A-SURG1B	A-SURG1B	A-SURG1B	A-SURG1B	A-SURG1B
AED3	AED3	AED3	AED3	AL	AL	AED3	AED3	AED3	AED3
A-MED2A	A-MED2A	A-MED2A	A-MED2A	A-MED2A	A-MED2A	A-MED2A	A-MED2A	A-MED2A	A-MED2A
SPINAL B	SPINAL B	SPINAL B	SPINAL B	SPINAL B	SPINAL B	SPINAL B	SPINAL B	SPINAL B	SPINAL B
MILDURA	MILDURA	MILDURA	MILDURA	MILDURA	MILDURA	MILDURA	MILDURA	MILDURA	MILDURA
A-SURG1C	A-SURG1C	A-SURG1C	A-SURG1C	A-SURG1C	A-SURG1C	A-SURG1C	A-SURG1C	A-SURG1C	A-SURG1C
AED4	AED4	AED4	AED4	AED4	AED4	AL	AL	AED4	AED4
A-MED2B	A-MED2B	A-MED2B	A-MED2B	A-MED2B	A-MED2B	A-MED2B	A-MED2B	A-MED2B	A-MED2B
ORTHO1	ORTHO1	ORTHO1	ORTHO1	ORTHO1	ORTHO1	ORTHO1	ORTHO1	ORTHO1	ORTHO1
A-GASTRC	A-GASTRC	A-GASTRC	A-GASTRC	A-GASTRC	A-GASTRC	A-GASTRC	A-GASTRC	A-GASTRC	A-GASTRC
A-SURG1D	A-SURG1D	A-SURG1D	A-SURG1D	A-SURG1D	A-SURG1D	A-SURG1D	A-SURG1D	A-SURG1D	A-SURG1D
AL	AL	AED5	AED5	AED5	AED5	AED5	AED5	AED5	AED5
A-MED3A	A-MED3A	A-MED3A	A-MED3A	A-MED3A	A-MED3A	A-MED3A	A-MED3A	A-MED3A	A-MED3A
ORTHO2	ORTHO2	ORTHO2	ORTHO2	ORTHO2	ORTHO2	ORTHO2	ORTHO2	ORTHO2	ORTHO2
A-LTU1	A-LTU1	A-LTU1	A-LTU1	A-LTU1	A-LTU1	A-LTU1	A-LTU1	A-LTU1	A-LTU1
A-SURG3A	A-SURG3A	A-SURG3A	A-SURG3A	A-SURG3A	A-SURG3A	A-SURG3A	A-SURG3A	A-SURG3A	A-SURG3A
AED6	AED6	AL	AL	AED6	AED6	AED6	AED6	AED6	AED6
A-MED3B	A-MED3B	A-MED3B	A-MED3B	A-MED3B	A-MED3B	A-MED3B	A-MED3B	A-MED3B	A-MED3B
RADIOLOC	RADIOLOC	RADIOLOC	RADIOLOC	RADIOLOC	RADIOLOC	RADIOLOC	RADIOLOC	RADIOLOC	RADIOLOC
A-WD10A	A-WD10A	A-WD10A	A-WD10A	A-WD10A	A-WD10A	A-WD10A	A-WD10A	A-WD10A	A-WD10A
A-SURG3B	A-SURG3B	A-SURG3B	A-SURG3B	A-SURG3B	A-SURG3B	A-SURG3B	A-SURG3B	A-SURG3B	A-SURG3B
AED7	AED7	AED7	AED7	AL	AL	AED7	AED7	AED7	AED7
A-MED4A	A-MED4A	A-MED4A	A-MED4A	A-MED4A	A-MED4A	A-MED4A	A-MED4A	A-MED4A	A-MED4A
WARD12	WARD12	WARD12	WARD12	WARD12	WARD12	WARD12	WARD12	WARD12	WARD12
A-TSC	A-TSC	A-TSC	A-TSC	A-TSC	A-TSC	A-TSC	A-TSC	A-TSC	A-TSC
A-SURG3C	A-SURG3C	A-SURG3C	A-SURG3C	A-SURG3C	A-SURG3C	A-SURG3C	A-SURG3C	A-SURG3C	A-SURG3C
AED8	AED8	AED8	AED8	AED8	AED8	AL	AL	AED8	AED8
A-MED4B	A-MED4B	A-MED4B	A-MED4B	A-MED4B	A-MED4B	A-MED4B	A-MED4B	A-MED4B	A-MED4B
ECHUCA2	ECHUCA2	ECHUCA2	ECHUCA2	ECHUCA2	ECHUCA2	ECHUCA2	ECHUCA2	ECHUCA2	ECHUCA2
A-STROKE	A-STROKE	A-STROKE	A-STROKE	A-STROKE	A-STROKE	A-STROKE	A-STROKE	A-STROKE	A-STROKE
A-SURG4A	A-SURG4A	A-SURG4A	A-SURG4A	A-SURG4A	A-SURG4A	A-SURG4A	A-SURG4A	A-SURG4A	A-SURG4A
AED9	AED9	AED9	AED9	AED9	AED9	AED9	AED9	AED9	AED9
A-MED5A	A-MED5A	A-MED5A	A-MED5A	A-MED5A	A-MED5A	A-MED5A	A-MED5A	A-MED5A	A-MED5A
CARD SUR	CARD SUR	CARD SUR	CARD SUR	CARD SUR	CARD SUR	CARD SUR	CARD SUR	CARD SUR	CARD SUR
A-STROKE	A-STROKE	A-STROKE	A-STROKE	A-STROKE	A-STROKE	A-STROKE	A-STROKE	A-STROKE	A-STROKE
A-SURG4B	A-SURG4B	A-SURG4B	A-SURG4B	A-SURG4B	A-SURG4B	A-SURG4B	A-SURG4B	A-SURG4B	A-SURG4B
AED10	AED10	AED10	AED10	AED10	AED10	AED10	AED10	AL	AL
A-MED5B	A-MED5B	A-MED5B	A-MED5B	A-MED5B	A-MED5B	A-MED5B	A-MED5B	A-MED5B	A-MED5B
VASC	VASC	VASC	VASC	VASC	VASC	VASC	VASC	VASC	VASC
A-MED AD	A-MED AD	A-MED AD	A-MED AD	A-MED AD	A-MED AD	A-MED AD	A-MED AD	A-MED AD	A-MED AD
A-ENT1	A-ENT1	A-ENT1	A-ENT1	A-ENT1	A-ENT1	A-ENT1	A-ENT1	A-ENT1	A-ENT1
MILDURA	MILDURA	MILDURA	MILDURA	MILDURA	MILDURA	MILDURA	MILDURA	MILDURA	MILDURA
A-ENDO/F	A-ENDO/F	A-ENDO/F	A-ENDO/F	A-ENDO/F	A-ENDO/F	A-ENDO/F	A-ENDO/F	A-ENDO/F	A-ENDO/F
ORTHO5	ORTHO5	ORTHO5	ORTHO5	ORTHO5	ORTHO5	ORTHO5	ORTHO5	ORTHO5	ORTHO5
A-WD10B	A-WD10B	A-WD10B	A-WD10B	A-WD10B	A-WD10B	A-WD10B	A-WD10B	A-WD10B	A-WD10B
A-ENT2	A-ENT2	A-ENT2	A-ENT2	A-ENT2	A-ENT2	A-ENT2	A-ENT2	A-ENT2	A-ENT2

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WEEK41	WEEK42	WEEK43	WEEK44	WEEK45	WEEK46	WEEK47	WEEK48	WEEK49	WEEK50	WEEK51	WEEK52
A-MED AD	A-MED AD	A-MED AD	A-MED AD	A-MED AD	A-MED AD	A-MED AD	A-MED AD	A-MED AD	A-MED AD	A-MED AD	A-MED AD
ECHUCA1	ECHUCA1	ECHUCA1	ECHUCA1	ECHUCA1	ECHUCA1	ECHUCA1	ECHUCA1	ECHUCA1	ECHUCA1	ECHUCA1	ECHUCA1
A-PSYCH1	A-PSYCH1	A-PSYCH1	A-PSYCH1	A-PSYCH1	A-PSYCH1	A-PSYCH1	A-PSYCH1	A-PSYCH1	A-PSYCH1	A-PSYCH1	A-PSYCH1
A-UROL 1	A-UROL 1	A-UROL 1	A-UROL 1	A-UROL 1	A-UROL 1	A-UROL 1	A-UROL 1	A-UROL 1	A-UROL 1	A-UROL 1	A-UROL 1
AL	AL	AED1	AED1	AED1	AED1	AED1	AED1	AED1	AED1	CARD SUR	CARD SUR
A-MED1A	A-MED1A	A-MED1A	A-MED1A	A-MED1A	A-MED1A	A-MED1A	A-MED1A	A-MED1A	A-MED1A	A-MED1A	A-MED1A
A-SURG2	A-SURG2	A-SURG2	A-SURG2	A-SURG2	A-SURG2	A-SURG2	A-SURG2	A-SURG2	A-SURG2	A-SURG2	A-SURG2
A-STROKE	A-STROKE	AED2	AED2	AED3	AED3	AED4	AED4	AED5	AED5	AL	AL
A-SURG1A	A-SURG1A	A-SURG1A	A-SURG1A	A-SURG1A	A-SURG1A	A-SURG1A	A-SURG1A	A-SURG1A	A-SURG1A	A-SURG1A	A-SURG1A
AED2	AED2	AL	AL	ORTHO5	ORTHO5	AED2	AED2	AED2	AED2	AED2	AED2
A-MED1B	A-MED1B	A-MED1B	A-MED1B	A-MED1B	A-MED1B	A-MED1B	A-MED1B	A-MED1B	A-MED1B	A-MED1B	A-MED1B
SPINAL A	SPINAL A	SPINAL A	SPINAL A	SPINAL A	SPINAL A	SPINAL A	SPINAL A	SPINAL A	SPINAL A	SPINAL A	SPINAL A
AED6	AED6	AED7	AED7	AED8	AED8	AED9	AED9	A-WD10B	A-WD10B	AL	AL
A-ENT2	A-ENT2	A-ENT2	A-ENT2	A-ENT2	A-ENT2	A-ENT2	A-ENT2	A-ENT2	A-ENT2	A-ENT2	A-ENT2
AED3	AED3	A-SURG1B	A-SURG1B	AL	AL	AED3	AED3	AED3	AED3	AED3	AED3
A-MED2A	A-MED2A	A-MED2A	A-MED2A	A-MED2A	A-MED2A	A-MED2A	A-MED2A	A-MED2A	A-MED2A	A-MED2A	A-MED2A
SPINAL B	SPINAL B	SPINAL B	SPINAL B	SPINAL B	SPINAL B	SPINAL B	SPINAL B	SPINAL B	SPINAL B	SPINAL B	SPINAL B
MILDURA	MILDURA	MILDURA	MILDURA	MILDURA	MILDURA	MILDURA	MILDURA	MILDURA	MILDURA	MILDURA	MILDURA
A-SURG1C	A-SURG1C	A-SURG1C	A-SURG1C	A-SURG1C	A-SURG1C	A-SURG1C	A-SURG1C	A-SURG1C	A-SURG1C	A-SURG1C	A-SURG1C
AED4	AED4	AED4	AED4	AED4	AED4	AL	AL	AED4	AED4	AED4	AED4
A-MED2B	A-MED2B	A-MED2B	A-MED2B	A-MED2B	A-MED2B	A-MED2B	A-MED2B	A-MED2B	A-MED2B	A-MED2B	A-MED2B
ORTHO1	ORTHO1	ORTHO1	ORTHO1	ORTHO1	ORTHO1	ORTHO1	ORTHO1	ORTHO1	ORTHO1	ORTHO1	ORTHO1
A-GASTRO	A-GASTRO	A-GASTRO	A-GASTRO	A-GASTRO	A-GASTRO	A-GASTRO	A-GASTRO	A-GASTRO	A-GASTRO	A-GASTRO	A-GASTRO
A-SURG1D	A-SURG1D	A-SURG1D	A-SURG1D	A-SURG1D	A-SURG1D	A-SURG1D	A-SURG1D	A-SURG1D	A-SURG1D	A-SURG1D	A-SURG1D
AED5	AED5	AED5	AED5	AED5	AED5	AED5	AED5	AL	AL	VASC	VASC
A-MED3A	A-MED3A	A-MED3A	A-MED3A	A-MED3A	A-MED3A	A-MED3A	A-MED3A	A-MED3A	A-MED3A	A-MED3A	A-MED3A
ORTHO2	ORTHO2	ORTHO2	ORTHO2	ORTHO2	ORTHO2	ORTHO2	ORTHO2	ORTHO2	ORTHO2	ORTHO2	ORTHO2
A-LTU1	A-LTU1	A-LTU1	A-LTU1	A-LTU1	A-LTU1	A-LTU1	A-LTU1	A-LTU1	A-LTU1	A-LTU1	A-LTU1
A-SURG3A	A-SURG3A	A-SURG3A	A-SURG3A	A-SURG3A	A-SURG3A	A-SURG3A	A-SURG3A	A-SURG3A	A-SURG3A	A-SURG3A	A-SURG3A
AL	AL	A-STROKE	A-STROKE	AED6	AED6	AED6	AED6	AED6	AED6	AED6	AED6
A-MED3B	A-MED3B	A-MED3B	A-MED3B	A-MED3B	A-MED3B	A-MED3B	A-MED3B	A-MED3B	A-MED3B	A-MED3B	A-MED3B
RADIOLOG	RADIOLOG	RADIOLOG	RADIOLOG	RADIOLOG	RADIOLOG	RADIOLOG	RADIOLOG	RADIOLOG	RADIOLOG	RADIOLOG	RADIOLOG
A-MED5B	A-MED5B	A-MED5B	A-MED5B	A-MED5B	A-MED5B	A-MED5B	A-MED5B	A-MED5B	A-MED5B	A-MED5B	A-MED5B
A-SURG3B	A-SURG3B	A-SURG3B	A-SURG3B	A-SURG3B	A-SURG3B	A-SURG3B	A-SURG3B	A-SURG3B	A-SURG3B	A-SURG3B	A-SURG3B
AED7	AED7	AL	AL	A-SURG4A	A-SURG4A	AED7	AED7	AED7	AED7	AED7	AED7
A-MED4A	A-MED4A	A-MED4A	A-MED4A	A-MED4A	A-MED4A	A-MED4A	A-MED4A	A-MED4A	A-MED4A	A-MED4A	A-MED4A
WARD12	WARD12	WARD12	WARD12	WARD12	WARD12	WARD12	WARD12	WARD12	WARD12	WARD12	WARD12
A-WD10A	A-WD10A	A-WD10A	A-WD10A	A-WD10A	A-WD10A	A-WD10A	A-WD10A	A-WD10A	A-WD10A	A-WD10A	A-WD10A
A-SURG3C	A-SURG3C	A-SURG3C	A-SURG3C	A-SURG3C	A-SURG3C	A-SURG3C	A-SURG3C	A-SURG3C	A-SURG3C	A-SURG3C	A-SURG3C
AED8	AED8	AED8	AED8	AL	AL	A-MED4B	A-MED4B	AED8	AED8	AED8	AED8
A-MED4B	A-MED4B	A-MED4B	A-MED4B	A-MED4B	A-MED4B	AL	AL	A-MED4B	A-MED4B	A-MED4B	A-MED4B
ECHUCA2	ECHUCA2	ECHUCA2	ECHUCA2	ECHUCA2	ECHUCA2	ECHUCA2	ECHUCA2	ECHUCA2	ECHUCA2	ECHUCA2	ECHUCA2
A-STROKE	A-STROKE	AL	AL	A-STROKE	A-STROKE	A-STROKE	A-STROKE	A-STROKE	A-STROKE	A-STROKE	A-STROKE
A-SURG4A	A-SURG4A	A-SURG4A	A-SURG4A	AL	AL	A-SURG4A	A-SURG4A	A-SURG4A	A-SURG4A	A-SURG4A	A-SURG4A
AED9	AED9	AED9	AED9	AED9	AED9	AL	AL	A-MED5A	A-MED5A	AED9	AED9
A-MED5A	A-MED5A	A-MED5A	A-MED5A	A-MED5A	A-MED5A	A-MED5A	A-MED5A	AL	AL	A-MED5A	A-MED5A
CARD SUR	CARD SUR	CARD SUR	CARD SUR	CARD SUR	CARD SUR	CARD SUR	CARD SUR	CARD SUR	CARD SUR	AL	AL
AL	AL	A-STROKE	A-STROKE	A-STROKE	A-STROKE	A-STROKE	A-STROKE	A-STROKE	A-STROKE	A-STROKE	A-STROKE
A-SURG4B	A-SURG4B	A-SURG4B	A-SURG4B	A-SURG4B	A-SURG4B	A-SURG4B	A-SURG4B	A-SURG4B	A-SURG4B	A-SURG4B	A-SURG4B
AED10	AED10	AED10	AED10	AED10	AED10	A-ENDO/F	A-ENDO/F	AL	AL	AED10	AED10
A-SURG1B	A-SURG1B	AL	AL	A-SURG1B	A-SURG1B	A-SURG1B	A-SURG1B	A-SURG1B	A-SURG1B	A-SURG1B	A-SURG1B
VASC	VASC	VASC	VASC	VASC	VASC	VASC	VASC	VASC	VASC	AL	AL
A-TSC	A-TSC	A-TSC	A-TSC	A-TSC	A-TSC	A-TSC	A-TSC	A-TSC	A-TSC	AL	AL
MILDURA	MILDURA	A-ENT1	A-ENT1	A-ENT1	A-ENT1	A-ENT1	A-ENT1	A-ENT1	A-ENT1	A-ENT1	A-ENT1
AL	AL	MILDURA	MILDURA	MILDURA	MILDURA	MILDURA	MILDURA	MILDURA	MILDURA	MILDURA	MILDURA
A-ENDO/F	A-ENDO/F	A-ENDO/F	A-ENDO/F	A-ENDO/F	A-ENDO/F	AL	AL	A-ENDO/F	A-ENDO/F	A-ENDO/F	A-ENDO/F
ORTHO5	ORTHO5	ORTHO5	ORTHO5	AL	AL	ORTHO5	ORTHO5	ORTHO5	ORTHO5	ORTHO5	ORTHO5
A-WD10B	A-WD10B	A-WD10B	A-WD10B	A-WD10B	A-WD10B	A-WD10B	A-WD10B	AL	AL	A-WD10B	A-WD10B

APPENDIX 3 - SAMPLE UNIT ROSTER

Week 1	Unit	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Intern	GMA1	08:00-17:00	08:00-17:00	08:00-17:00	08:00-13:00	08:00-21:30	OFF	OFF
Intern	GMA2	08:00-17:00	08:00-17:00	08:00-13:00	08:00-17:00	08:00-17:00	OFF	OFF
Intern	GMB1	08:00-17:00	08:00-17:00	08:00-17:00	08:00-13:00	08:00-17:00	OFF	OFF
Intern	GMB2	08:00-17:00	08:00-13:00	08:00-17:00	08:00-17:00	08:00-13:00	08:00-21:30	OFF
Intern	GMC1	08:00-17:00	08:00-17:00	08:00-13:00	08:00-17:00	OFF	OFF	08:00-21:30
Intern	GMC2	08:00-17:00	08:00-13:00	08:00-17:00	08:00-17:00	08:00-17:00	OFF	OFF
Intern	GMR1	08:00-21:30	08:00-18:00	08:00-21:30	08:00-13:00	OFF	OFF	OFF
Intern	GMR2	OFF	OFF	OFF	08:00-21:30	08:00-18:00	08:00-15:00	08:00-15:00
HMO2	GMR3	08:00-17:00	08:00-17:00	08:00-13:00	08:00-17:00	08:00-17:00	OFF	OFF
			Resp1					

Week 2	Unit	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Intern	GMA1	08:00-17:00	08:00-13:00	08:00-17:00	08:00-17:00	08:00-17:00	OFF	OFF
Intern	GMA2	08:00-17:00	08:00-17:00	08:00-13:00	08:00-17:00	OFF	OFF	08:00-21:30
Intern	GMB1	08:00-17:00	08:00-17:00	08:00-17:00	08:00-13:00	08:00-21:30	OFF	OFF
Intern	GMB2	08:00-17:00	08:00-17:00	08:00-13:00	08:00-17:00	08:00-17:00	OFF	OFF
Intern	GMC1	08:00-17:00	08:00-17:00	08:00-17:00	08:00-13:00	08:00-17:00	OFF	OFF
Intern	GMC2	08:00-17:00	08:00-13:00	08:00-17:00	08:00-17:00	08:00-13:00	08:00-21:30	OFF
Intern	GMR1	OFF	OFF	OFF	08:00-21:30	08:00-18:00	08:00-15:00	08:00-15:00
Intern	GMR2	08:00-21:30	08:00-18:00	08:00-21:30	08:00-13:00	OFF	OFF	OFF
HMO2	GMR3	08:00-17:00	08:00-17:00	08:00-13:00	08:00-17:00	08:00-17:00	OFF	OFF
			Cardiology					

Week 3	Unit	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Intern	GMA1	08:00-17:00	08:00-13:00	08:00-17:00	08:00-17:00	08:00-13:00	08:00-21:30	OFF
Intern	GMA2	08:00-17:00	08:00-17:00	08:00-17:00	08:00-13:00	08:00-17:00	OFF	OFF
Intern	GMB1	08:00-17:00	08:00-13:00	08:00-17:00	08:00-17:00	08:00-17:00	OFF	OFF
Intern	GMB2	08:00-17:00	08:00-17:00	08:00-13:00	08:00-17:00	OFF	OFF	08:00-21:30
Intern	GMC1	08:00-17:00	08:00-17:00	08:00-17:00	08:00-13:00	08:00-21:30	OFF	OFF
Intern	GMC2	08:00-17:00	08:00-17:00	08:00-13:00	08:00-17:00	08:00-17:00	OFF	OFF
Intern	GMR1	08:00-21:30	08:00-18:00	08:00-21:30	08:00-13:00	OFF	OFF	OFF
Intern	GMR2	OFF	OFF	OFF	08:00-21:30	08:00-18:00	08:00-15:00	08:00-15:00
HMO2	GMR3	08:00-17:00	08:00-17:00	08:00-13:00	08:00-17:00	08:00-17:00	OFF	OFF
			Resp2					

Week 4	Unit	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Intern	GMA1	08:00-17:00	08:00-17:00	08:00-13:00	08:00-17:00	08:00-17:00	OFF	OFF
Intern	GMA2	08:00-17:00	08:00-17:00	08:00-17:00	08:00-13:00	08:00-21:30	OFF	OFF
Intern	GMB1	08:00-17:00	08:00-13:00	08:00-17:00	08:00-17:00	08:00-13:00	08:00-21:30	OFF
Intern	GMB2	08:00-17:00	08:00-17:00	08:00-17:00	08:00-13:00	08:00-17:00	OFF	OFF
Intern	GMC1	08:00-17:00	08:00-13:00	08:00-17:00	08:00-17:00	08:00-17:00	OFF	OFF
Intern	GMC2	08:00-17:00	08:00-17:00	08:00-13:00	08:00-17:00	OFF	OFF	08:00-21:30
Intern	GMR1	OFF	OFF	OFF	08:00-21:30	08:00-18:00	08:00-15:00	08:00-15:00
Intern	GMR2	08:00-21:30	08:00-18:00	08:00-21:30	08:00-13:00	OFF	OFF	OFF
HMO2	GMR3	08:00-17:00	08:00-17:00	08:00-13:00	08:00-17:00	08:00-17:00	OFF	OFF
			Stroke					

Week 5	Unit	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Intern	GMA1	08:00-17:00	08:00-17:00	08:00-13:00	08:00-17:00	OFF	OFF	08:00-21:30
Intern	GMA2	08:00-17:00	08:00-13:00	08:00-17:00	08:00-17:00	08:00-17:00	OFF	OFF
Intern	GMB1	08:00-17:00	08:00-17:00	08:00-13:00	08:00-17:00	08:00-17:00	OFF	OFF
Intern	GMB2	08:00-17:00	08:00-17:00	08:00-17:00	08:00-13:00	08:00-21:30	OFF	OFF
Intern	GMC1	08:00-17:00	08:00-13:00	08:00-17:00	08:00-17:00	08:00-13:00	08:00-21:30	OFF
Intern	GMC2	08:00-17:00	08:00-17:00	08:00-17:00	08:00-13:00	08:00-17:00	OFF	OFF
Intern	GMR1	08:00-21:30	08:00-18:00	08:00-21:30	08:00-13:00	OFF	OFF	OFF
Intern	GMR2	OFF	OFF	OFF	08:00-21:30	08:00-18:00	08:00-15:00	08:00-15:00
HMO2	GMR3	08:00-17:00	08:00-17:00	08:00-13:00	08:00-17:00	08:00-17:00	OFF	OFF
			Resp1					

Week 6	Unit	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Intern	GMA1	08:00-17:00	08:00-17:00	08:00-17:00	08:00-13:00	08:00-17:00	OFF	OFF
Intern	GMA2	08:00-17:00	08:00-13:00	08:00-17:00	08:00-17:00	08:00-13:00	08:00-21:30	OFF
Intern	GMB1	08:00-17:00	08:00-17:00	08:00-13:00	08:00-17:00	OFF	OFF	08:00-21:30
Intern	GMB2	08:00-17:00	08:00-13:00	08:00-17:00	08:00-17:00	08:00-17:00	OFF	OFF
Intern	GMC1	08:00-17:00	08:00-17:00	08:00-13:00	08:00-17:00	08:00-17:00	OFF	OFF
Intern	GMC2	08:00-17:00	08:00-17:00	08:00-17:00	08:00-13:00	08:00-21:30	OFF	OFF
Intern	GMR1	OFF	OFF	OFF	08:00-21:30	08:00-18:00	08:00-15:00	08:00-15:00
Intern	GMR2	08:00-21:30	08:00-18:00	08:00-21:30	08:00-13:00	OFF	OFF	OFF
HMO2	GMR3	08:00-17:00	08:00-17:00	08:00-13:00	08:00-17:00	08:00-17:00	OFF	OFF
			Cardiology					

Week 7	Unit	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Intern	GMA1	08:00-17:00	08:00-17:00	08:00-17:00	08:00-13:00	08:00-21:30	OFF	OFF
Intern	GMA2	08:00-17:00	08:00-17:00	08:00-13:00	08:00-17:00	08:00-17:00	OFF	OFF
Intern	GMB1	08:00-17:00	08:00-17:00	08:00-17:00	08:00-13:00	08:00-17:00	OFF	OFF
Intern	GMB2	08:00-17:00	08:00-13:00	08:00-17:00	08:00-17:00	08:00-13:00	08:00-21:30	OFF
Intern	GMC1	08:00-17:00	08:00-17:00	08:00-13:00	08:00-17:00	OFF	OFF	08:00-21:30
Intern	GMC2	08:00-17:00	08:00-13:00	08:00-17:00	08:00-17:00	08:00-17:00	OFF	OFF
Intern	GMR1	08:00-21:30	08:00-18:00	08:00-21:30	08:00-13:00	OFF	OFF	OFF
Intern	GMR2	OFF	OFF	OFF	08:00-21:30	08:00-18:00	08:00-15:00	08:00-15:00
HMO2	GMR3	08:00-17:00	08:00-17:00	08:00-13:00	08:00-17:00	08:00-17:00	OFF	OFF
			Resp2					

Week 8	Unit	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Intern	GMA1	08:00-17:00	08:00-13:00	08:00-17:00	08:00-17:00	08:00-17:00	OFF	OFF
Intern	GMA2	08:00-17:00	08:00-17:00	08:00-13:00	08:00-17:00	OFF	OFF	08:00-21:30
Intern	GMB1	08:00-17:00	08:00-17:00	08:00-17:00	08:00-13:00	08:00-21:30	OFF	OFF
Intern	GMB2	08:00-17:00	08:00-17:00	08:00-13:00	08:00-17:00	08:00-17:00	OFF	OFF
Intern	GMC1	08:00-17:00	08:00-17:00	08:00-17:00	08:00-13:00	08:00-17:00	OFF	OFF
Intern	GMC2	08:00-17:00	08:00-13:00	08:00-17:00	08:00-17:00	08:00-13:00	08:00-21:30	OFF
Intern	GMR1	OFF	OFF	OFF	08:00-21:30	08:00-18:00	08:00-15:00	08:00-15:00
Intern	GMR2	08:00-21:30	08:00-18:00	08:00-21:30	08:00-13:00	OFF	OFF	OFF
HMO2	GMR3	08:00-17:00	08:00-17:00	08:00-13:00	08:00-17:00	08:00-17:00	OFF	OFF
			Stroke					

Week 9	Unit	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Intern	GMA1	08:00-17:00	08:00-13:00	08:00-17:00	08:00-17:00	08:00-13:00	08:00-21:30	OFF
Intern	GMA2	08:00-17:00	08:00-17:00	08:00-17:00	08:00-13:00	08:00-17:00	OFF	OFF
Intern	GMB1	08:00-17:00	08:00-13:00	08:00-17:00	08:00-17:00	08:00-17:00	OFF	OFF
Intern	GMB2	08:00-17:00	08:00-17:00	08:00-13:00	08:00-17:00	OFF	OFF	08:00-21:30
Intern	GMC1	08:00-17:00	08:00-17:00	08:00-17:00	08:00-13:00	08:00-21:30	OFF	OFF
Intern	GMC2	08:00-17:00	08:00-17:00	08:00-13:00	08:00-17:00	08:00-17:00	OFF	OFF
Intern	GMR1	08:00-21:30	08:00-18:00	08:00-21:30	08:00-13:00	OFF	OFF	OFF
Intern	GMR2	OFF	OFF	OFF	08:00-21:30	08:00-18:00	08:00-15:00	08:00-15:00
HMO2	GMR3	08:00-17:00	08:00-17:00	08:00-13:00	08:00-17:00	08:00-17:00	OFF	OFF
			Resp1					

Week 10	Unit	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Intern	GMA1	08:00-17:00	08:00-17:00	08:00-13:00	08:00-17:00	08:00-17:00	OFF	OFF
Intern	GMA2	08:00-17:00	08:00-17:00	08:00-17:00	08:00-13:00	08:00-21:30	OFF	OFF
Intern	GMB1	08:00-17:00	08:00-13:00	08:00-17:00	08:00-17:00	08:00-13:00	08:00-21:30	OFF
Intern	GMB2	08:00-17:00	08:00-17:00	08:00-17:00	08:00-13:00	08:00-17:00	OFF	OFF
Intern	GMC1	08:00-17:00	08:00-13:00	08:00-17:00	08:00-17:00	08:00-17:00	OFF	OFF
Intern	GMC2	08:00-17:00	08:00-17:00	08:00-13:00	08:00-17:00	OFF	OFF	08:00-21:30
Intern	GMR1	OFF	OFF	OFF	08:00-21:30	08:00-18:00	08:00-15:00	08:00-15:00
Intern	GMR2	08:00-21:30	08:00-18:00	08:00-21:30	08:00-13:00	OFF	OFF	OFF
HMO2	GMR3	08:00-17:00	08:00-17:00	08:00-13:00	08:00-17:00	08:00-17:00	OFF	OFF
			Cardiology					

APPENDIX 4 - SAMPLE DUTY ROSTER

STANDARD WEEKLY HOURS - DUTY ROSTER

ENDOCRINOLOGY/DIABETES INTERN

Pager number: 4511 **Unit Head: [insert name]** **Date authorised:** XX/XX/XXXX

	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY
Morning	**8:00am - start** Ward round and ward work - Endocrinology	**8:00am - start** Ward round and ward work – Endocrinology 12:00-12:30pm – handover to resident	**8:00am - start** Ward round and ward work – Endocrinology 12-12:30pm – handover to HMO 3	**8:00am - start** Ward round and ward work – Rheumatology	**8:00am - start** Ward round and ward work - Rheumatology
Afternoon	Ward work/referrals 5:00-5:30pm – handover to evening resident **5:30pm - finish**	Intern teaching 12:30-1:30pm **1:30pm - finish**	Grand round 12:30-1:30pm Ward work/referrals 5:00-5:30pm – handover to evening resident **5:30pm - finish**	**1:30pm – finish**	12:30-1:30pm – Endo Unit meeting Ward work/referrals 5:00-5:30pm – handover to evening resident **5:30pm - finish**
Evening					
Hours	9.5	5.5	9.5	5.5	9.5

Total rostered hours: 39.5 hours (including 1.5 hours rostered overtime)

Please Note:

Hours fixed as above unless prior arrangement with Medical Workforce Unit

Interns must attend mandatory Education Session, every Tuesday, 12:30pm-1:30pm at Medical Education Precinct, Level 4 Austin Tower (Room 4.6, check MEU on intranet for changes). Pagers should be handed to registrar or to medical education unit secretary.

Out of hours and on call requirement:

- It is the responsibility of all staff to check rosters for out-of-hours requirements
- Weekend and after hours roster as per separate duty roster
- HMO is required to participate in the on-call Sick Leave roster to ensure that appropriate cover is available for sick leave

Afternoon off : handover to HMO 3

Please note: hours worked outside standard daily hours and evening/weekend cover roster, are to be claimed on an Extended Duty Notification Form (pink) and signed by the appropriate Unit Head or Consultant

Any and all roster swaps must be notified to and approved by the Medical Workforce Unit

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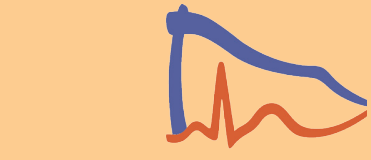

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