The Curriculum Prototype: *a medical education perspective*

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Greg Spencer, CfT Chair, NFPT member

RANZCP Congress

May 2026

Acknowledgement of country

- We respectfully acknowledge the Traditional custodians of the land on which we meet and pay respect to elders past, present and future
- We extend respect to the Aboriginal and Torres Strait Island People here today

Acknowledgment of lived experience

We recognise those with lived and living experience of mental health challenges and distress, their chosen families, whānau, carers and kin. Their contributions, diverse perspectives, insight, and courage keep us grounded and inclusive, and focused on humanity, healing, and hope.

We strive to work in genuine partnership in all that we do, honouring their voices by centring their experiences and expertise.

Thank you to the Taskforce

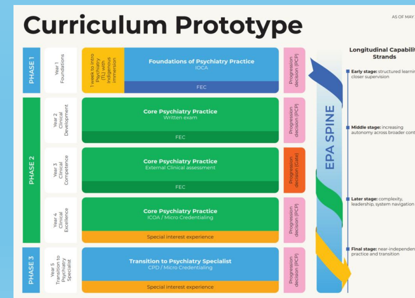
- Georgia Ramsden
- Elise Witter
- Simon Stafrace
- Lisa Lampe
- Brett Emmerson
- Wayne De Beer
- Jenepher Martin
- Greg Spencer
- Anita Hill
- Anthony Llewellyn
- Kane Vellar
- Damian Ferrie
- Diana Kopua
- Kathleen Ryan
- Rebecca Egan
- Alex Mealey
- Alisha David
- Ruby Parker
- Nicole Wheals

An ambitious project at an early stage.

Education considerations

Prototype Design

Next steps

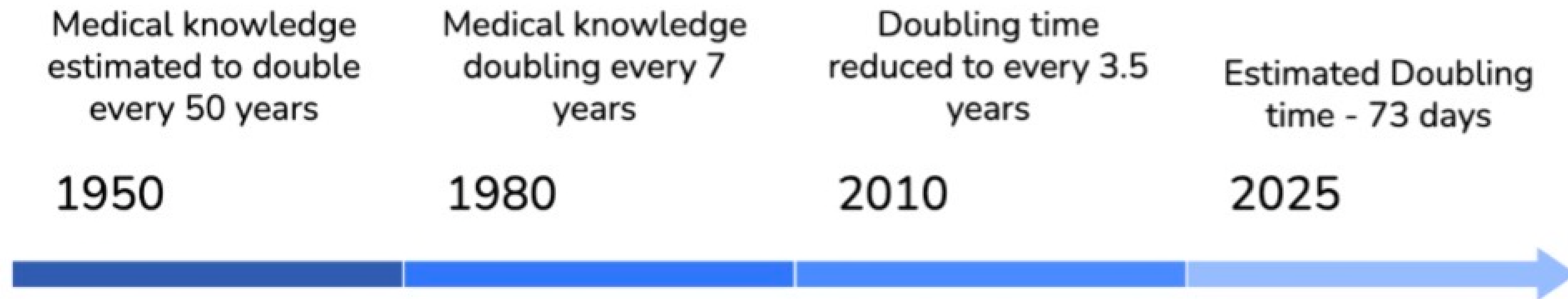


The purposes of a curriculum (2026)

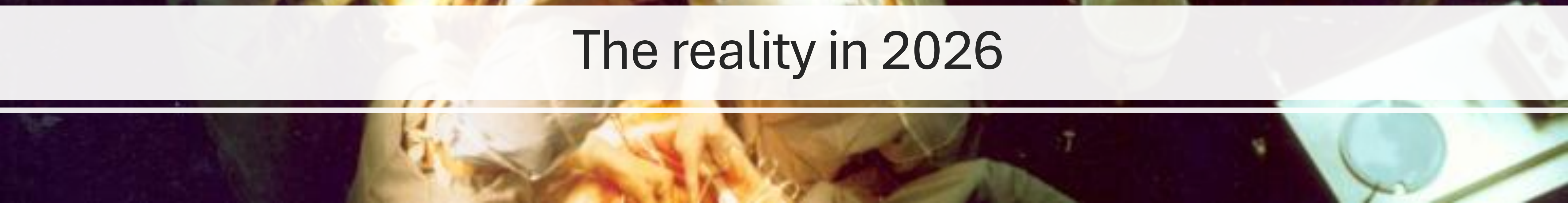
1. To shape best quality and evidence training experiences for the trainee
2. To meet population demand in terms of workforce capability
3. To define professional identity and ensure future readiness

Curriculum change in Medical Education (Spencer, 2006)

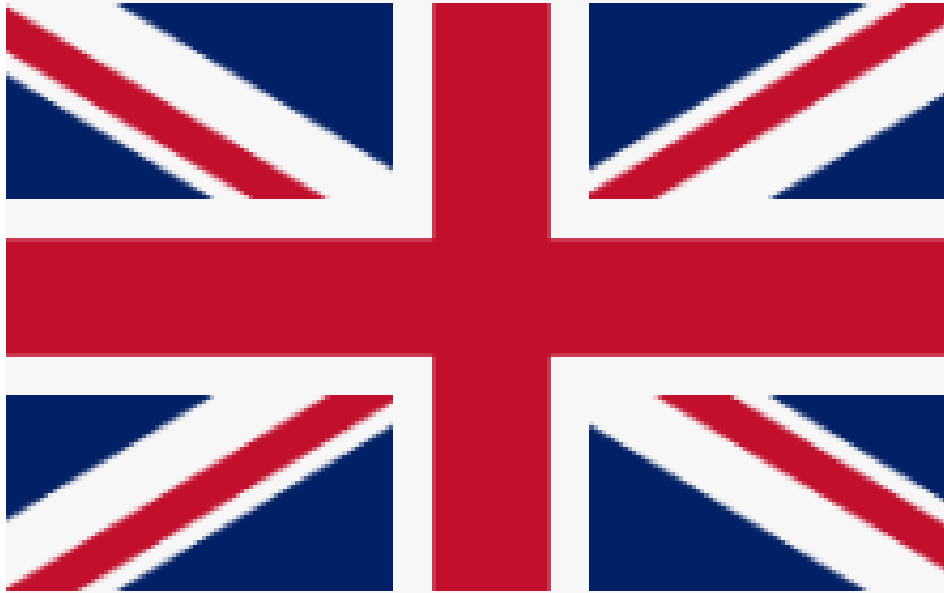
The Knowledge challenge



The reality in 2026



A tale of two curricula



Modernising Medical Careers

Competency by Design

Learning from past failures MMC

- Lack of a shared vision
- Rushed implementation without Pilots led to system failure
- Over centralisation eroded flexibility and judgement
- Late engagement led to loss of legitimacy
- Poor workforce modelling created bottle necks
- Exposed limitations of CBME
- Fragmented governance made accountability impossible

Competency by Design: a Safe Comparator

- Clear and Explicit Educational Philosophy
- Incremental phased roll out
- Strong Professional ownership
- Realistic handling of professional burden
- Protected transitions
- Governance with ownership

Goals of the TF:
A concept design

- Through consultation to firm the vision and principles for a new Fellowship
- Develop a structure and that will meet the vision and allow innovation
- A product that manages the trade offs such that have a Fellowship that has educational validity, workforce viability and stakeholder credibility

Education considerations

Prototype Design

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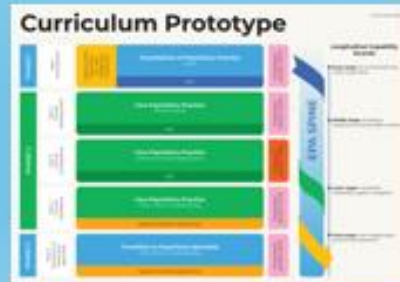
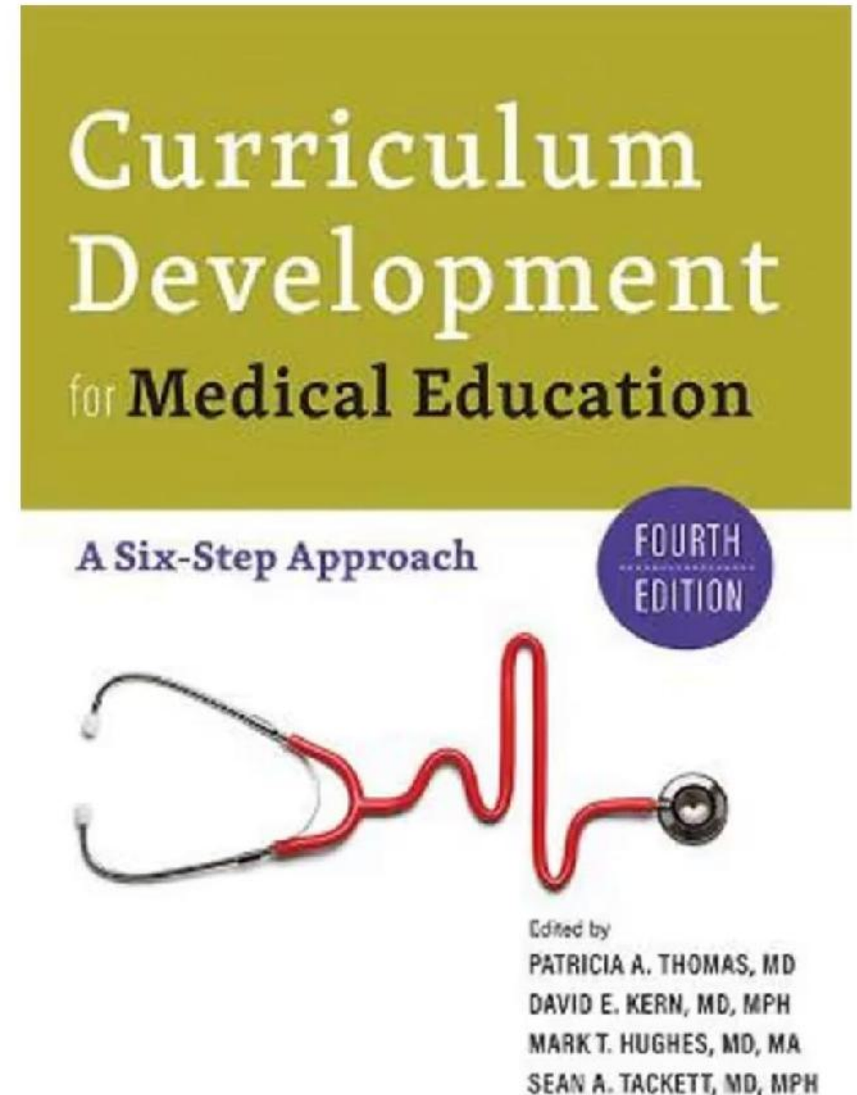


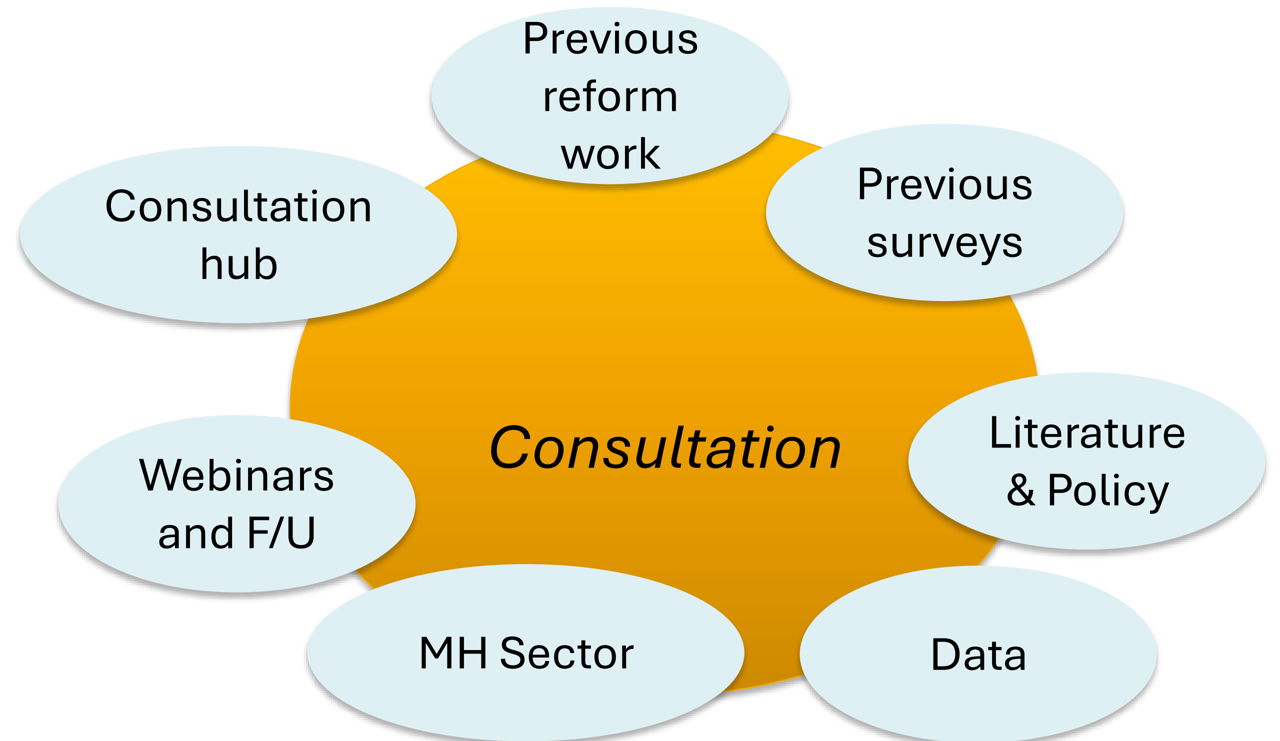
Developing the 2030 curriculum (Kern)

1) Problem identification and general needs assessment
2) Targeted needs assessment
3) Goals and objectives
4) Educational strategies
5) Implementation
6) Evaluation



6 step Curriculum change model (Kern)

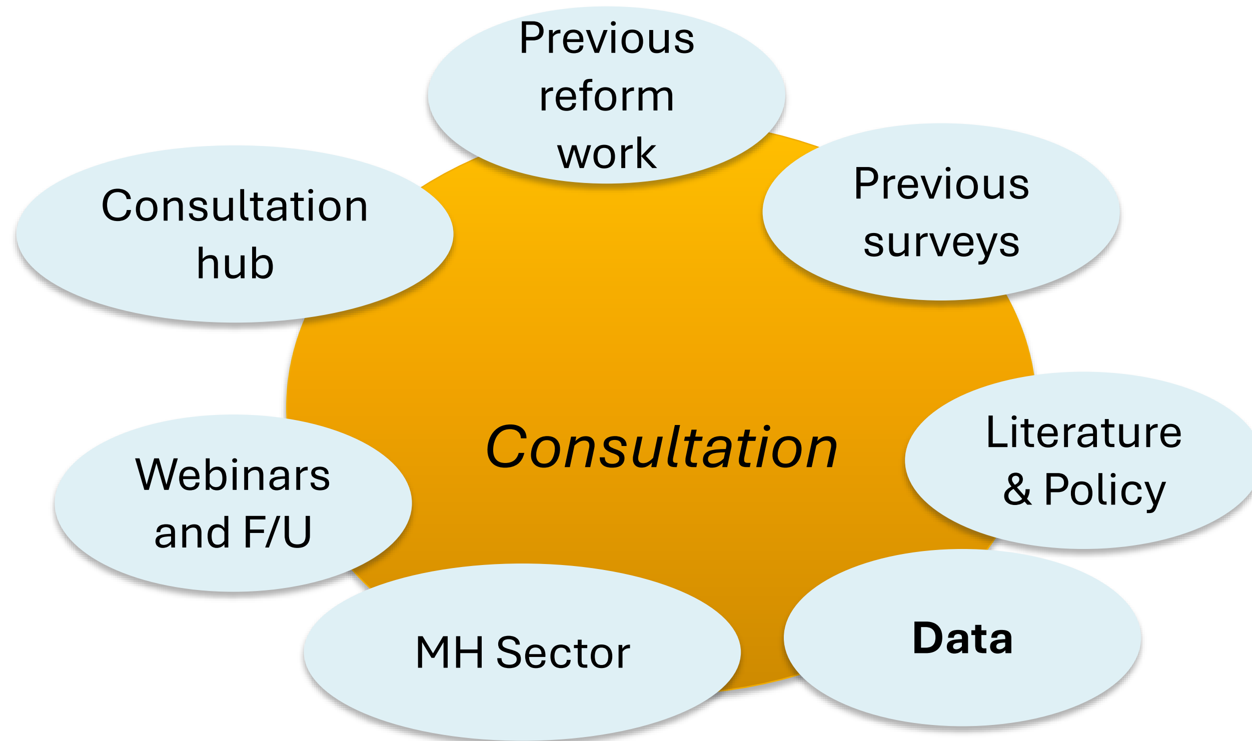
1) Problem identification and general needs assessment
2) Targeted needs assessment
3) Goals and objectives
4) Educational strategies
5) Implementation
6) Evaluation

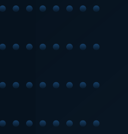


The Problems

- Insufficient production
  - Bottle necks
- Public standard assurance
- Curriculum gaps
  - Leadership training, lived experience, cultural competence and WH
- Lack of coordinated evaluation, learning resources and evaluation
- Burdensome and overcomplicated assessments with curriculum drift
- Future orientation, adaptability to service models and digital vulnerability

QUESTION 1:
WHO AND WHAT ELSE HAVE WE MISSED?





Vision

The Fellowship Program grows* patient-centred, capable, compassionate and culturally safe psychiatrists for Australia and Aotearoa New Zealand who can meet current and future mental health needs with confidence, accountability and strong community connection.

6 step Curriculum change model (Kern)

1) Problem identification and general needs assessment
2) Targeted needs assessment
3) Goals and objectives
4) Educational strategies
5) Implementation
6) Evaluation

AS OF MAY 2026

Our Identity

· Reflective, scholarly, and adaptive
· Advocate for mental health and equitable care

· Collaborative partner in care
· Works with and for communities
· Navigates complexity, uncertainty, and systems
· Leader and steward of quality care

· Medical expert in mental illness
· Culturally safe and responsive
· Therapeutic and skilled communicator

The Psychiatry Specialist

QUESTION 2
WHAT IS MISSING WITH THE VISION OR IDENTITY

Vision

The Fellowship Program grows* patient-centred, capable, compassionate and culturally safe psychiatrists for Australia and Aotearoa New Zealand who can meet current and future mental health needs with confidence, accountability and strong community connection.

6 step Curriculum change model (Kern)

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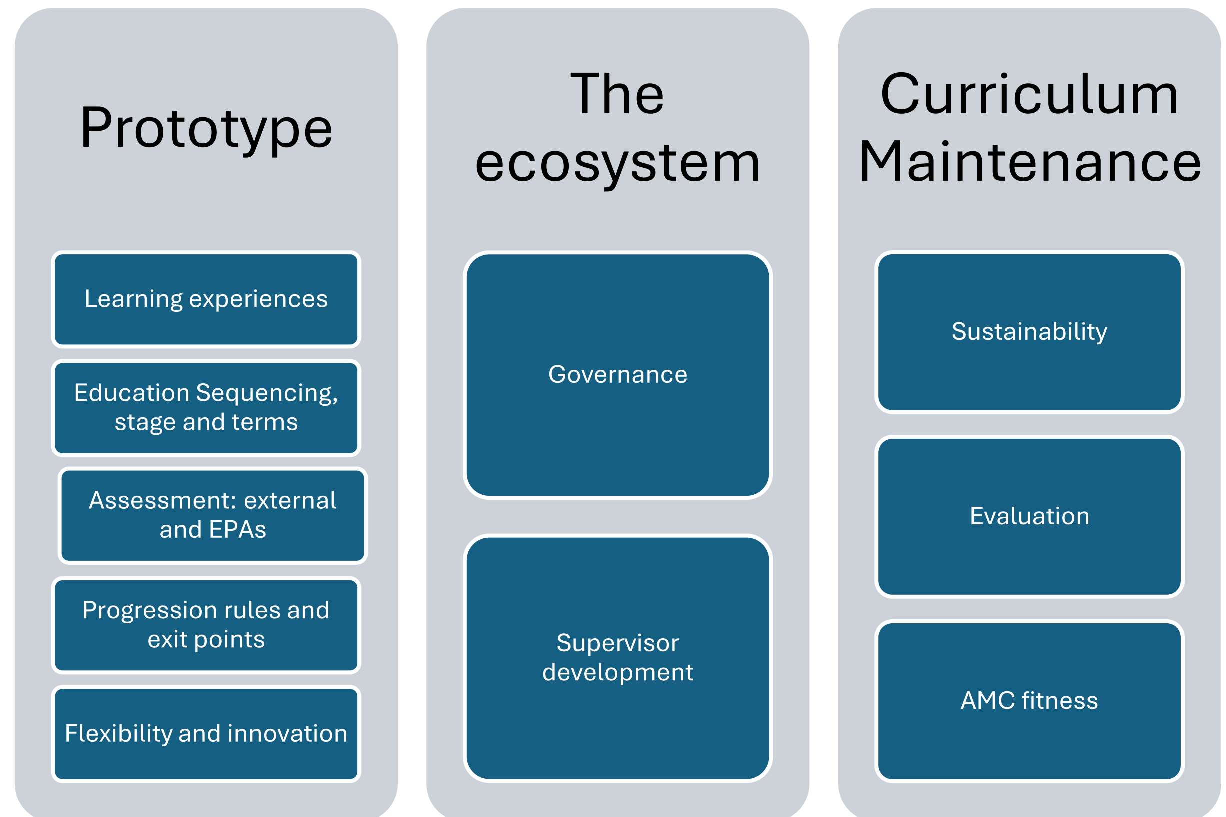
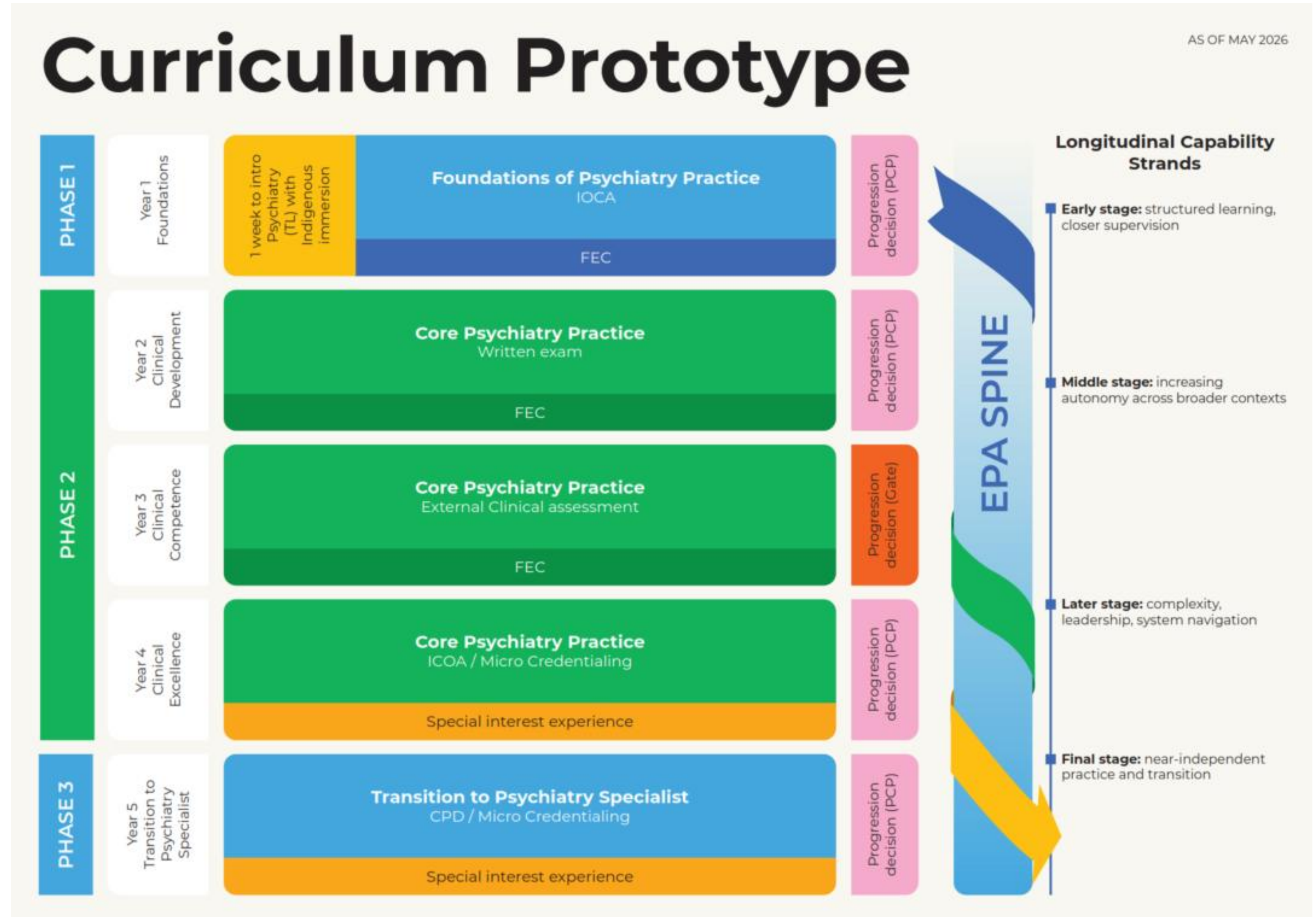


Proposals under consideration

Five year hybrid outcome focussed model

3 Phases

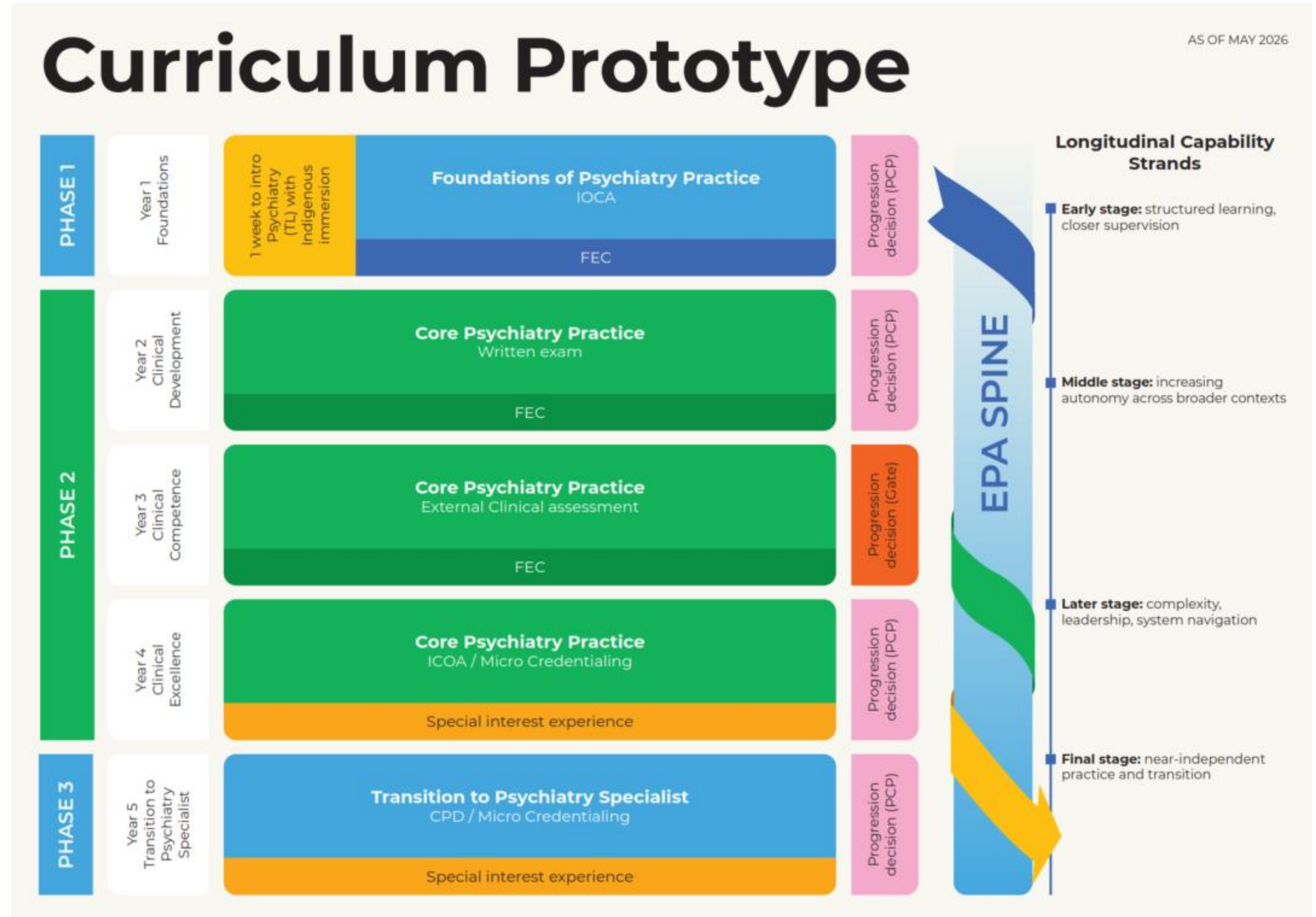
6-month terms



Proposals under consideration

Focus on transitions

- year 1 becoming a Registrar
- Year 5 becoming a SMO



Assessment Overview

Single integrated assessment system

Workbased Assessment

- Formative workbased assessments (AFL)[1]
- EPA entrustment decision by clinical supervisor
- Mulitple sources & longitudinal

External Written Assessment

- Core knowledge
- Clinical reasoning
- Evidence application
- Summative External

External Clinical Assessment

- Blue printed and mapped (AOL)[2]
- Assures standards
- Summative External and Front loaded
- Maximum number attempts

Reflective Portfolio

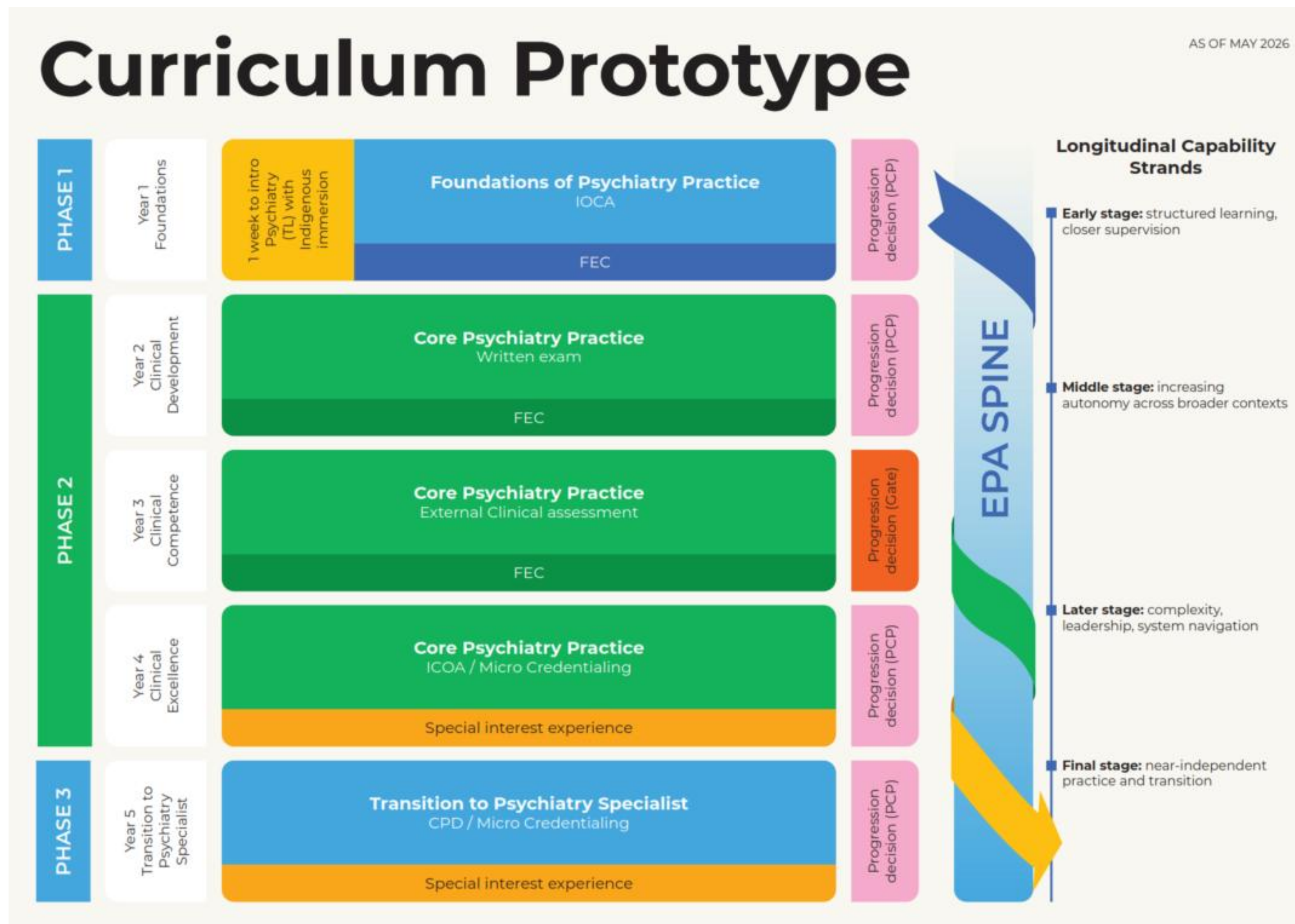
- Evidence of attainment and capabilities
- Transformative threshold learning linked to EPAs[3]
- Overseen by an education mentor

1 Assessment for learning
2 Assessment of learning
3 Entrustable Professional Activity
PCP exist to support remediation as well as determine progression

Proposals under consideration

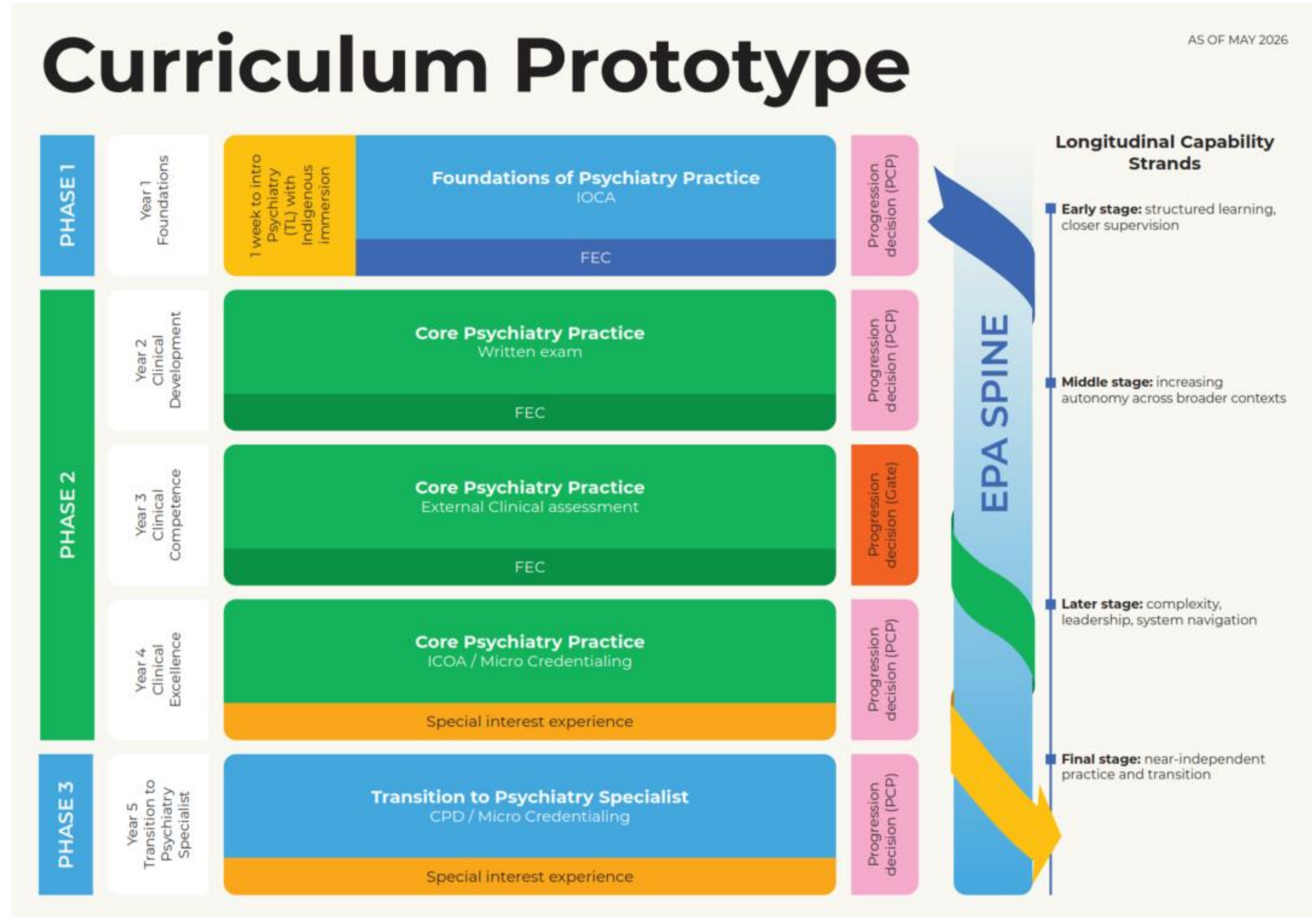
Introduction of an external clinical examination in year 3

Retention of written assessments year 2



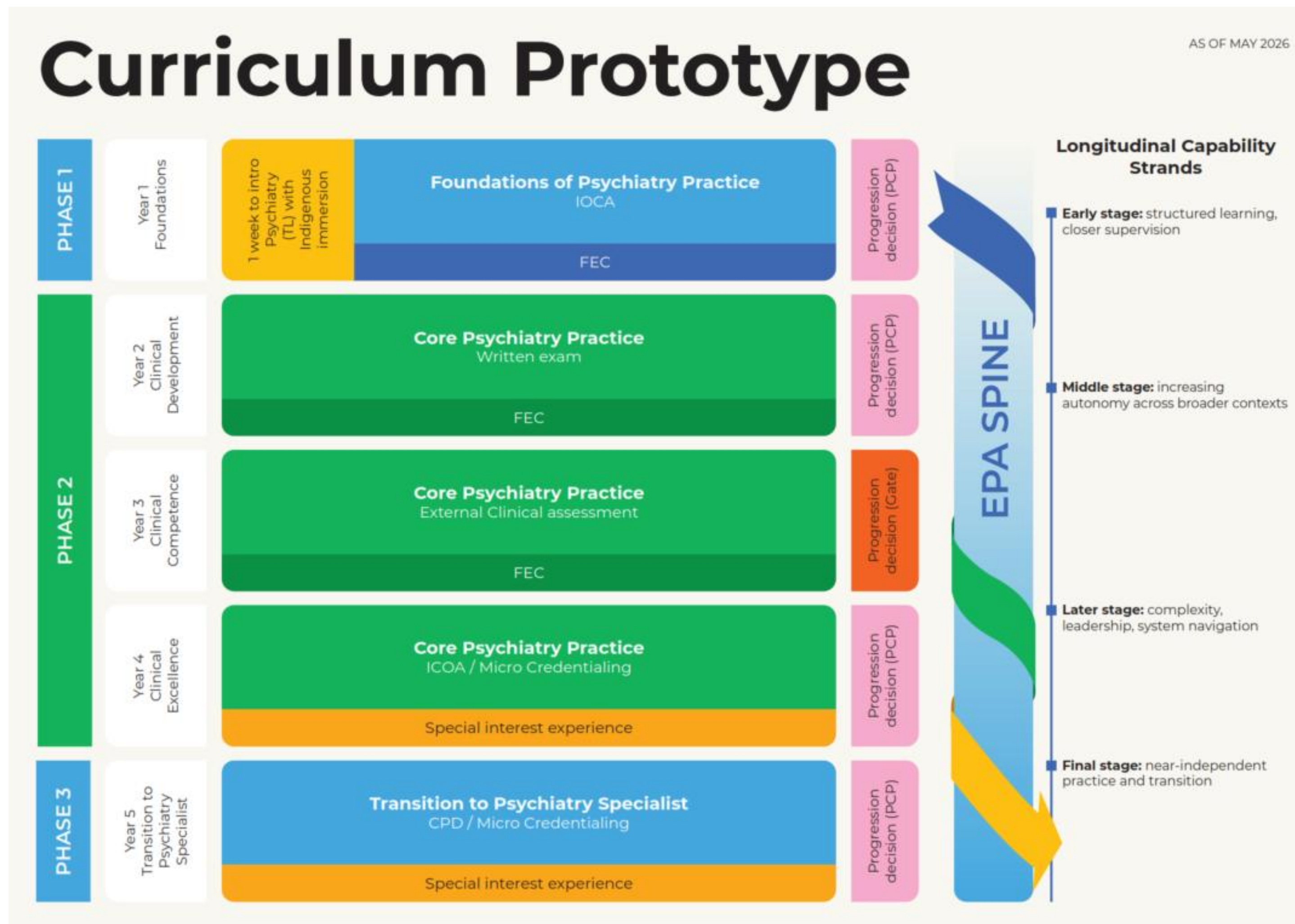
Proposals under consideration

- Gateway progression Yr 3 to 4 and PCP decisions
- limited attempts
- Exit point with qualification
- Progression panels



Proposals under consideration

- EPA spine to act as the learning spine in the workplace



Draft EPA suite

Concurrent 8L: Training and education

Wednesday, May 6, 2026

1:30pm - 3:00pm

Meeting Room 219, MCEC

Add to my program

Title

Advancing the 2012 RANZCP Fellowship: Integrating curriculum, assessment, and supervision reform [CAPE]

EPA 1 – Clinical assessment
EPA 2 – Formulation
EPA 3 – Developing a person-centred acute care plan
EPA 4 – Developing a person-centred recovery plan
EPA 5 – Developing a person-centred risk management plan
EPA 6 – Developing a culturally responsive plan
EPA 7 – Written communication
EPA 8 – Engaging with carers
EPA 9 – Neurostimulation
EPA 10 – Capacity and the law
EPA 11 – Comorbidity
EPA 12 – Quality improvement and patient safety
EPA 13 – Psychotherapy
EPA 14 – Pharmacology
EPA 15 – Teaching and feedback
EPA 16 – Teamwork

Proposals under consideration

- Capability strand to allow transformative learning on future capabilities
- Supported by Formal education course years 1 to 3

Curriculum Prototype

AS OF MAY 2026

PHASE 1

Year 1 Foundations

1 week to intro Psychiatry (TL) with Indigenous immersion

Foundations of Psychiatry Practice
IOCA
FEC

Progression decision (PCP)

PHASE 2

Year 2 Clinical Development

Core Psychiatry Practice
Written exam
FEC

Progression decision (PCP)

Year 3 Clinical Competence

Core Psychiatry Practice
External Clinical assessment
FEC

Progression decision (Gate)

Year 4 Clinical Excellence

Core Psychiatry Practice
ICOA / Micro Credentialing
Special interest experience

Progression decision (PCP)

PHASE 3

Year 5 Transition to Psychiatry Specialist

Transition to Psychiatry Specialist
CPD / Micro Credentialing
Special interest experience

Progression decision (PCP)

EPA SPINE

Longitudinal Capability Strands

Early stage: structured learning, closer supervision

Middle stage: increasing autonomy across broader contexts

Later stage: complexity, leadership, system navigation

Final stage: near-independent practice and transition

Longitudinal Capability Strands Across the Program

Personalised Reflective Portfolio

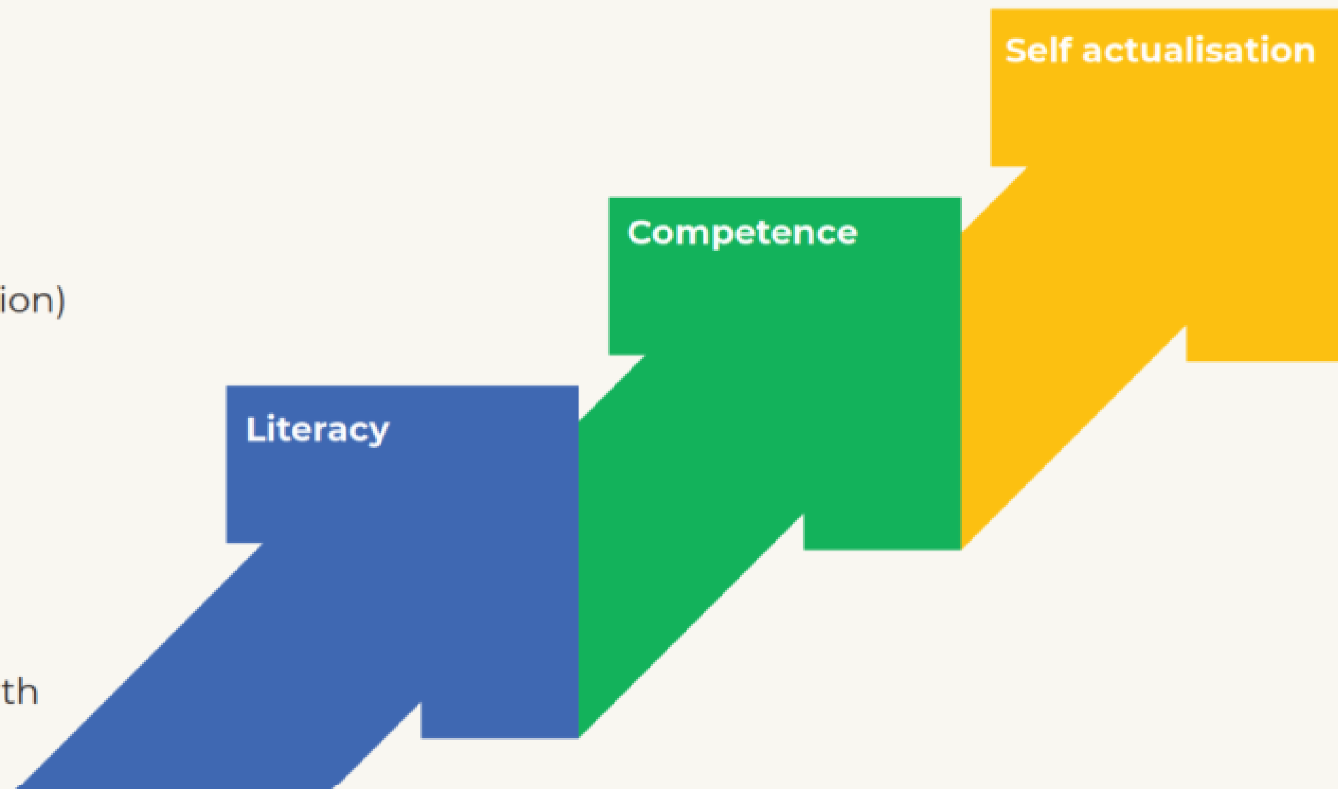
Clinical & Therapeutic
- Biological
- Psychotherapeutic

Relational & Cultural
- Lived experience
- Indigenous
- Collaboration

Professional & Systems
- Leadership & management
- Scholarship (research, QI, education)
- AI & Telehealth

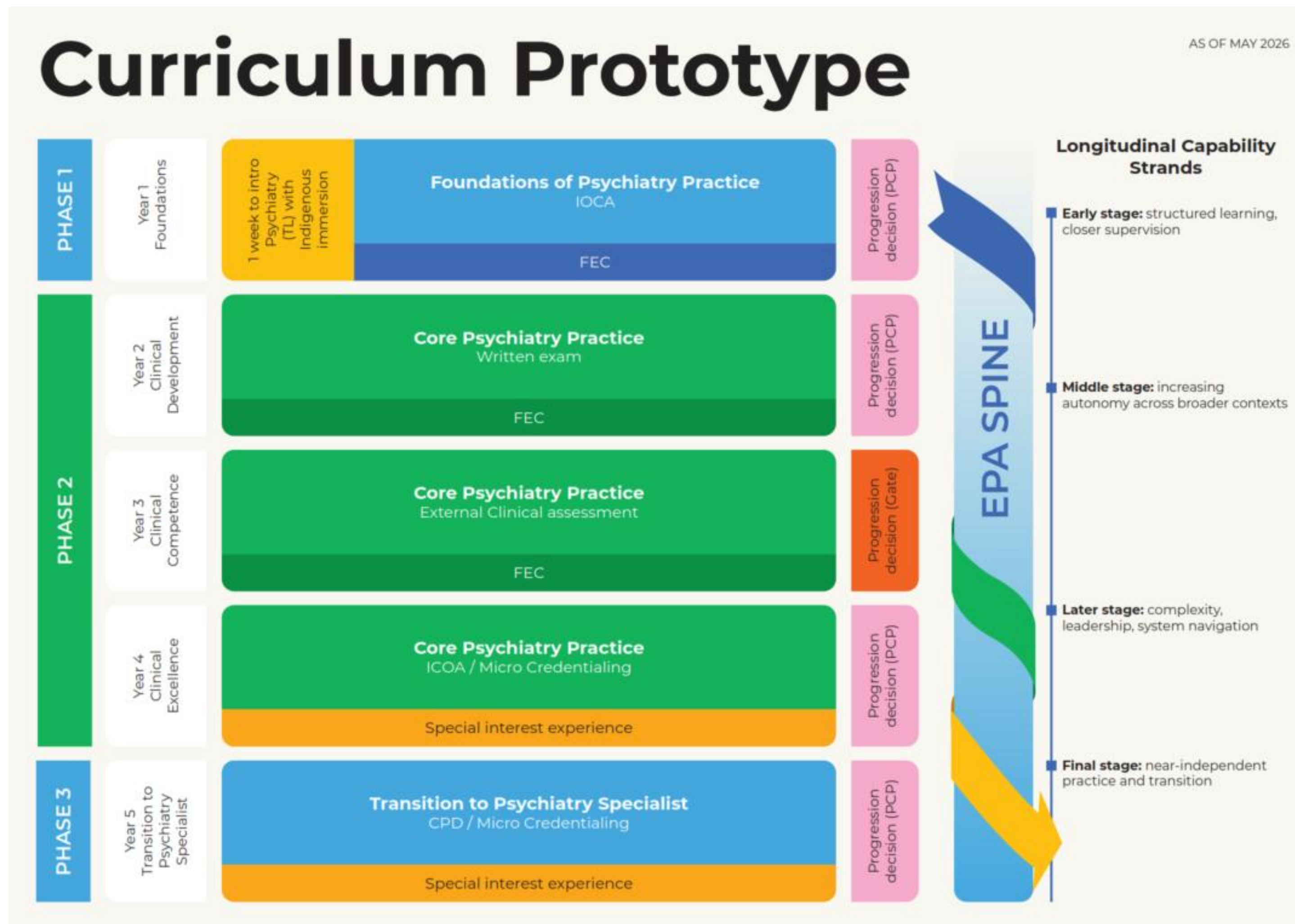
Personal development
- Wellbeing
- Reflective practice & supervision

These strands are developed longitudinally across all training experiences and are integrated with EPAs and assessment



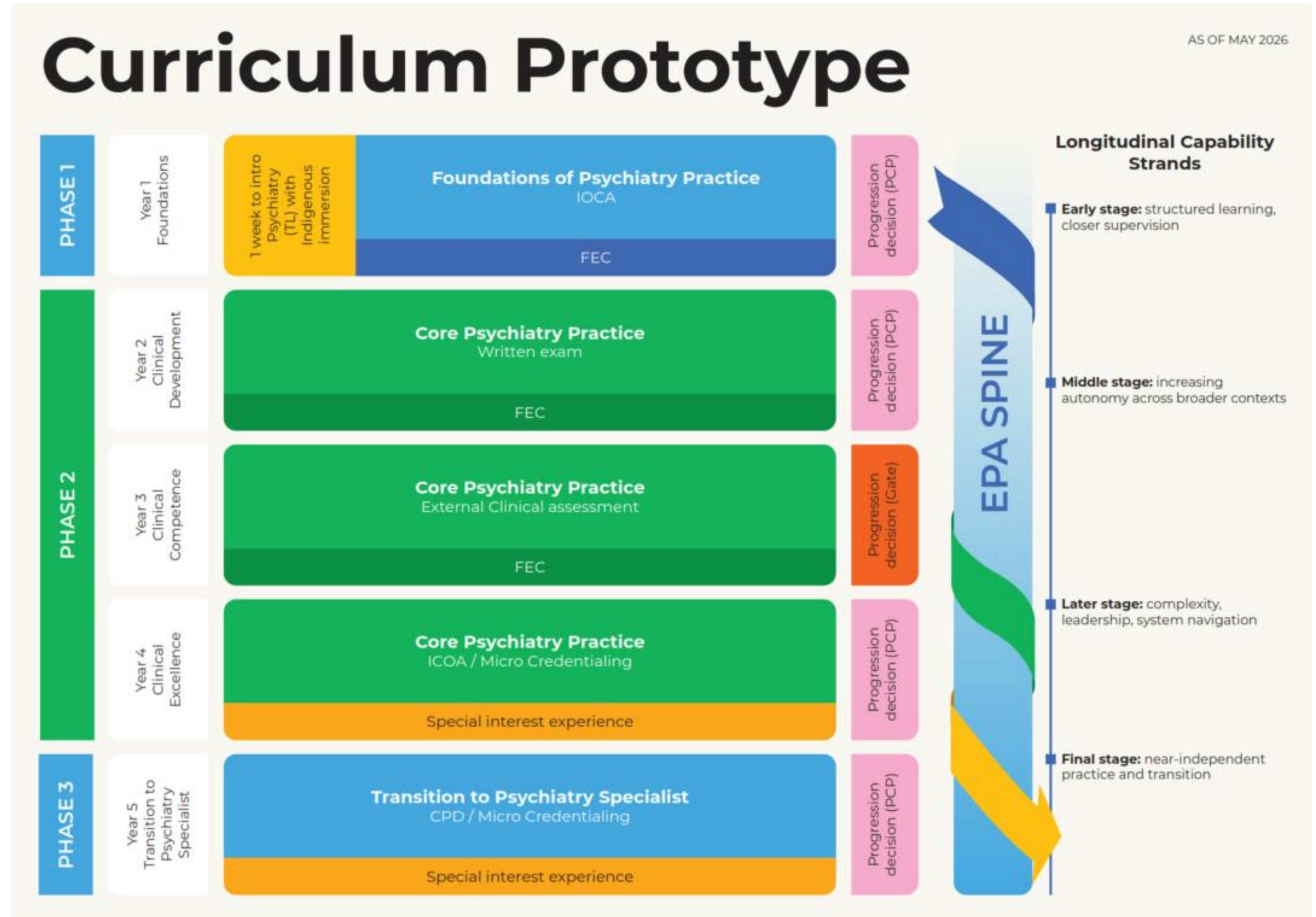
Proposals under consideration

- Requirement for Clinical supervisor and a longitudinal 5 year Education mentor



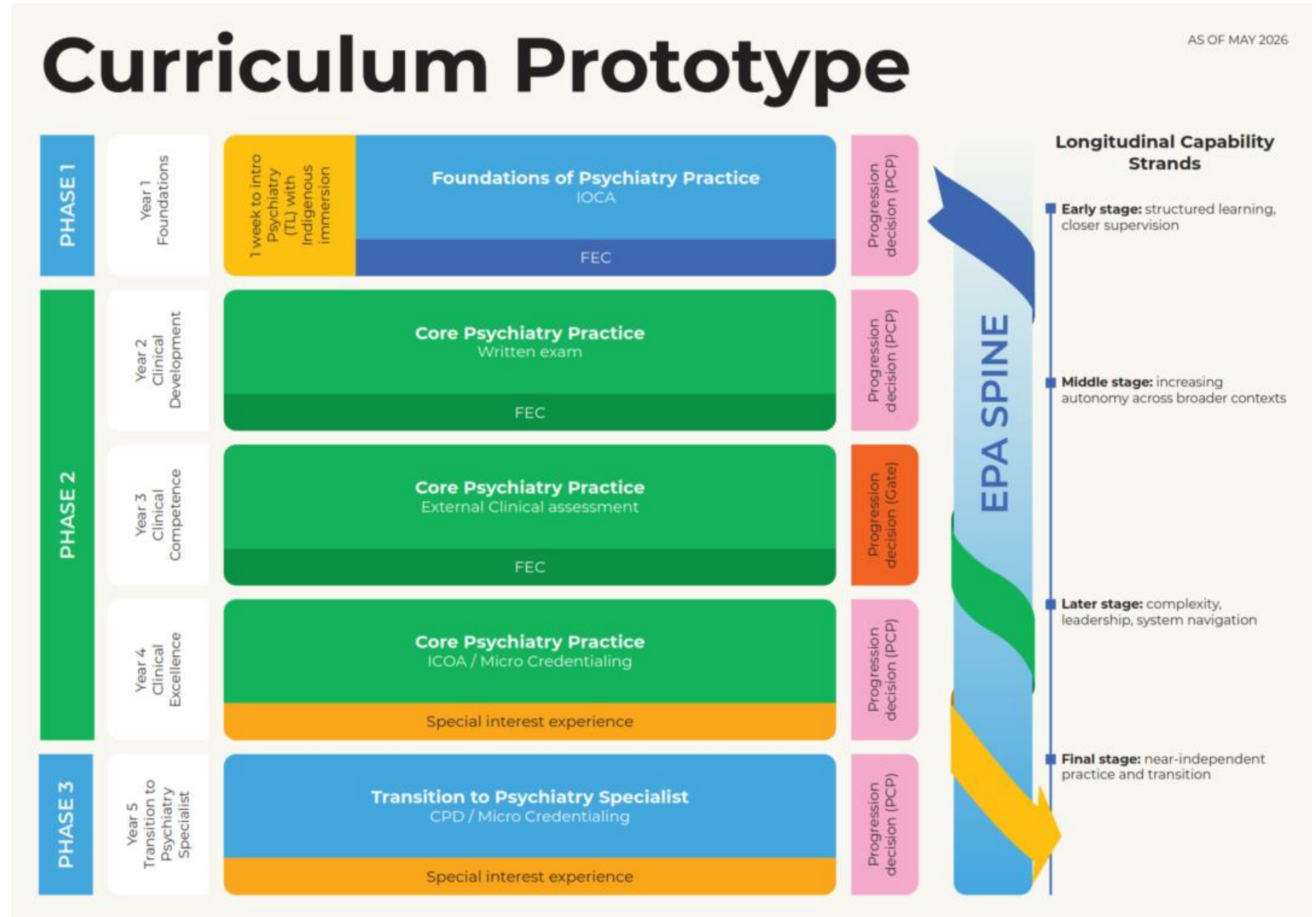
Proposals under consideration

- Final two year undertaken exam free
- Greater flexibility with special interest sessions in years 4 and 5
- Start of CPD program final year



Proposals under consideration

- Mandatory experiences rather than terms to allow discipline capabilities to be achieved, if necessary, on the basis of competencies rather than placements
- Principle of allowing greater flexibility and workforce adaptability

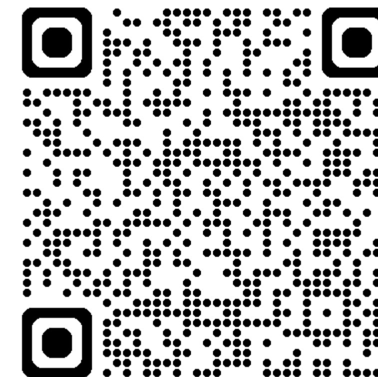


★ Core rotations

Minimum time required *Maximum time allowed*

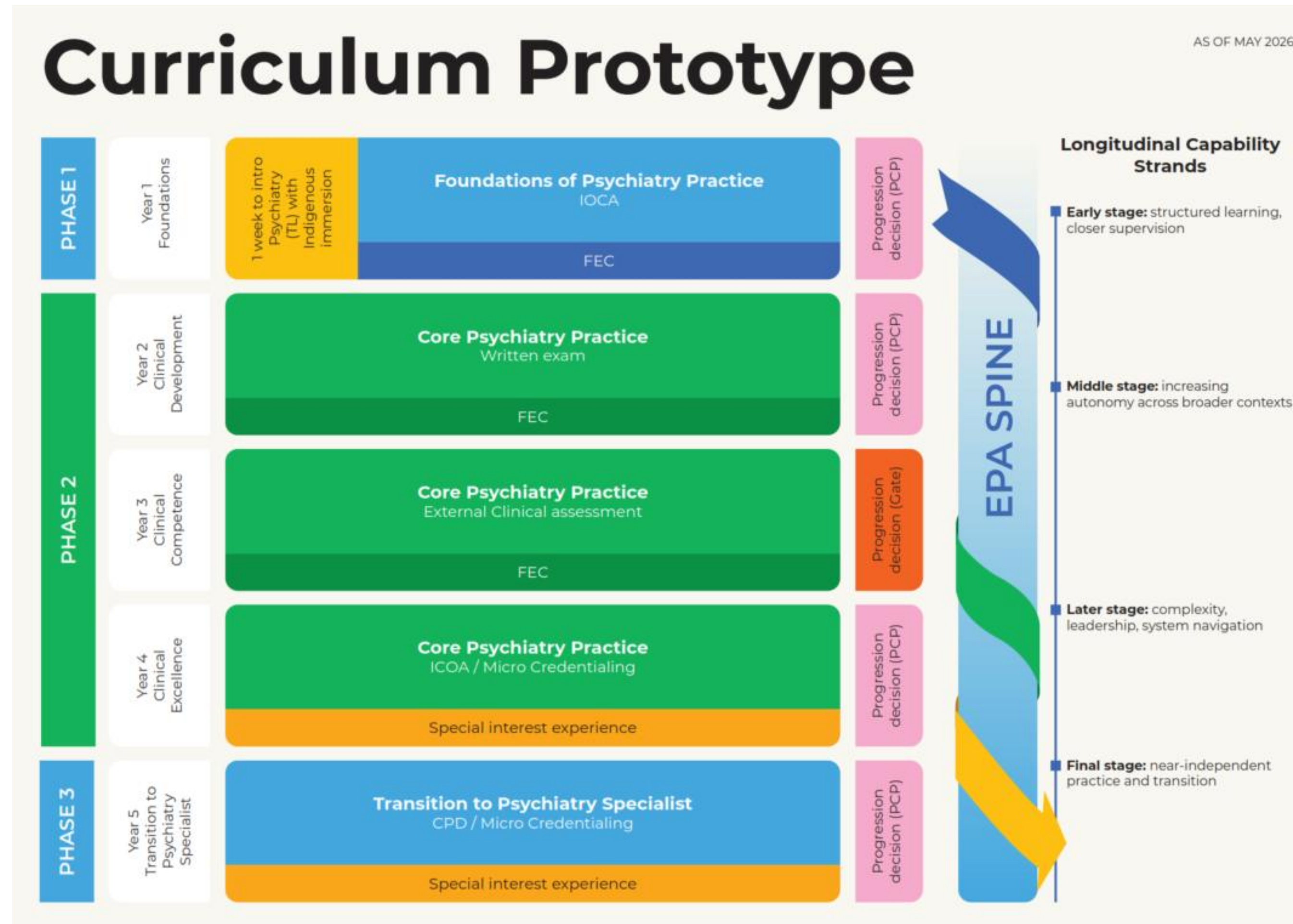
Rotation type (Australia)	Related Knowledge Guide(s) and additional notes
General and acute care medicine *Min time:* **3 months** (10-13 weeks) *Max time:* **24 months**	• General Medicine Knowledge Guide » • Medical Obstetrics Knowledge Guide » **Notes** General medicine rotations may include, but do not exclusively consist of: • peri-operative medicine • obstetric medicine • admitting medical registrar • medical assessment unit • acute assessment • adolescent and young adult medicine A total of 12 months general and acute care medicine can count as 'core' rotations. A further 12 months can count as 'non-core' rotations. Trainees should only complete up to 6 months of general medicine at any one training setting.
Medical specialties* *Min time:* **12 months** (44-52 weeks) *Max time:* **33 months**	**Notes** To count as adequate medical specialty training time, trainees will need to spend at least 50% of their time in the specialty, in at least two of the following areas: • inpatients • consults • ambulatory care Up to 6 months in any one specialty can count as 'core' rotations. An additional 6 months can count towards 'non-core' training.
Cardiology* *Min time:* **0 months** *Max time:* **6 months**	• Cardiology Knowledge Guide »

- Core minimum and maximum time specifiers to add structure and promote breadth of learning
  - General
  - Specialties
  - Settings



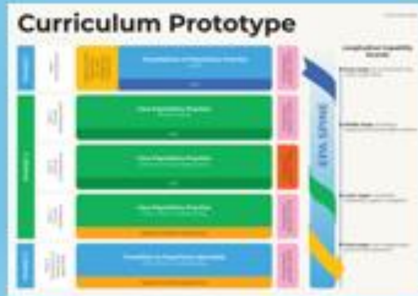
elearning.racp.edu.au

Proposals under consideration



- Development of sub specialist identity in years 4 and 5 and micro credentialing

Education considerations
Prototype Design
Next steps


Curriculum Prototype

Further project directions

- The clinical and written examination format
- Advanced certificates
- How and if can we capture mandatory experience to introduce greater flexibility and increase breadth
- Ensuring the prototype is rural and private psychiatry ready
- Selection
- FEC design
- Supervisor development and communities of practice
- International medical graduate need
- Inclusivity, flexibility and wellbeing
- Transition
- Implementation
- Governance
- Workforce and Economic modelling
- Evaluation and sustainability

Timeline

Now

- Ongoing Consultation and co-design
- Refinement of vision, outcome, education activities and prototype

Intensive (August 2026)

Report output, mapping to regulators and recommendations to Board (Sept/Oct 2026)

Beyond

- Creation of new Fellowship Design and implementation group
- Further refinement of construction plans
- Adaption of the Learning outcomes
- Pilot, pilot, pilot
- Setting up of communities of practice

Additional principles

- Ensure those trainees of 2012 program are not disadvantaged.
- Build on work that may be already happening e.g. Evaluation framework and Alternate rural pathways
- Share the principles and vision early to promote ownership
- Design and align with wider developments in the College
- Pilot and promote innovation opportunities within our College to land the NF
- Implement to reduce system disruption in a phased manner
    1. New assessment model, new outcomes, improving trainee experience, capability models and EPA portfolios
    2. Changes to training posts only after piloting and modelling

Summary

- An ambitious early-stage project which has exposed need for trade-offs in design
- Triple curriculum purpose:
  - Training design, meeting population need and defining the Psychiatry specialist of the future
- Commitment to safeguard standards, support transitions, reduce bottle necks, reduce assessment burden and increase the breadth of experience
- Aim is to develop a curriculum that will be adaptable to meet workforce changes, promote innovation, meets the vision but is workforce viable and educationally coherent

Thank you !