2022 Adult Internal Medicine Director of Physician Education Forum

Report
24 March 2022

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Contents

Executive Summary

Purpose of the fourth annual Director of Physician Education (DPE) Forum

- Provide a chance to learn from fellow DPEs and network.
- Provide an update on the RACP Education Renewal projects and the College Learning Series.
- Provide an update on Examinations:
    - Divisional Written Exam (DWE) delivery, design, and outcomes.
    - Divisional Clinical Exam (DCE) 2020-2021 overview.
- Provide an update on the Situational Judgement Test (SJT) Pilot and Selection into Training.
- Reflect on how COVID-19 has impacted learning and teaching.
- Understand the needs of rural and regional settings.
- Explore the needs of DPEs and provide a platform for discussion of common concerns.

Education, Learning and Assessment (ELA) Projects

- Entry into Basic Training with a focus on growing the Indigenous Physician workforce.
- The full implementation of the new Basic Training Program is delayed to 2024.
- Advanced Training common Curricula Standards agreed.
- All DPEs and Supervisors to complete SPDP 3 by end of 2022.
- Implementation of new Accreditation Standards is complete.

College Learning Series (CLS) Update

- CLS program will include a lecture evaluation option in future.
- Fellows are sought to review lectures in the following subspecialties: Haematology, Immunology, Infectious Diseases, Gastroenterology and Oncology.

Divisional Written Exam (DWE) Including Computer Based Testing (CBT)

- February 2022 DWE candidates experienced varying levels of disruption due to unexpected technical and process issues. Results release was expedited and unsuccessful candidates were offered a back-up exam on 8 March 2022.
- March 2022 DWE was successfully delivered, and the results release expedited.
- KPMG is undertaking a review of February 2022 DWE issues.

Divisional Clinical Exam (DCE) 2020-2021 Overview

- 2020 and 2021 DCE Short Case delivery was delivered in four formats (rather than the traditional format) due to COVID-19 impacts and resource limitations.
- 2020 and 2021 DCE deliveries were resource intensive relative to prior years.
- Australian 2021 DCE pass rates were marginally higher than previous years.
- The 2022 DCE delivery will utilise the traditional format for all states, apart from WA.
- Refresh Project created to review and redesign the format and delivery model of the DCE

Situational Judgement Test (SJT) Pilot and Selection into Training

- The “Casper” SJT pilot is in the evaluation phase. “Casper” assesses professional and personal characteristics, focussing on those included in the selection criteria for entry into Basic Training.
- “Casper will be an additional tool to inform the candidate screening and recruitment process.
- The Trainee Selection Pulse Survey occurred in November 2021 and results are provided for consideration.

Learning and Teaching in the COVID-19 Age

Discussion focused on:

- The importance of reliable internet, microphones, and cameras.
- The use of case information and simulated symptoms to promote differential diagnosis.
- Trainees to consider involving members of their household as simulated patients.

Supporting Rural and Regional Settings

- A working group has been formed to consider rural, regional, and remote (RRR) training issues and opportunities.

Discussion focused on:

- Accreditation processes and difficulties faced by RRR settings when applying for Accreditation.
- How to incentivise trainees to undertake RRR rotations.

Agenda

Time	Session
10.00am	Welcome • Dr Spencer Toombes, Chair, AIM BT Committee • Dr Jacqueline Small, RACP President Elect • A/Prof Mitra Guha, Chair, College Education Committee (CEC)
10.25am	Update: Education, Learning and Assessment (ELA) Projects
10.50am	Update: College Learning Series (CLS)
11.00am	Delivery, Design & Outcomes Update: Divisional Written Exam (DWE) (followed by Q&A)
11.40am	Break
11.55am	Overview: 2020-2021 Divisional Clinical Exam (DCE) (followed by Q&A)
12.35pm	Lunch Break
1.35pm	SJT Pilot & Selection into Training (followed by Q&A)
2.05pm	Table discussion: Learning & Teaching in the COVID-19 Age
2.45pm	Break
3.00pm	Supporting Rural & Regional Settings (followed by Q&A)
3.40pm	Q&A to Expert Panel
3.50pm	Wrap-up and Thank You
4.00pm	Meeting closed

Participants

Facilitators	Role
1. Dr Spencer Toombes	Chair, AIM BT Committee and DPE at Toowoomba General Hospital, QLD
2. Dr Jacqueline Small	RACP President Elect
3. A/Professor Mitra Guha	Chair, College Education Committee
4. Dr Kee Meng Tan	Chair of the Divisional Written Exam Committee
5. Professor Nicholas Buckmaster	Chair, College Council and Chair, Rural and Regional Physician Working Group
6. Dr Andrew Henderson	Deputy-Chair, AIM BT Committee and DPE - Westmead Hospital, NSW
7. Dr Claire Dendle	Member, AIM BT Committee and DPE - Monash Medical Centre, VIC
8. Dr Alice O'Connell	Member, AIM BT Committee and DPE - Royal Adelaide Hospital, SA
9. Dr Tracey McMillan	Proxy Member, AIM BT Committee - Representing AoNZ AMDEC
10. Dr Elizabeth Whiting	Member, AIM BT Committee and Chair of the Divisional Clinical Exam Committee
11. A/Prof Michael Woodward	Member, AIM BT Committee and Chair of the Accreditation Subcommittee
Directors of Physician Education	**Hospital and State**
1. Dr Abu Abraham	Fiona Stanley Hospital, WA
2. A/Professor Wilma Beswick	St Vincent's Hospital, VIC
3. Dr Lauren Bradbury	Orange Health Service, NSW
4. Dr Philip Butler	Orange Base Hospital, NSW
5. Dr Kim Caldwell	St George Hospital, NSW
6. Dr Paul Chapman	Royal Brisbane & Women's Hospital, QLD
7. Dr Yog Chopra	Hornsby Ku-ring-gai Hospital, NSW
8. Dr Suet-Wan Choy	Austin Health, VIC
9. Dr Melita Cirillo	Fiona Stanley Hospital, WA
10. Dr Heather Cooke	John Hunter Hospital Newcastle, NSW
11. Dr Heather Curley	Toowoomba Hospital, QLD
12. Dr Lisa Dark	Tamworth Rural Referral Hospital, NSW

13. Dr Bianca Devitt	Box Hill Hospital, VIC
14. Dr Joseph Duncan	Lismore Base Hospital, NSW
15. Dr Renee Eslick	Liverpool Hospital, NSW
16. Dr Sean George	Kalgoorlie Hospital, WA
17. Dr Elizabeth Gillett	Royal Brisbane and Women's Hospital, QLD
18. Dr James Gome	Warrnambool Base Hospital, VIC
19. Dr Alice Grey	Royal Prince Alfred Hospital, NSW
20. Dr Jessica Hafner	Queen Elizabeth Hospital, SA
21. Dr Elke Hendrich	Footscray Hospital / Sunshine Hospital, VIC
22. Dr Sanjaya Herath	Redland Hospital, QLD
23. Dr Edwina Holbeach	The Northern Hospital, VIC
24. A/Professor Samuel Hume	Royal Melbourne Hospital, VIC
25. Dr Paul Jauncey	Nambour Hospital, QLD
26. Dr Cameron Jeremiah	University Hospital Geelong, VIC
27. Dr Shanthi Kannan	Queen Elizabeth II Jubilee, QLD
28. Dr Kenneth Koo	Calvary Bruce Hospital, ACT
29. Dr Soe Ko	Ballarat Base Hospital, VIC
30. Dr Miranda Lam	Lyell McEwin Hospital, SA
31. Dr Sophia Lam	Cairns Base Hospital, QLD
32. Dr Heather Lane	Sir Charles Gairdner Hospital, WA
33. Dr Marc Lanteri	Werribee Mercy Hospital, VIC
34. Dr Dayna Law	Logan Hospital, QLD
35. Dr Adrian Lee	Royal North Shore Hospital, NSW
36. Dr Matthew Lee-Archer	Launceston General Hospital, TAS
37. Dr Anthony Linton	Concord Repatriation General Hospital, NSW
38. Dr Michael Low	Casey Hospital, VIC
39. Dr Rajasekar Malvathu	Rockingham General Hospital, WA
40. Dr Annabel Martin	Albury Wodonga Health, VIC
41. Dr Natalie Martin	Royal Hobart Hospital, TAS
42. Dr Rhianna Miles	Greenslopes Private Hospital, QLD
43. Dr Afshin Moghadam	Robina Hospital, QLD
44. Dr Nadia Patel	Princess Alexandra Hospital, QLD

45. Dr Susan Petrie	Royal Brisbane and Women's Hospital, QLD
46. Dr Anne Powell	Alfred Hospital, VIC
47. Dr Mukhlesur Rahman	Caboolture Hospital, QLD
48. Dr Mohammed Nabil Richi	Geraldton Regional Hospital, WA
49. Dr Dhiraj Saini	Rockhampton Base Hospital, QLD
50. Dr Conceicao Santos	Campbelltown Hospital, NSW
51. Dr Vasant Shenoy	Townsville University Hospital, QLD
52. Dr Belinda Smith	St Vincent's Hospital, VIC
53. Dr Brian Smith	Bendigo Health Hospital Campus, VIC
54. A/Prof Adrian Taylor	Shoalhaven District Memorial Hospital
55. Dr Corinne Tey	St Vincent's Hospital, VIC
56. Dr Josephine Thomas	Royal Adelaide Hospital, SA
57. Dr Sajan Thomas	Alice Springs Hospital, NT
58. Dr AKM Nizam	Central Gippsland Health Services, VIC
59. Dr Krishnan Varikara	Lyell McEwin Hospital, SA
60. Dr Emily Woolnough	St John of God Midland Public and Private Hospitals, WA
61. Dr Tricia Wright	Latrobe Regional Hospital, VIC

College staff	Role
Peter McIntyre	Chief Executive Officer, RACP
Robyn Burley	Director of Education, Learning and Assessment
Desley Ward	Manager, Assessments and Selection
Louise Rigby	Project Manager, Educational Renewal Program
Shalini Purohit	Acting Manager, Training Support & Operations, Australia & Aotearoa New Zealand
Sarah Millar	Acting Manager, Training Operations
Emily Morrison	Manager, Training Accreditation Services
Curtis Lee	Psychometrician, Assessment & Selection
Libby Newton	Manager, Education Policy, Research and Evaluation (EPRE)

Rebecca Udemans	Senior Executive Officer, EPRE
Imogene Rothnie	Senior Project Specialist, EPRE
Jennifer Gili	Senior Executive Officer, Basic Training
David Van Boom	Executive Officer, Basic Training
Victoria Arifin	Education Officer, Basic Training
Catarina Cunha	Education Officer, Basic Training

Welcome

Dr Spencer Toombes, Chair of the Adult Internal Medicine (AIM) Basic Training (BT) Committee, welcomed attendees to the first hybrid DPE Forum comprising of in person attendance in both NSW and VIC as well as virtual attendance from attendees across Australasia. Dr Toombes additionally gave an overview of the Forum's Agenda.

Dr Jacqueline Small, RACP President Elect, welcomed the DPEs present. Dr Small detailed her history with the College and her commitment to providing collaborative leadership during her future tenure as RACP President. She acknowledged the difficulties and expanded workload experienced in recent years due to COVID-19 impacts and the increased risk of burnout. Additionally, she highlighted the opportunity to create change that any major event brings.

A/Prof Mitra Guha, Chair, welcomed the DPEs present. A/Prof Guha reflected on her time as a DPE and the importance of and challenges faced during the role. She highlighted the value of this Forum as a stage to meet and discuss the issues relevant to DPEs. DPEs are at the coalface and the College must recognise their importance and continue to provide support. Additionally, she highlighted the importance of the topics of discussion, the Divisional Written and Clinical Exams, Capacity to Train, and support for Rural and Regional settings.

Education, Learning and Assessment (ELA) Update

Robyn Burley, Director of Education - ELA, provided an update on the following:

Education Renewal Projects

Entry into Basic Training

- Focus on growing the Indigenous Physician Workforce through:
    - Fee reimbursement initiative which will cover the cost of training and examination (first attempt only) for eligible trainees.
    - Welcome activities and networking opportunities for Indigenous trainees
    - Coaching initiative available to Māori and / or Pasifika trainees.
    - Selection into training policy update to provide support and commitment to growing the number of Indigenous trainees.
    - Expressions of interest are open for Aboriginal and /or Torres Strait Islander trainees / Fellows for a working group developing a video to support the growth of the Indigenous medical workforce.
    - AIDA seeking Fellow/s with detailed knowledge of the RACP's selection processes and training programs to participate in their 'Yarn Up' sessions.

New Basic Training Program

- Early Adopter (EA) Settings who commenced Foundation phase in 2021 have trainees moving into the Consolidation phase in 2022. Two new Early Adopters (Queensland Paediatric Network and Taranaki Base Hospital) commencing from 2022.
- Implementation at all BT settings was tentatively scheduled for 2023, now delayed to 2024. The delay is a result of COVID-19 and supporting technology impacts.
- New Basic Training Program evaluation findings:
    - Trainees and supervisors are supportive of the competency focused curriculum.
    - Learning goals align with most respondents' perspectives on the important competencies, skills and knowledge to develop in training.
    - Support for the rationale of work-based training and assessment practices, in particular frequent feedback on observed practice.

- Increased focus on observing and monitoring trainee performance creates opportunities for earlier intervention.
- Education technology workflow is creating barriers to completing learning and teaching activities
- Severe workforce shortages restricting access to supervision and educational activities.
- Competence is contextualised to rotation specialty. Trainees are finding it difficult to locate appropriate learning goals when they have no knowledge of the specialty.
- Preparation for the DWE and DCE require learning and teaching activities in addition to those embedded in the program.

Advanced Training (AT) Curricula Renewal

- Common Curricula Standards have been agreed.
- Currently in design phase of learning, teaching, and assessment (LTA) program for six (6) specialties in the first wave: Cardiology, Paediatric Cardiology, Gastroenterology, Geriatric Medicine, Nephrology, Rehabilitation Medicine. Estimate is for draft LTA program to be completed by end of 2022.
- Second wave specialties still to be confirmed and estimated to commence planning from 2023.
- Evaluation underway of current process.

RACP Supervisor Training

- From 2023 approved / provisionally approved Supervisors are eligible to supervise trainees within RACP physician training programs. RACP Fellows who have not met the supervisor training requirements are ineligible to hold training supervisory roles and formally supervise RACP trainees.
- Target for all DPEs and Supervisors to complete Supervisor Professional Development Program (SPDP) module 3 by end of 2022.
- All DPEs and Supervisors must complete (or be exempt from) SPDP modules 1 and 2 by end of 2022 or in line with their site accreditation cycle (whichever date is later).
- Rotational Supervisors / Ward Service Consultants are only required to complete SPDP 3 (non-members are encouraged to complete SPDP 3 but there is no requirement).
- SPDP completion status of current supervisors in March 2022:
  - 46% fully completed
  - 38% partially completed
  - 16% yet to start
- Strategies to increase SPDP completion include:
  - Increasing the number of SPDP facilitators through training support and promotion of regular facilitators
  - Increasing attendance through regular reminders to registrants and working with settings to provide on-site workshops. Virtual sessions have proven to be popular.
  - An SPDP communication campaign is in progress to highlight benefits of participation.

Accreditation Renewal

- As of September 2021, Phase1 implementation of the new Accreditation Standards is complete. The new Training Provider Standards and Basic Training Accreditation Requirements were rolled out to all settings offering Basic Training in Australia and Aotearoa New Zealand.
- BT programs have transitioned to the terminology of the new classification framework.
- New Accreditation forms and processes are now in use.
- Planning for Phase 2 is now underway, and a high-level implementation plan has been approved by the CEC.
- In Phase 2, we will:
  - Commence accrediting formalised Training Networks – this will commence in 2023 for NSW BPT networks

    - To support training network accreditation, we will continue the roll out of the Basic Training Program Classification
    - Introduce reporting and monitoring tools and processes.
- Tools and processes to be developed in Phase 2 include:
    - A training network Accreditation form
    - A training network Accreditation and classification guide
    - Rolling out the 'Managing a Change of Circumstances' and 'Managing a Reported Breach of Training Provider Standards' forms.

Participants raised and discussed the following matters:

New Basic Training Program

- Expressions of interest will be offered for settings to be Early Adopters in 2023.
- TRACC software is experiencing significant issues. Strategy to deal with issues being developed. Current EA settings are being supported through a combination of TRACC and electronic forms.

RACP Supervisor Training

- Opening SPDP workshops to interstate attendees would increase attendance.
- DPEs can obtain SPDP completion status by emailing a list of supervisors at their setting to Supervisor@racp.edu.au.
- Supervisors have been sent an emailed update regarding their completion status.
- Access to SPDP completion status via MyRACP would be convenient. This was acknowledged and being considered.
- SPDP completion requirements are the same for all Fellows. Exemption can be sought for SPDP modules 1 and 2. Information about how to seek exemption is available on the RACP website. Completion of SPDP module 3 is mandatory for all supervisors.
- Educational Supervisors oversee the summative reports whereas Rotational Supervisors (Ward Service Consultants) typically supervise the trainee for a single rotation.

Participants thanked Robyn Burley for her contribution to the College over the years

College Learning Series (CLS) Update

Michael Davidson, Program Manager, CLS, provided an update on the College Learning Series. The Adult Internal Medicine CLS program (formerly Physician Education Program, PEP) is in its fifth year. The CLS is a bi-national program with Fellows and trainees from all jurisdictions contributing to program development.

A live demonstration of how to navigate the CLS site was provided.

An option to evaluate lectures will be added to the site soon.

The CLS program is seeking Fellows to review lectures before they go live. Specifically, Fellows are sought to review lectures in the following subspecialties: Haematology, Immunology, Infectious Diseases, Gastroenterology and Oncology. The DPEs were encouraged to email CLS@racp.edu.au to get involved in reviewing lectures.

Participants raised and discussed the following matters:

- The CLS is appreciated and recognised as one of the most beneficial teaching tools available to DPEs.

Divisional Written Exam (DWE) including Computer Based Testing (CBT)

Dr Kee Meng Tan, Chair of the Divisional Written Exam Committee and Desley Ward, Manager, Assessment and Selection provided the following update on the 14 February 2022 DWE.

- 25 candidates attempted the DWE via CBT in October 2021. Five candidates experienced issues with data synchronisation and data loss. Overall pass rate of 45% was lower than the historical average, however, the pass mark was in-line with historical average.

14 February 2022 DWE

- The DWE (for Adult Internal Medicine and Paediatrics and Child Health) was delivered on 14 February 2022 to 1078 candidates using CBT at 21 venues across 19 locations and 36 candidates using paper-based testing at six venues.
- During CBT delivery candidates experienced varying levels of disruption related to technical and process issues. Some candidates at Perth, Auckland, Brisbane and one venue in Melbourne, experienced significant disruption to their exam.
- There were varying levels of disruption in several venues over and above the major incidents first identified. Issues included delays with logins, slow downloads of the exam content, exam pausing for short periods, delays with data synching.
- A preliminary review of data had indicated no data loss. Further investigation identified that six (6) Adult Medicine candidates from the Perth venue had incomplete exam result data from the first paper.
- The release of results was expedited and released on 1 March 2022. This was to ensure candidates had results in advance of the 8 March exam.
- All 14 February DWE candidates who did not pass were provided with their raw score for the exam to enable them to determine whether they would sit one or both papers at the backup exam on 8 March. 48 candidates chose to sit one (1) paper only.

College Response to 14 February 2022 DWE

Communication	Supporting progression	Analysis and management
Ongoing messaging to candidates and DPEs	Results release date brought forward to 1 March 2022 **Pass rate for AM = 74.0%** (comparable to previous years)	Establishment of cross-College response management team
FAQs, updated as required		Continued meetings of the DWE Decision Panel
Personal phone call to each directly affected candidate	All unsuccessful candidates were offered opportunity to sit exam on 8 March, without requirement to submit request for special consideration	Data collection Survey of candidates Documentation following phone calls with affected candidates
Other key stakeholders kept informed, including: Education and training committees Regional committees DPE groups Trainees' Committees Health departments AMC and MCNZ	Advocacy to health departments for candidates to be granted leave to sit the 8 March exam	KPMG engaged to work with us on investigating what went wrong - causes and associated recommendations to be released
Webinars for DPEs and candidates 2 March	Preparation for paper-based exam on 8 March including candidate allocations and provision of option to sit one or both papers	Decision to issue full refund of exam fee refund to 14 February CBT candidates who failed, did not complete both papers and or had incomplete data for one paper

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Figure 1: College response to DWE in February 2022

8 March 2022 DWE

- The back-up paper-based exam was successfully delivered for 300 (AIM and PCH) candidates on 8 March 2022.
- Results for 8 March exam will be released 12 April 2022. Result processing is being expedited and this release date will be brought forward if possible.
- Candidates are conditionally eligible to apply for the Divisional Clinical Examination (DCE).

Participants raised and discussed the following matters:

- 8 March DWE results release should be brought forward as much as possible to help alleviate concern for already stressed trainees. This was acknowledged, however, as this was a paper-based exam the process for finalising results involves additional checks and takes more time. Results release prior to 12 April is possible, however, cannot be guaranteed.
- Several candidates only sat one (1) paper on 8 March. A separate reconciliation with the 14 February results for these candidates is required. Accuracy of results is paramount to ensure no further incidents.
- Although it is unfortunate this occurred, the response from the College was vastly improved relative to the February 2018 CBT failure. College staff deserve recognition for their tireless efforts in ensuring a swift response.
- Feedback provided that WA trainees felt the communication from the College underplayed their experiences, seemed tokenistic and did not acknowledge that the majority of candidates in Perth had technical issues.
- The October 2022 DWE will be delivered as a paper-based exam. It was suggested future CBT attempts should ensure a paper-based back-up is readily available.
- Re-attempting CBT for future exams is not ruled out, however, a review by KPMG is underway to understand what occurred. Following review, the College will be able to understand the potential future of CBT. There are significant potential benefits to CBT and this should not be completely abandoned based on recent failures.
- Ensuring an exam provider can deliver CBT to RACP's requirements and standards is essential. Assurance must be provided of successful delivery given the history of CBT at the College. Additionally, testing on smaller exams at the College should occur extensively prior to attempting CBT on the Basic Training Divisional Written Exam in future.
- Consideration can be given to how similar exams are offered by other colleges, however, the number of candidates and the diversity of exam locations the exam is unique and limits the number of potential suppliers.
- The aspiration of CBT has been to deliver an exam on demand.
- The College made the decision to proceed with the 14 February 2022 DWE in good faith as it was the understanding the issues identified during the October 2021 DWE trial had been resolved.
- Trainees showed great poise and forbearance in their response to this event. Apologies were extended to trainees impacted by 14 February 2022 DWE failure.

Divisional Clinical Exam (DCE) 2020-2021 Overview

Dr Elizabeth Whiting, Chair of the Divisional Clinical Exam Committee, and Desley Ward, Manager, Assessment and Selection and presented an overview of the DCE from 2020-21:

2020 & 2021 exam short cases were delivered in four different ways due to COVID-19 and resource limitations:

A. Traditional: Short cases on the same day as long cases.

B. Modular 4 short cases: Four short cases on separate day to long cases.

C. Modular 2+2: Two short cases on separate day to long cases. Performance on short cases determined if candidates returned for a further exam day with an additional 2 cases.

D. Deferrals: Candidates were given the option to delay their 2020 assessment. Candidates may have just taken Short Cases.

DCE Timelines in 2020 and 2021 were drawn-out due to COVID-19 impacts.

Impact of exam format on resources (2019)

Resources 2019	Adult Medicine		Paediatrics and Child Health	
	Aust	*NZ*	*Aust*	*NZ*
Candidates	762	122	260	48
Examiners	489	54	200	32
Hospitals	76	9	27	5
Patients	1705	248	655	96
Days	10	3	10	3

Figure 2: Impact of exam format on resources (2019)

Impact of exam format on resources (2021)

Resources 2021	Adult Medicine		Paediatrics and Child Health	
	Aust	*NZ*	*Aust* *excl NSW / ACT SC	*NZ*
Candidates	**834**	**77**	**298**	**36**
Examiners	**797**	**49**	**283***	**25**
Total Hospitals	**92**	**8**	**44***	**5**
- Traditional format	*28*	*8*	-	5
- Long Case - Hosting	*46*	-	*27*	-
- Sitting	*46*	-	*39*	-
- Short Case	*47*	-	*15**	-
Patients - Total	**1530**	**164**	**435***	**80**
Days - Traditional format	**20**	**3 + 1 supp**	**-**	**3**
Days - Long Case	**27**	**-**	**20**	**-**
Days - Short Case	**44**	**-**	**12***	**-**

Figure 3: Impact of exam format on resources (2021)

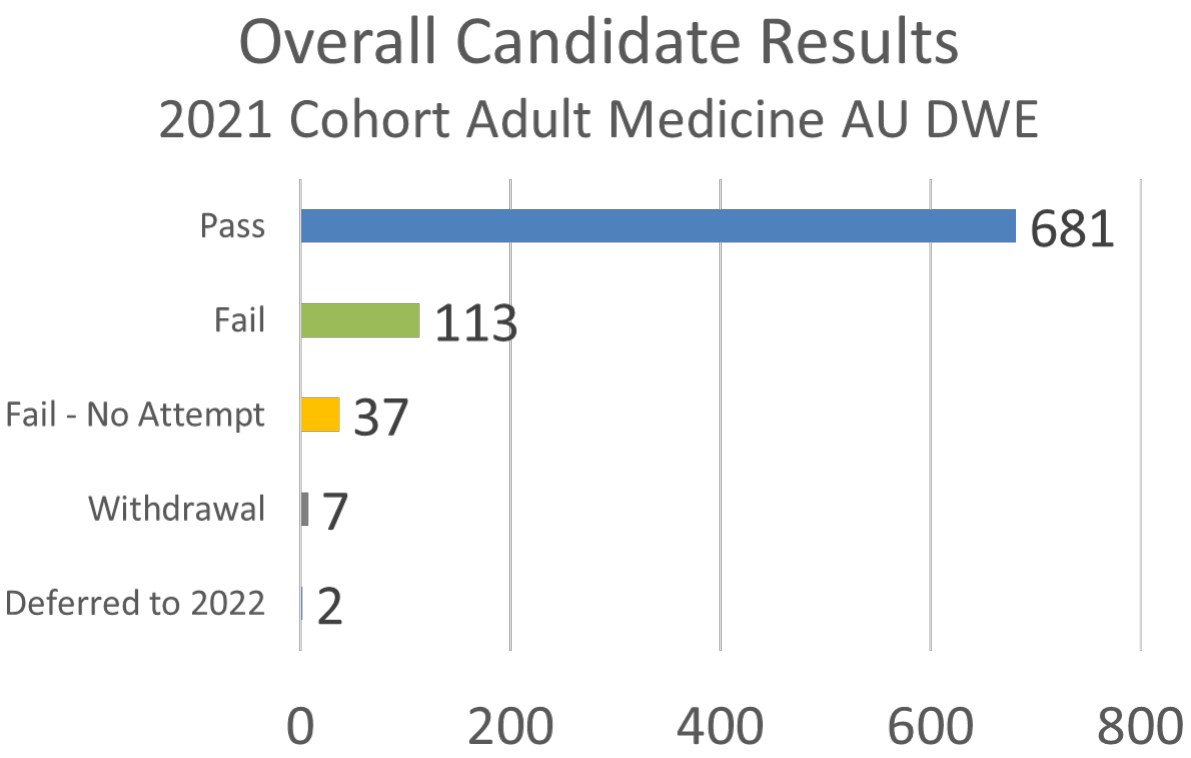
2021 DCE – Adult Medicine Australia

Historical Pass Rate

Year	Pass Rate – Overall	Pass Rate – Australia	Pass Rate – Aotearoa New Zealand
2021	**82.2% (746/908)**	**81.9% (681/831)**	**84.4% (65/77)**
2020	80.4% (771/960)	79.7% (694/871)	87.6% (78/89)
2019	71.0% (628/884)	69.6% (530/762)	80.3% (98/122)
2018	71.3% (724/1015)	70.6% (635/899)	76.7% (89/116)

Figure 4: Historical Pass Rate (AIM AU)

2021 DCE Overall Candidate Results (AIM AU)



Note: Candidates in NSW/ACT candidates who did not progress to Short Cases due to Long Case Band Score 0 were considered 'Fail – No attempt' due to COVID restrictions

Figure 5: 2021 DCE Overall Candidate Results (AIM AU)

Number of Candidates and Pass Rate Per Model

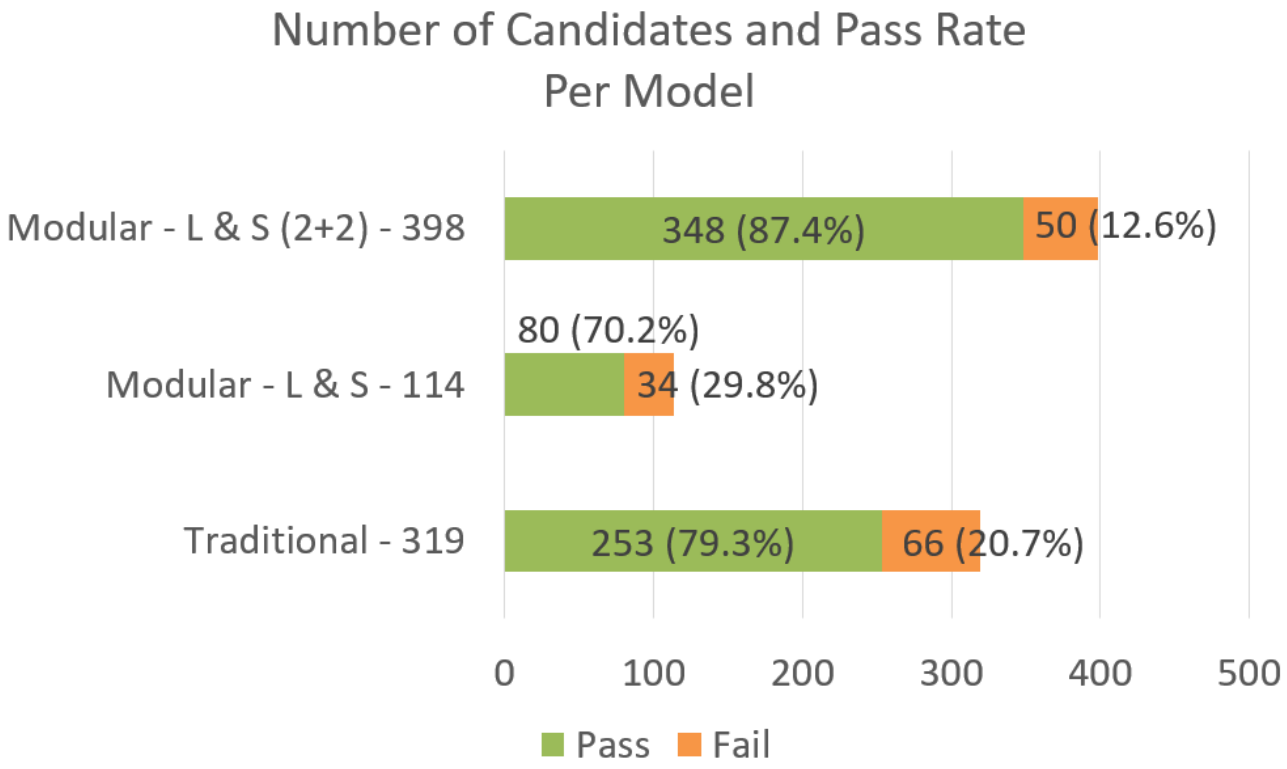
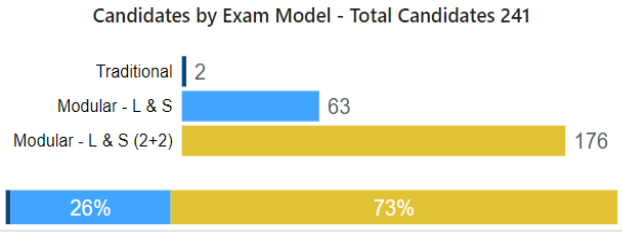


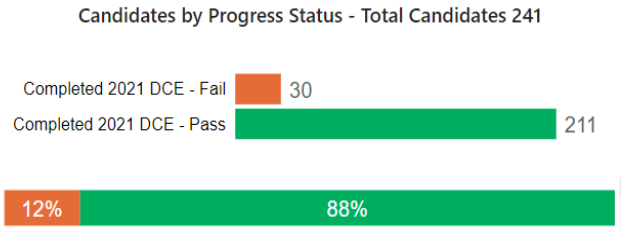
Figure 6: Number of Candidates and Pass Rate Per Model

2021 DCE Results by State: Candidates by Format / Pass Rate

New South Wales

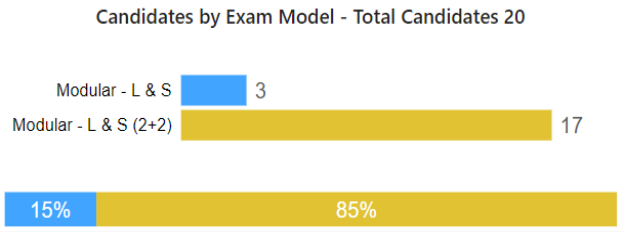
FAIL - No Attempt

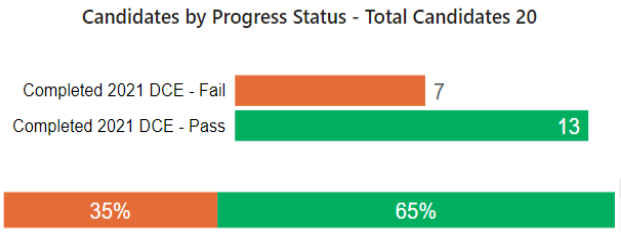




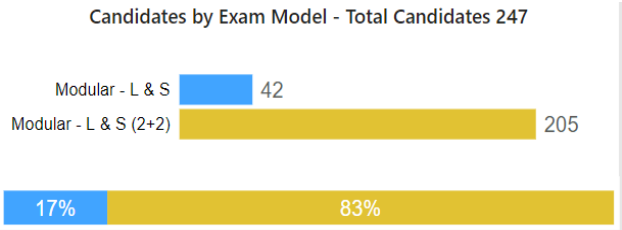
Australian Capital Territory

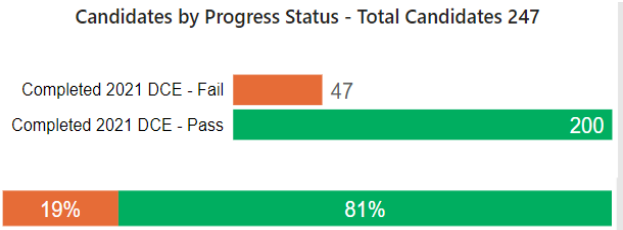
FAIL - No Attempt



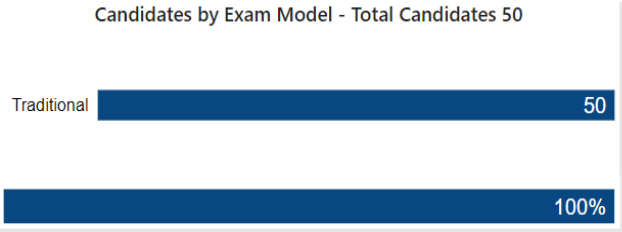


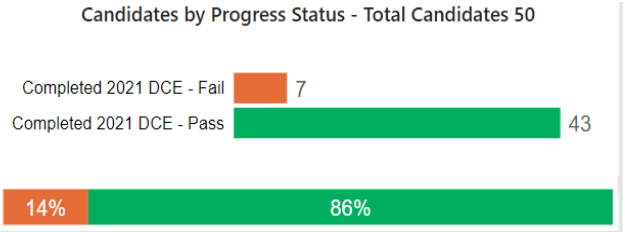
Victoria





South Australia





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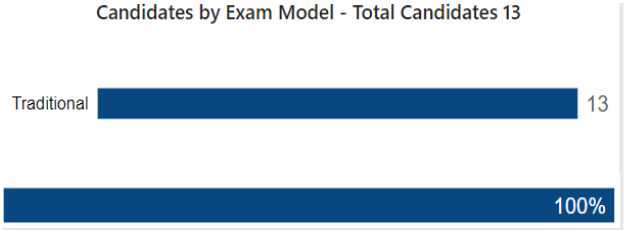
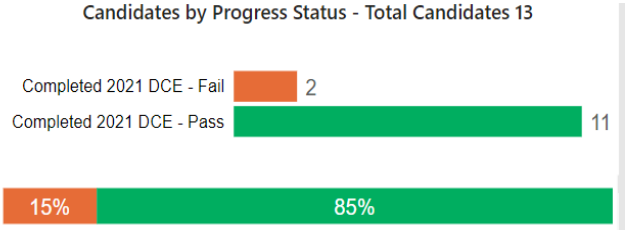
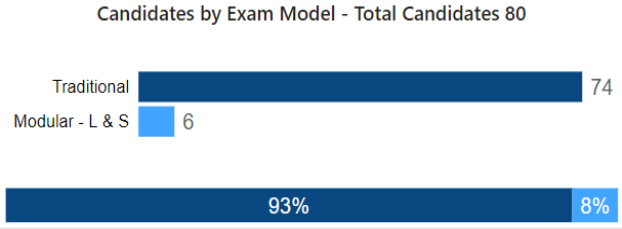
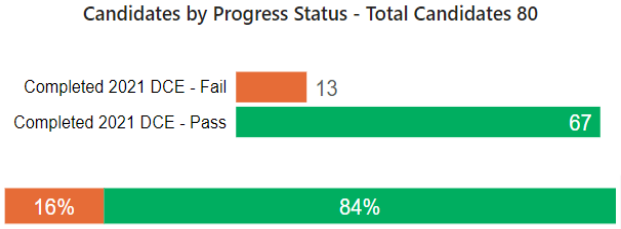


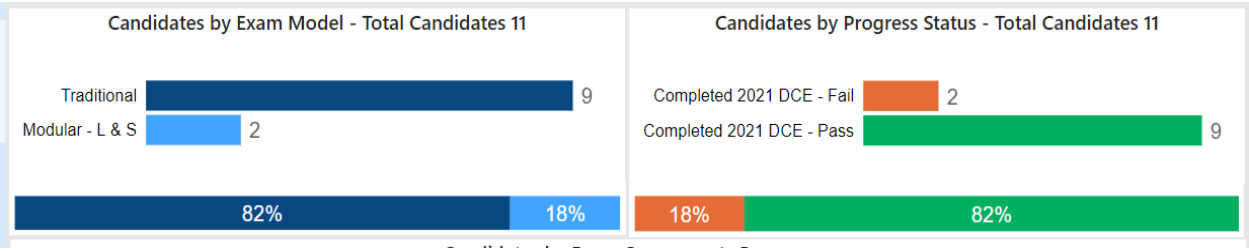


Western Australia





Northern Territory



Queensland

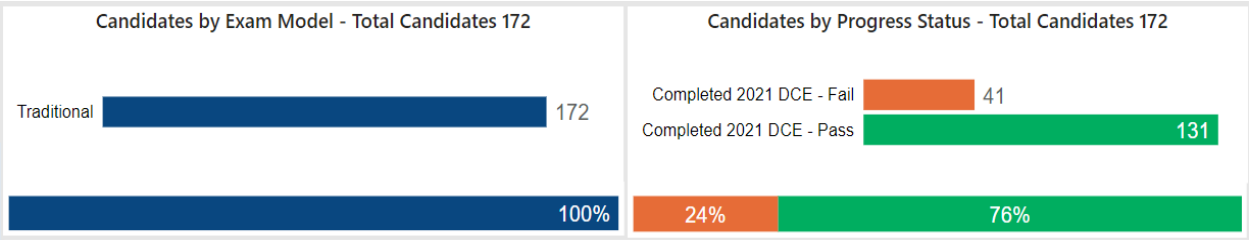


Figure 7: 2021 DCE Results by State: Candidates by Format / Pass Rate

2022 DCE Format, Timing and Preparations

- DCE Applications open 10-28 March 2022.
- Delivery format will be traditional (two long cases and four short cases) face-to-face on the same day except for WA which has requested to deliver in the modular format (two virtual long cases and four locally delivered face-to-face short cases) due to evolving COVID-19 impacts.
- The timing of the WA DCE and AoNZ have also been moved to later in the delivery window (August and September) due to COVID impacts.
- DCE largely delivered within state (in Australia) with some examiner and candidate travel between states expected.
- Projected candidate numbers are 900 for AU and 90-130 for AoNZ.
- Trainees to be provided minimum 4 weeks' notice regarding their allocation.
- Calibrations to occur face-to-face and virtually.
- Contingency plans in place to reschedule and pivot to modular format.

DCE Refresh Project

Purpose: to review and redesign the format and delivery model of the DCE and recommend a model that:

- is valid and reliable
- maintains the established purpose of the DCE which is to test a candidate's clinical examination skills in defined domains to determine if they are ready to progress to AT
- is flexible and sustainable into the future minimising the risk of major disruption
- is feasible to deliver to the current and projected future volumes of trainees within the physician training system
- aligns with the new Basic Training Program and the planned shift towards programmatic assessment.

The role and responsibilities of the DCE Refresh Reference Group:

1. Identify and evaluate appropriate alternative options for the format and delivery model of the DCE
2. Plan and oversee the piloting of preferred alternative option(s) for the DCE.
3. Evaluate outcomes of pilot studies and refine approaches.

4. Recommend to the DCE Committees an appropriate future format for the DCE.
5. Provide advice as to an appropriate communication and implementation strategy for the future DCE format.
6. Monitor the first year of implementation and identify improvements to address risks.

DCE Refresh Working Group is a subgroup of the DCE Reference Group that will meet more frequently to progress the work.

The Reference Group is an advisory and recommending body only. Decisions about the format of the DCE will be made by the College Education Committee (CEC) following recommendation by the DCE Committees and endorsement by the College Assessment Committee.

The aim is for new approaches to be piloted this year which, following evaluation, will be used to provide recommendations.

The participants raised and discussed the following matters:

- Changes in pass rates over time may be cause for concern. Potential factors include:
    - local examination due to COVID-19 impacts.
    - exams occurring over a protracted time-period.
    - opportunities for additional training between the long and short cases.
    - improved exam preparation within training settings over time.
    - Introduction of the CLEAR rubric in 2018 which made the pass/fail distinction clearer.
- ACT found it difficult to accommodate local examination due to all trainees being examined in two hospitals only in 2021. It is hoped ACT trainees will be able to join the NSW cohort in 2022.
- Allocation of hospital exam dates will be confirmed once National Examining Panel (NEP) member availability is finalised. It is expected NEP availability should be finalised this week.
- Results release schedule is being finalised and will be released shortly.
- The digital score sheet allows exam results to be available sooner.
- Inequity in result release dates may impact recruitment processes as some trainees may feel disadvantaged when other trainees have received their results and they have not.
- Ideas or suggestions for the DCE Refresh project can be emailed to examinations@racp.edu.au. The options developed by the Working Group will be consulted on more broadly with key stakeholders including DPEs.
- Feedback provided that most settings in Victoria have too many trainees to prepare for the DCE. Victorian DPEs are seeking urgent solutions on how to reduce the number of DCE candidates. This was acknowledged as concern relating to capacity to train and capacity to examine.
    - New accreditation standards have clear ratios of trainees to supervisors. This is not currently mandatory but long term the intention is to enforce these standards. This was acknowledged as being beneficial in the long term, however, the current environment in Victoria is not sustainable and trainee preparation for the DCE is being impacted.
    - In the short-term, when examples of inequity in training are provided to the College, the College can contact training settings to seek additional support for the DPE and training program. It was noted that trainees may be intentionally receiving reduced support when preparing for their second or third DCE attempt.
    - Accreditation should be made aware of training settings where trainees are not receiving equitable training.
- Rural and regional settings may be able to take some pressure off metro settings and assist by preparing trainees for the DCE.
- Trainees are focusing on passing the DCE rather than becoming a good Physician. The assessment method should change from a single-day high-stakes exam to help alleviate stress on trainees and make DCE preparation more manageable.
- Workplace based assessments may increase the pressure on the training setting, not reduce this.

- Trainee numbers should be reduced at the entry point. Once a trainee is in training there is an obligation to prepare them for examinations.
- Australian training programs appear to be under-resourced compared to their international counterparts. Lack of resourcing is a key factor and providing adequate resources should be mandated by the College. It was acknowledged this is addressed in the new Accreditation Standards.
- The Australian DCE is fair and robust. The working group should resist the temptation to lower the standard. Any solution to the capacity to train issue should not involve reducing the standard of the DCE.

Participants thanked Dr Elizabeth Whiting for her contribution to the DCE Committee

Situational Judgement Test (SJT) Pilot and Selection into Training

Spencer Toombes, Chair, AIM BT Committee and Imogene Rothnie, Senior Project Specialist, EPRE and presented on the SJT Pilot and Selection into Training.

Selection into Training Roadmap Progress

Entry into Basic Training	Status
1. Publish jurisdictional selection information on the RACP website	Detailed Australian and general AoNZ content will be live as recruitment campaigns open.
2. Pilot the use of an online screening assessment tool (SJT)	Blueprinting test content to training context. Pilot scheduled for recruitment 2022
3. Develop new **Capacity to Train Guidance**	Developed and approved by the CEC for circulation
4. Establishment of Network Training	This has been incorporated into phase two of the accreditation implementation project.
5. Develop and publish **a 'Selection Toolkit'** for Training Providers	This will be progressed once the online screen assessment tool pilot is complete

Figure 8: Selection into Training Roadmap Progress

A live demonstration of how to navigate the Entry into Basic Training page on the RACP website was provided.

“Casper” SJT Pilot

- “Casper” is a form of SJT that assesses candidates on personal and professional characteristics, focussing on those included in the selection criteria for entry into Basic Training.
- Prospective Basic Trainees should demonstrate:
    - The capacity and commitment to pursue a career as a physician or paediatrician.
    - The ability to plan and manage their learning.
    - The ability and willingness to achieve the Basic Training Competencies, particularly those associated with:
        - Communication
        - Cultural safety
        - Ethics and professional behaviour
        - Leadership, management, and teamwork.
- “Casper” is being delivered by Altus Assessments, the selected vendor to deliver the pilot assessment in 2022.
- “Casper” is an online open-response format SJT to determine what an applicant would do in a tough situation, and more importantly why. The test uses fifteen (15) video or text-based scenarios with time-limitations for each response. Each scenario response is then assessed by a different assessor. The ratings from all responses are then used to determine a standardised aggregate score per candidate called their Casper Score.
- “Casper” is in the pilot phase of the project which will run from April to September 2022.
- During the pilot, SJT test results will not be disseminated to the candidate or networks or used to inform any shortlisting / selection decisions.
- Applicants in 2022 to PCH Basic Training in QLD, SA, NSW, VIC and WA will sit the SJT as part of the pilot.
- The evaluation phase will occur from July to November 2022 and assess the success of the pilot. Long term analysis may also be conducted after the pilot has ended.

The participants raised and discussed the following matters:

- Questions are not randomized and may be repeated for candidates. However, research on the format of the exam, the conditions in which it is delivered, and the type of questions being asked, show a high degree of variability in measures and levels.
- The tool is intended to ease the burden and augment the local selection of trainees processes. It is not anticipated this will be mandated in future.
- Research is beginning to show that inclusion of video responses to some questions has reduced the gap in scores for different demographic groups, such as individuals who have English as a second language.
- It is envisioned the SJT would occur early in the selection process and be an additional piece of information used to screen candidates prior to interview.
- The SJT tests different attributes in potential trainees such as teamwork, cultural safety, problem solving, conflict resolution, communication and whole of life experience. Scenarios may require candidates to draw on multiple attributes to formulate their response and are not restricted to clinical situations.
- At this stage it is unknown if candidates were to re-attempt the SJT in future if their score would vary or stay the same.
- The SJT is delivered remotely, and candidates should not have to travel to take the test.
- A holistic framework will be used for the evaluation of the test looking at feasibility, acceptability, and value for the settings. A validation study will determine how well results have extrapolated into real-world outcomes.
- The SJT aims to take a 360-degree view and open response approach to reduce uniform bias and ensure diversity of candidates.

Trainee Selection Pulse Survey

The Trainee Selection Pulse Survey was delivered to all trainees in November 2021. The survey sought input regarding their experience in the selection into training and recruitment processes. This was a repeat of a survey offered in 2019 to determine changes in their responses over time.

Respondents were asked to rate their agreement with a series of statements regarding information provided prior to the interview process.

Respondents who agreed:	2019	2021	2021 Detail by Program: Advanced Training (n=118)	Basic Training (n=31)	Faculty Chapter (n=13)
Application information was easily accessible	73% (n=371)	82% (n=161)	79%	87%	100%
Able to access a copy of the position description	85% (n=428)	83% (n=164)	79%	90%	82%
Opportunity to attend an information session	Not asked	27% (n=54)	24%	42%	8%

Figure 9: TSPS results: Information provided prior to interview process

Respondents were asked to indicate the availability of tools or information about the selection process.

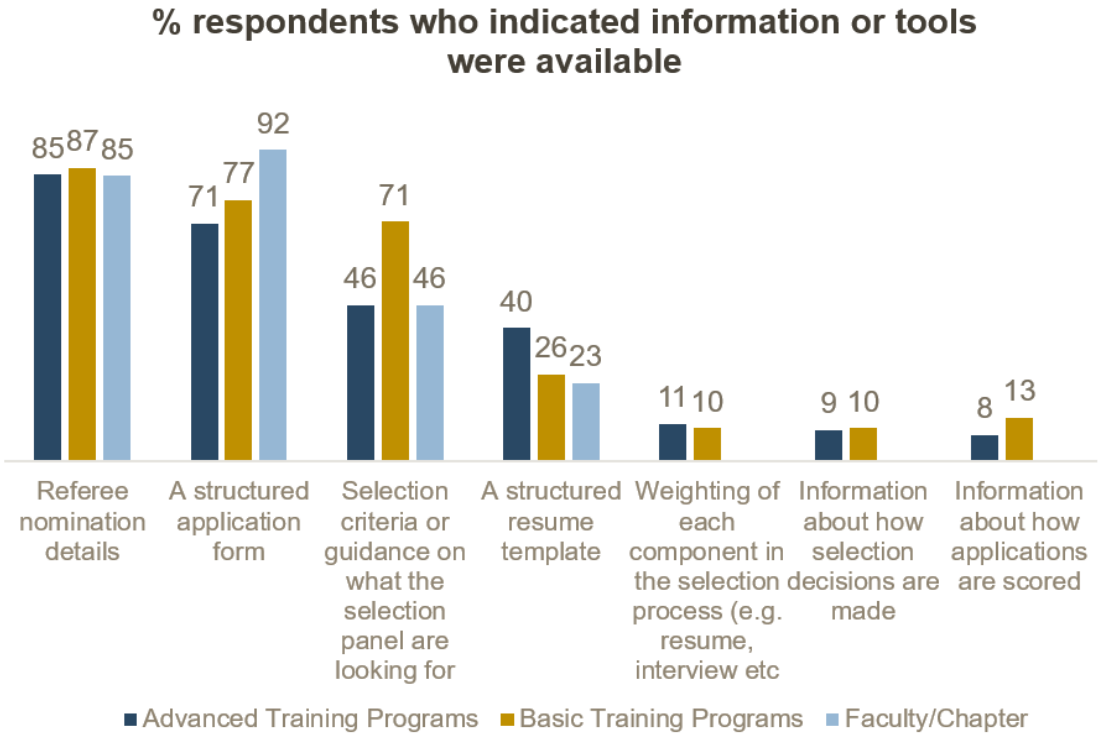


Figure 10: TSPS results: Availability of tools or information about selection process

Respondents were asked to indicate their involvement in pre-interview meetings.

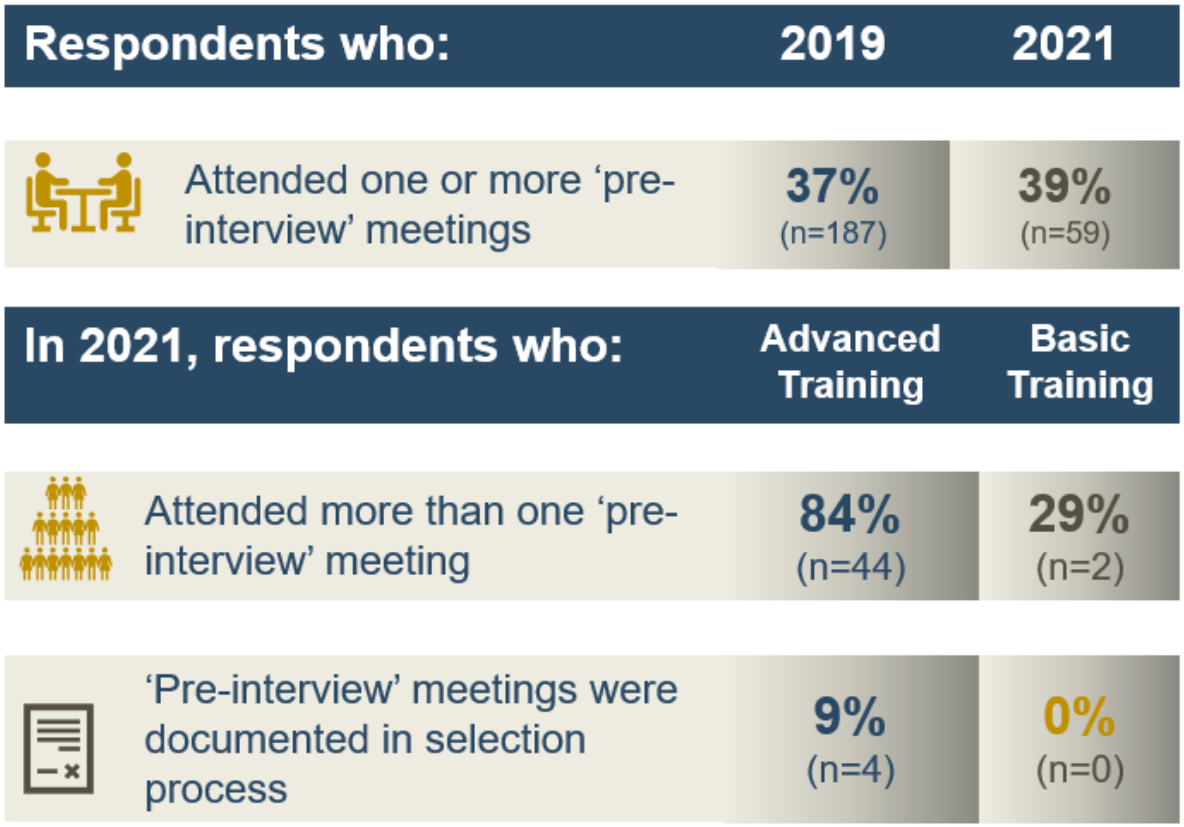


Figure 11: TSPS results: Involvement in pre-interview meetings

The participants raised and discussed the following matters:

- There should be greater recognition of the skills gained in rural and regional settings and advocacy across all training programs for this to be considered.
- The QLD BPT Network has attempted to incorporate recognition of pre-vocational skills gained in rural and regional settings in their recruitment processes.
- Bias towards certain qualities in the SJT and selection process may not have the desired outcomes in the long run.
- Recruitment for rural and regional settings can involve selling the setting to the applicant as well as trying to select the right applicant.
- Feedback was provided that current selection into training information provided by the College can be resource intense and has only served to exclude a small number of candidates when implemented.
- Merit based, defensible, transparent selection into training processes is required.
- Referees provided by trainees should be limited to supervisors from their last two clinical rotations to ensure they are relevant.

Learning and Teaching in the COVID-19 Age

Dr Spencer Toombes, Chair, AIM BT Committee sought input from the DPEs present regarding how COVID-19 impacts have changed Physician training. The group were presented with three questions for consideration.

1. **What tips do you have for running virtual teaching for large groups?**
2. **What tips do you have for teaching physical examination techniques during COVID-19?**
3. **What is the role of simulation for physical examination skills?**

The participants provided the following input:

- Attendees should have reliable internet, microphones, and cameras active during the session.
- Include instruction on how to arrive on the day for the exam so they know what to expect.
- Present trainees with information and simulated symptoms to promote differential diagnosis and discussion. Deliberately practice non-contact patient assessment skills.
- Trainees should be encouraged to use members of their household as simulation patients.
- Specialised simulation devices are useful, although they can be expensive.
- The CLS should consider including simulations to assist trainees to prepare for the DCE.

The participants raised and discussed the following additional matters:

- Preparation for the next DCE is currently occurring face-to-face. WA is only state offering a virtual DCE.
- Virtual examining is adequate for testing knowledge, however, the nuances that are present during an in-person physical exam cannot be duplicated in a virtual environment. The physical examination skills previously assessed in the DCE (pre-COVID-19 impacts) were only tested in the Short Case.
- Trainees and examiners will require a refamiliarization with the traditional face-to-face testing format following two years of virtual testing.
- Virtual consultations will be more prevalent going forward. As such, consideration should be given for how this can be assessed.
- Trainees are more anxious in the COVID-19 age and require additional pastoral support and consideration of their wellbeing.
- Different hospitals had differing levels of permission for interacting with patients during the COVID-19 outbreak. Trainees felt disadvantaged if they were based at hospitals that were more restricted.

Supporting Rural and Regional Settings

Prof Nick Buckmaster, Chair, College Council and Chair, Rural and Regional Physician Working Group presented on the work the College has been undertaking to support rural and regional settings.

- College Council highlighted College need to focus on supporting the provision of Physician services to rural and remote areas.
- The vision is to create equitable outcomes for AU and AoNZ residents living in rural, regional and remote (RRR) locations by advocating for and supporting regional and rural workforce training initiatives. This can be accomplished by facilitating collaboration between the government, employers, and the College to attract and retain Physicians in rural and regional areas.
- The working group has identified the following key focuses:
    - Raise the profile and recognise this is core business for the College
    - Accreditation barriers faced by rural and regional settings
    - Employer and workplace barriers

    - Trainee factors such as unwillingness to relocate due to family commitments and/or preconceptions about what rural and regional work entails.
    - Provision of training positions and funding for these positions
    - Supervision of training
- Draft recommendations include:
    - Create the Rural, Regional and Remote (RRR) Committee with the core business of addressing issues in practicing in RRR areas.
    - Representation on key College bodies
    - Create clear definitions of what is it to be RRR. This will likely be based on the Monash classification.
    - Consideration of revising Accreditation criteria to focus on the value of training outcomes obtained in RRR settings.
    - Support for RRR settings to navigate the Accreditation application process.
    - Seek further input on the value of compulsory RRR rotations.
    - Consideration of work-load management for trainees and supervisors and engaging with employers to realise the benefits of a successful training program.
    - Ensure facilities are adequate for training, have sufficient General Medicine supervision, and any current technological barriers are addressed.
    - Fly-in-fly-out may address immediate needs, however, does not resolve the aim of establishing a local workforce.

The Australian National Medical Workforce Strategy (ANMWS) was released in 2021.

Key points include:

- Increased collaboration between colleges, employers, and jurisdictions to plan and design workforces.
- Rebalance supply and distribution of the workforce.
- Reform training pathways to move away from pure experiential outcomes while not reducing the standards of achievement and competence.
- Build generalist capability.

Key themes include:

- Doctor well-being, culture, and leadership.
- Increasing the Aboriginal and Torres Strait Islander workforce and creating a culturally safe workforce.
- Service delivery and changing models of care.

Recommendation provided to attend RRR discussion at upcoming RACP Congress

The participants raised and discussed the following additional matters:

- RRR sites have been de-listed from AT specialty rotation status if they are missing required elements which are generally available at larger settings and not available at the RRR setting. This can make it difficult to attract trainees to the RRR setting. Strict adherence to requirements makes it difficult for RRR settings to obtain Accreditation and prevents trainees from gaining the unique experience offered by RRR training.
- Network models need to reconsider increasing the number of trainees required to rotate to RRR settings. It was noted mandatory rotation may lead to resentment amongst trainees. As such, the focus should be on the benefits of rotating to RRR settings.
- Increasing the duration of the RRR rotation may help to improve the experience and mitigate resentment amongst trainees.

- The Accreditation process required by the setting should be proportionate to the number of trainees that will rotate to the setting. For example, Level 1 or Secondment Teaching Hospitals should have a less onerous application process and should be provided additional assistance to complete the process.
- Tertiary based hospital networks where trainees return to the primary hospital to prepare for the DCE tend to promote the idea that RRR settings are not suitable locations to prepare for the DCE.
- Settings can incentivise trainees to rotate to RRR settings by providing their preferred rotations when they return to the primary hospital. This needs to be a measured approach as the need for incentives may lead trainees to believe the rotation is inferior.
- Australia Medical Council accreditation criteria for vocational education providers indicates that the training program must meet the needs of the community it serves. The Rural and Regional Physician Working Group is a step towards ensuring this criteria is met.
- Increased STP funding may assist to incentivise employers to rotate trainees to RRR settings. Additionally, rental assistance to trainees when rotating to RRR settings may assist to remove the financial burden of relocating.
- Remote supervision or a blend of supervision by a local doctor who is not FRACP in coordination with a remote FRACP is being considered as an approach to addressing supervision requirements.
- Providing RRR Advanced Training positions which lead to a pre-planned position in a metro area at later stage in the trainee's career may assist to incentivise trainees to take on the RRR position.
- Funding from the federal and state governments needs to be locally directed to RRR settings in order to meet the ANMWS.
- The Royal Australasian College of Surgeons' Rural Health Equity Strategic Action Plan was noted as being a commendable approach with clear domains for RRR training.

Questions to Expert Panel

Due to time limitations, there were no additional questions or discussion.

Participants were requested to email BasicTraining@racp.edu.au with further queries regarding any aspect of the Forum.

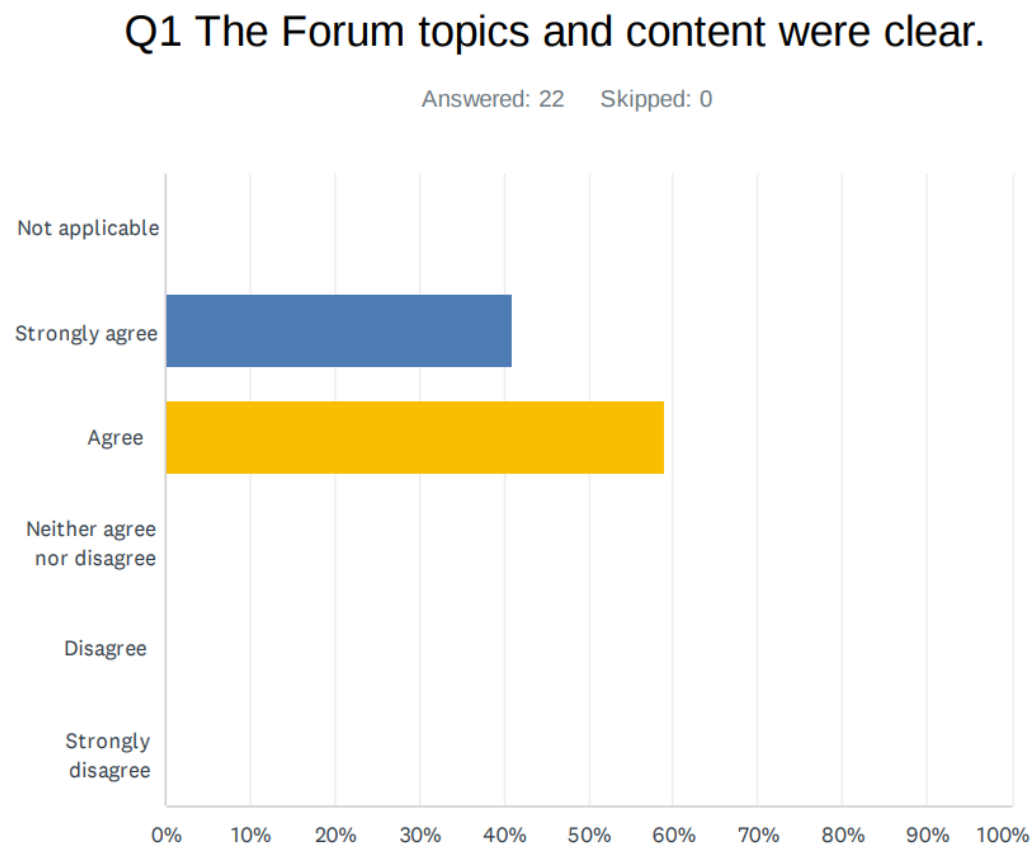
Conclusion

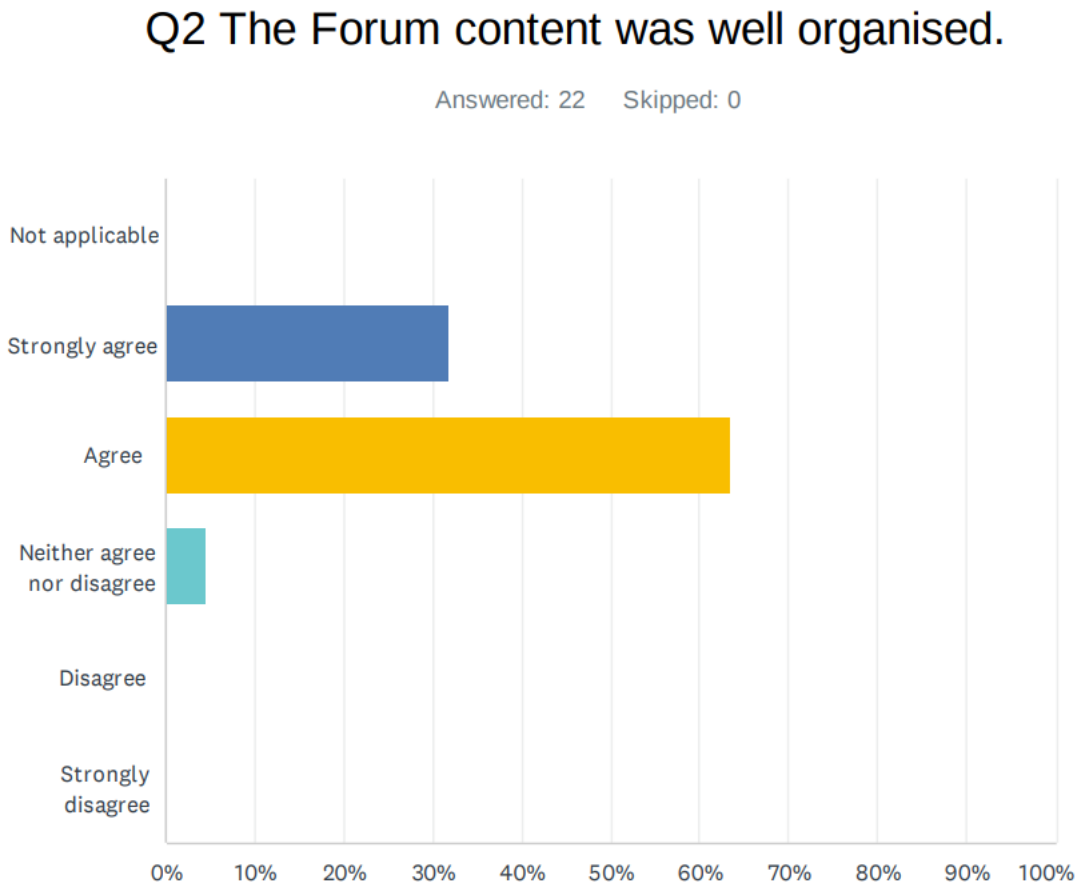
Dr Spencer Toombes thanked the presenters, College staff and those in attendance for a successful Forum.

A/Prof Mitra Guha, Chair, CEC acknowledged that Dr Toombes' term as Chair of the AIM BT Committee would conclude on 25 March 2022 and thanked him for his commitment to Basic Training over the years.

The 2022 DPE Forum concluded at 4:00pm AEST

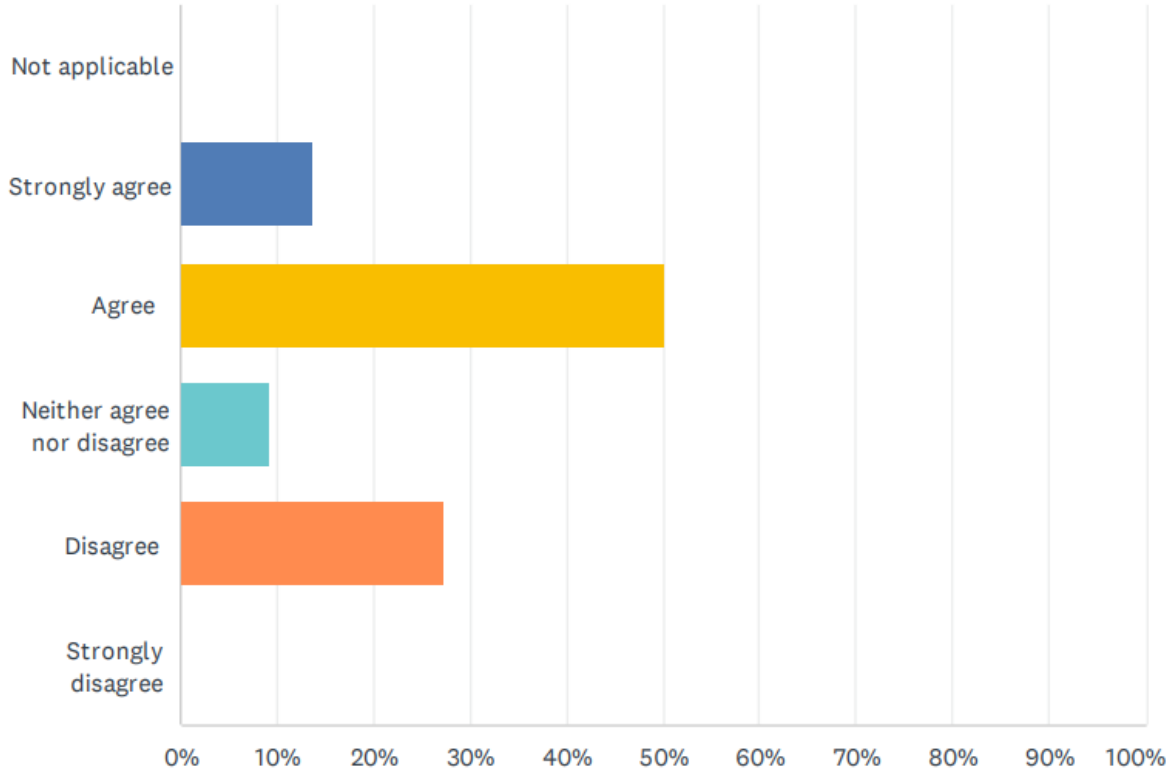
Appendix 1: Meeting evaluation





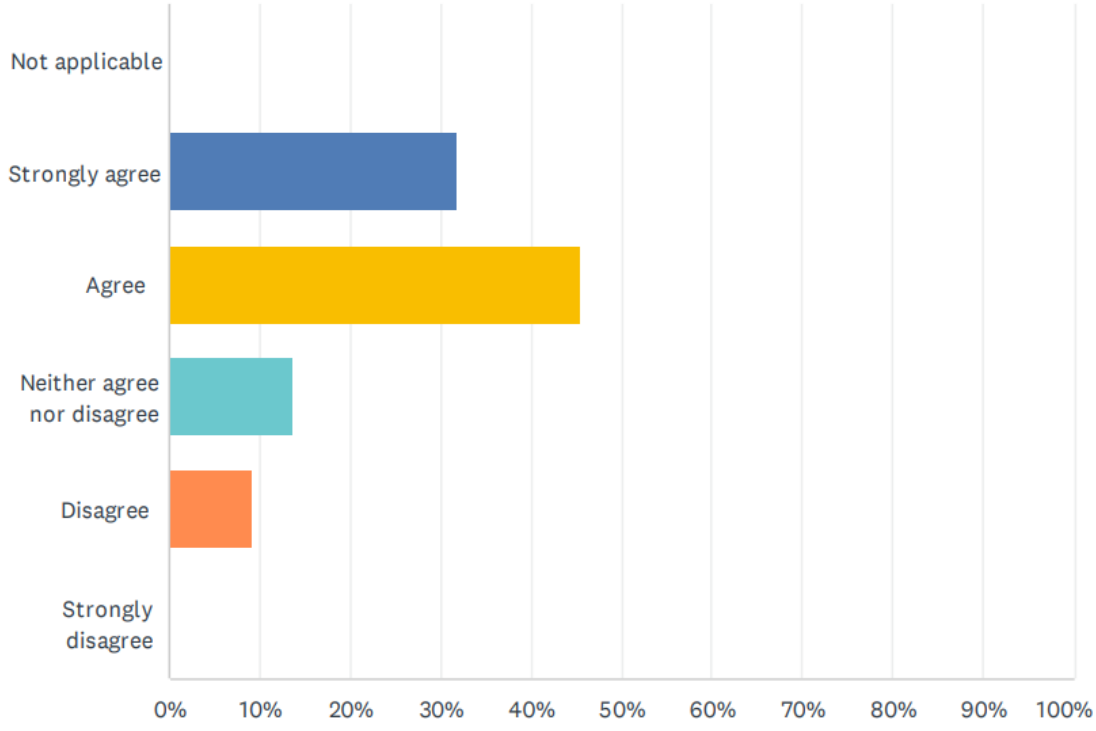
Q3 The length of the Forum was sufficient.

Answered: 22 Skipped: 0



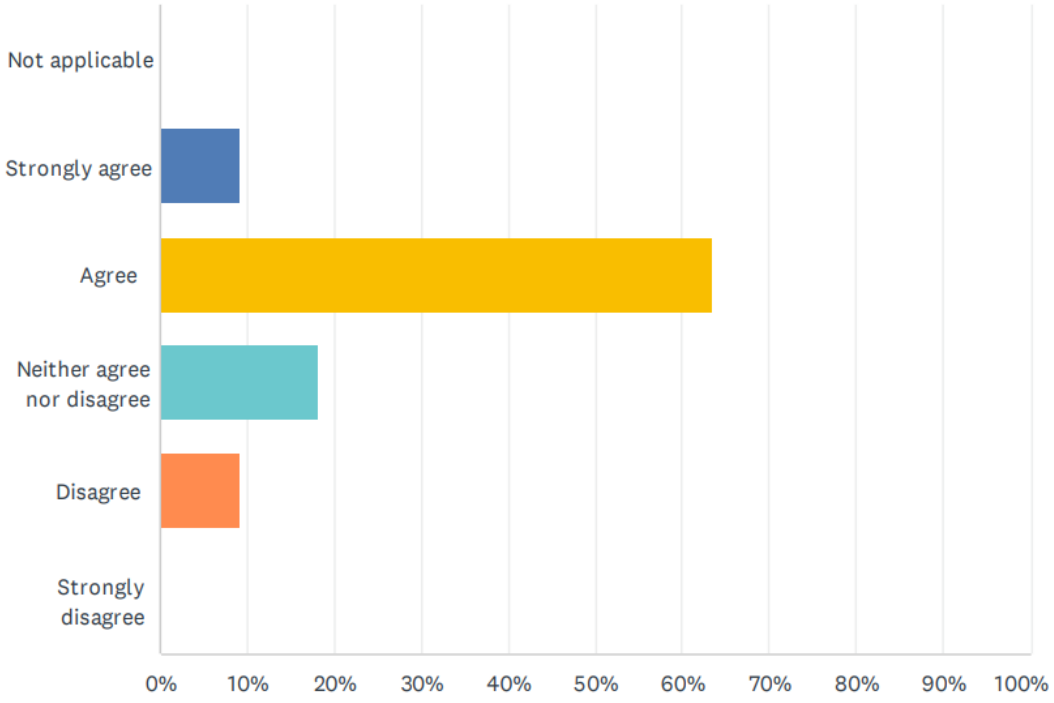
Q4 Questions were encouraged at the Forum.

Answered: 22 Skipped: 0



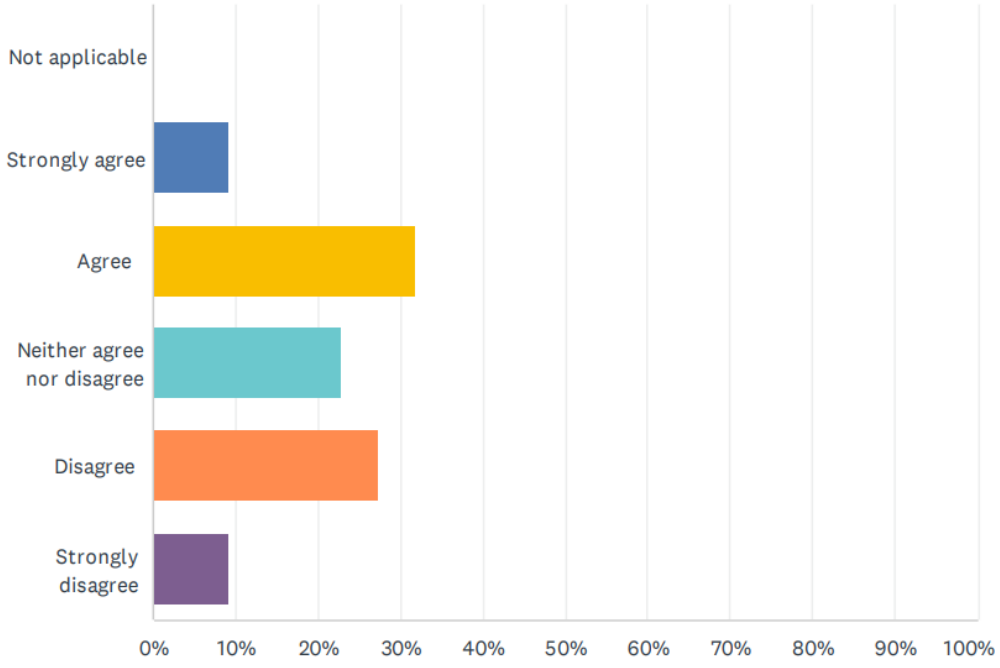
Q5 Questions asked were clearly answered.

Answered: 22 Skipped: 0



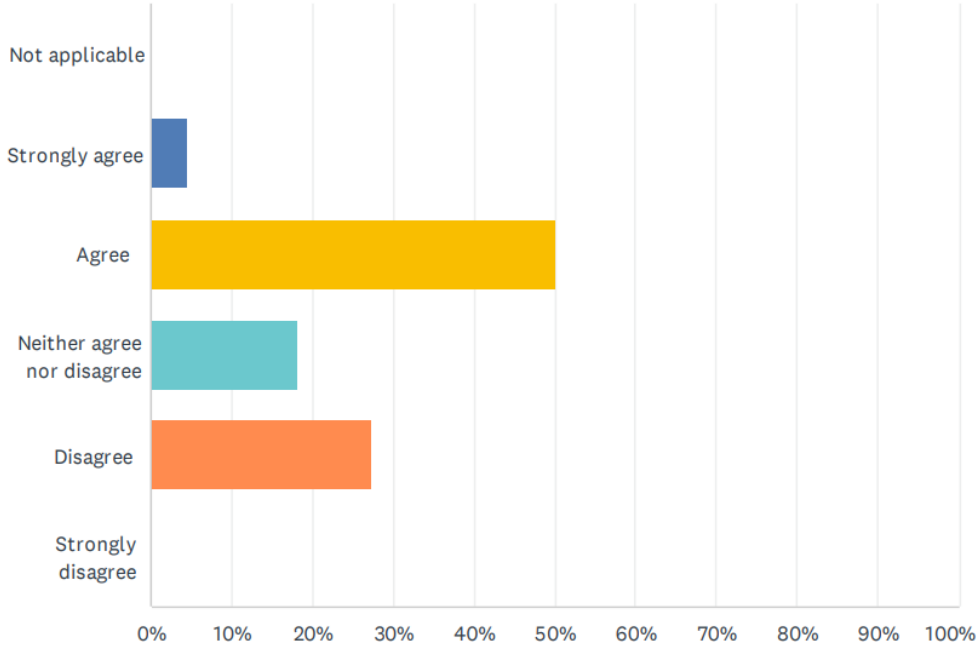
Q6 Participants had ample opportunity to present ideas and opinions.

Answered: 22 Skipped: 0



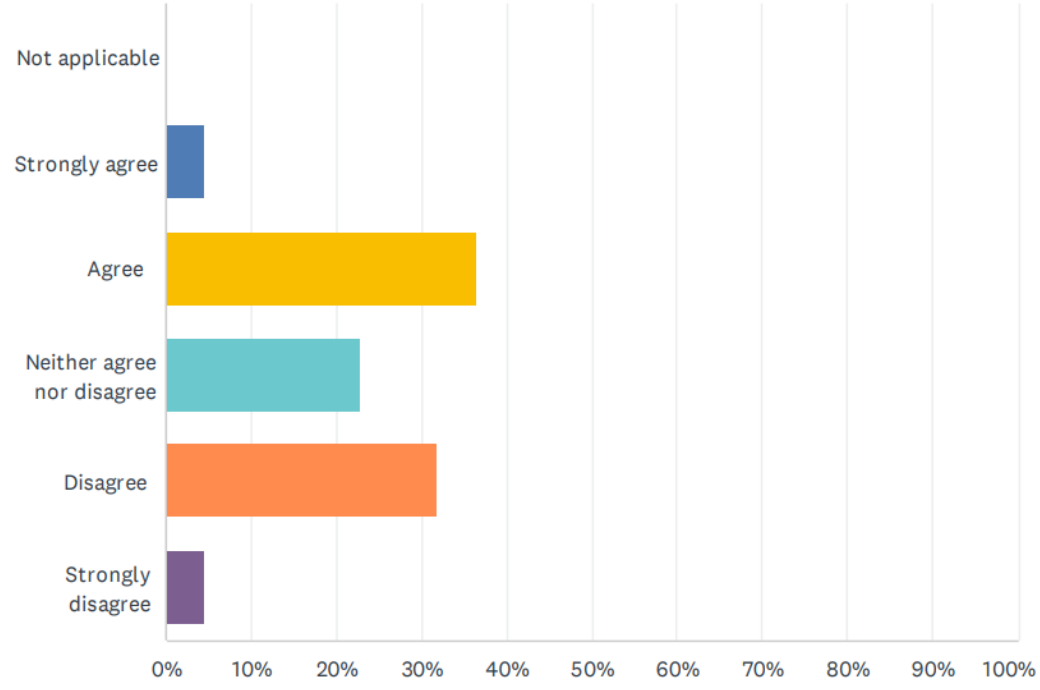
Q7 Forum structure helped the group to consider complex issues

Answered: 22 Skipped: 0



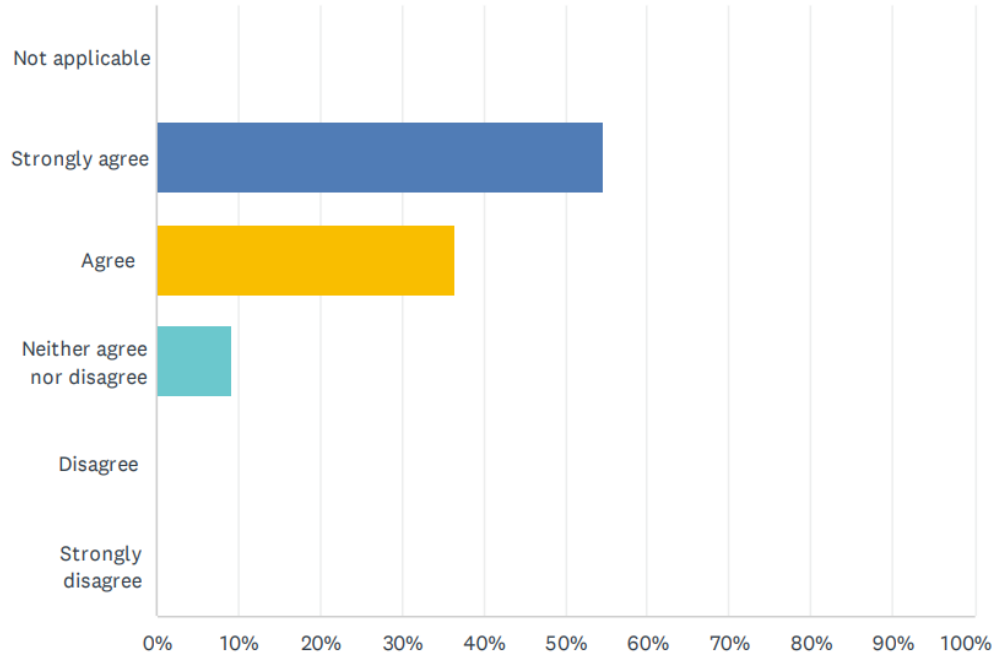
Q8 Forum structure helped the group to make effective recommendations.

Answered: 22 Skipped: 0



Q9 I would be prepared to participate in a similar Forum on another occasion.

Answered: 22 Skipped: 0



Which aspect(s) of the day did you find most useful?

- Discussions with other DPE's about complex topics, i.e. capacity to train, exam preparation and the examination itself.
- Recent Division written exam results issues and explanation. Proposed changes to BPT program candidates selection. The proposed introduction of Situational Judgement Test. Regional, Rural and Remote Medicine issues and proposed local training support.
- Updates on the new curriculum and SJT and selection into training
- Feedback on the written exam
- Networking with other DPEs and discussing about clinical exam preparation with covid-19 impact.
- The Rural and Regional discussion
- Sharing Ideas with other DPE's from across Australia
- Discussion on training in remote and rural sites
- It was wonderful being able to see DPEs face to face again, and to meet DPEs from other states to hear how they do things differently
- Exams, Accreditation and training.
- The entire session
- The discussion overviewing recent examination challenges was helpful to understand the College response and to hear other DPEs perspectives
- Hearing the plans towards new curriculum roll out.
- Various topics covered well - written & clinical exam issues in particular.
- Just hearing the experience from other DPEs and meeting other colleagues.
- Updates on accreditation and curriculum renewal.
- Lunchtime discussion with DPEs and networking.
- Opportunity to meet other DPEs.
- The face-to-face Discussions with other DPEs about training issues- capacity to train; accreditation issues etc.
- Discussion about the written and clinical examinations preparation issues during COVID19 pandemic. Insightful discussion on progress from this point and time, independent of COVID19.
- The face-to-face chats with colleagues in Melbourne. Created functional ideas to complex issues we all encounter.

Which aspect(s) of the day do you think could be improved?

- There is just not enough time to discuss the increasing complexity of being a DPE and cover all the planned content.
- More time allocation for questions and answers.
- More detail regarding the Divisional Clinical Exam. More information regarding selection into training and who will be deciding this i.e., will this be a formal process held by RACP or is this still undertaken by DPE at the local level.
- Timeliness
- Exploring the alternatives for FRACP clinic exam as it may not be sustainable forever. More effort to incentivize and support BPTs in remote and rural areas.
- Face to face would always be more ideal.
- None.
- Encourage more F2F attendance next year, although I know you have limited control over this.
- Rural and regional training.
- Q&A session.
- Attending virtually carries challenges - presenters could be encouraged to use the first 5 minutes of any discussion to encourage questions from out of the room(s) initially. This should mean less time spent in the chat function.
- Would like to actually feel like College staff are supportive of DPEs.
- More time for discussion - difficult though in a hybrid format.
- We probably need to talk a bit more about selection into training.
- With topics like curriculum renewal, changing accreditation requirements and examination renewal the presentations were necessarily succinct (given time constraints)- but lacked detail, with limited opportunity to ask the practical questions DPE have - like how will we roll this out?

What support and resources will we get? How does the accreditation committee interpret expectations re: handover/clinic exposure? It would be more useful to cover fewer topics in more detail. Perhaps 2 sessions a year - one virtual and one mixed are needed. DPEs could be surveyed in advance about priority topics.

- There is a lot of time allocated to reviewing 'what was done'. Big issues seem to be kicked down the road e.g., capacity to train. It would be helpful to have a 'big topic' to discuss at each forum and targeted presentations and discussion groups.
- Encouraging more interaction and problem-solving within groups of attendees.
- Scope for DPEs to direct some of the content. The day was at up with RACP agenda rather than what many of us would have liked to have discussed. Still great though- thanks!!
- Discussions.
- It was more information giving by the college rather than pulling the real expertise and issues encountered by the group.

Suggested topics for discussion at the next DPE Forum:

- I think we need to spend more time on delivery of the examination and capacity to train. I think there is a major pressure coming around safe staffing and the complexity that will result around capacity to train.
- How the RACP can support and contribute to the structured medical training in regional, rural and remote areas including resources, accreditation, formation of training hubs and linking with tertiary facilities.
- Assistance with Capacity to Train. Can RACP propose numbers/set limits or suggest trainee/supervisor ratios for existing centres or advocate for DPE's when local settings do not provide adequate funding for provision of educational resources (rather than just waiting for each accreditation cycle).
- More information on accreditation would be helpful.
- FRACP clinical exam alternatives.
- The new software system, TRACC.
- Larger discussion on capacity to train and restricting numbers. Bringing in a full 3-year training programme.
- Future shape of training program and sustainable models to continue with innovation. There is a need to discuss newer models for training rather than trying to repeat the same old systems. More emphasis on work based learning and longitudinal assessments. Are trainers given any due recognition for the time they devote for training as the capacity to train has increased and the burden is saved by a few.
- I would like to see some longitudinal data on DPE turnover rates (state based and national) from the RACP. If this were increasing, a forum to discuss why this might be the case may be helpful.
- capacity to train is a key issue with no simple answers, yet the mort pertinent affecting all of us.
- Supporting trainees in difficulty - what can the TSU offer, what are the expectations on DPEs. Improving engagement and the colleges reputation following examination issues occurring again. Our supervisors and exhausted and stressed from COVID and generally increasing workloads and are therefore reluctant to engage in extras like mock exams and examining for actual exams. The written examination problems have exacerbated this even further. How can the college reputation be repaired? How can engagement be improved?
- Capacity to train (learn from other states e.g., SA and WA how they restrict numbers) clinical examination (if it is to be altered).
- Capacity to train. Overall structure of what makes an adequate training experience. Ideas about exam format.
- Concentrate on the training and not on the exams. Perhaps, we could have discussions or present proven methods to improve medical education and retention, as well as methods to optimise the training of physicians for the future.
- Burnout of trainees - high turnover of DPE staff and functional support to make their jobs more sustainable.