2023 Adult Internal Medicine Director of Physician Education Forum

Report
22 March 2023

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Contents

Executive Summary

Education, Learning and Assessment (ELA) Update

Updates were provided on projects in flight regarding:

- Education Governance
- Education Technology
- Training Enquiry
- Supervisor Professional Development Program (SPDP)
- Growing the Indigenous Physician Workforce
- Entry into Basic Physician Training
- Training Surveys

Divisional Clinical Exam (DCE): 2023 Logistics

- An overview of the 2023 DCE logistics was provided.

Discussion focused on scoring, exam places, and how to become an examiner.

Changes to the Flexible Training Policy (FTP)

- The FTP has four key changes effective 1 January 2023:
    - Removal of 24-month cap on amount of parental leave excluded from maximum time limit to complete training.
    - Excluding medical leave from the maximum time limit to complete training.
    - Reduce minimum standard full-time equivalent (FTE) for part time training from 0.4FTE to 0.2FTE.
    - Introduction of 'return to training plan' concept following prolonged absence.

Selection into Training (SiT) Policy Consultation

- The SiT Policy has three key proposed changes for feedback:
    - Change from Principles to Strategic Goals and shift to Social accountability and Indigenous equity.
    - Provisions to drive growth of the rural and/or Indigenous health and/or Indigenous physician workforces.
    - Changes to the Standards for Selection Processes and integration of Standards into the main policy.

Accreditation Renewal

- Accreditation Renewal is currently in Phase 2 of the rollout which runs until December 2024.

Discussion focused on:

- The aim of Accreditation is to improve quality.
- The College is there to support DPEs through Accreditation to ensure the Standards and Requirements are met.

New Basic Training Program Update

- Due to delays with the supporting software, Tracc, full implementation has been further delayed until 2025.
- The new Basic Training program curriculum is excellent, however, supporting technology is pivotal given the format and increased number of assessments.

Trainee and Supervisor Burnout

Discussion focused on three key questions:

- What do you perceive as the key drivers to burnout for trainees, supervisors and DPEs?
- What program or online resources has your training setting implemented to address trainee and supervisor well-being?
- What key points would you like this Forum to feedback to the RACP Health and Wellbeing Committee?

Supporting Rural and Regional Settings

- A draft Regional, Rural and Remote Physician Strategy has been developed and is in consultation.

Discussion focused on:

- The difficulties faced by trainees and Fellows when relocating to rural and remote areas.
- How to incentivise trainees to undertake rural and remote rotations.

Agenda

Time	Session	Lead/Speaker	
10.00am (15 minutes)	Welcome • Acknowledgement of Country • Objectives • Introductions	Dr Andrew Henderson	Chair, Adult Internal Medicine (AIM) Basic Training (BT) Committee
10.15am (5 min)		A/Prof Mitra Guha	Chair, College Education Committee (CEC)
10.20am (30 minutes)	Introduction to new Executive General Manager, Education, Learning and Assessment (ELA) and Update on ELA projects	Prof Inam Haq	Executive General Manager (EGM), Education, Learning and Assessment (ELA)
10:50am (30 minutes)	Divisional Clinical Exam: 2023 Logistics	Naseem Anwar	Senior Executive Officer, Assessment and Selection
11.20am (15 minutes)	Break: Morning tea		
11:35am (20 minutes)	Changes to the Flexible Training Policy	Libby Newton	Manager, Education Policy, Research and Evaluation
11.55m (20 minutes)	Selection into Training Policy Consultation	Libby Newton	Manager, Education Policy, Research and Evaluation
12.15pm (30 minutes)	Accreditation Renewal	Emily Morrison	Manager, Training Accreditation Services
12.45pm (1 hour)	Break: Lunch		
1.45pm (30 minutes)	New Basic Training Program Update	Ella Veness	Manager, Program Implementation
2.15pm (45 minutes)	Trainee and Supervisor Burnout Discussion	Dr Andrew Henderson and Dr Claire Dendle	AIM BT Committee
3.00pm (10 minutes)	Break: Afternoon tea		
3.10pm (20 minutes)	Rural, Regional and Remote Settings Update and Discussion	Prof Martin Veysey	Member, Rural and Regional Physician Working Group
3.30pm (15 minutes)	Questions and Open Discussion	Dr Andrew Henderson	AIM BT Committee
3.45pm (5 min)	RACP President Address	Dr Jacqueline Small	RACP President
3.50pm (10 mins)	Wrap-up and Thank You	Dr Andrew Henderson	Chair, AIM BT Committee
4.00pm (2 hours)	Post Forum Networking		

Participants

Facilitators & AIM BT Committee Members	Role
1. Dr Andrew Henderson	Chair, AIM BT Committee & DPE - Westmead Hospital, NSW
2. Dr Jacqueline Small	RACP President
3. A/Professor Mitra Guha	Chair, College Education Committee Royal Adelaide Hospital, SA
4. Dr Abu Abraham	Member, AIM BT Committee & DPE – Fiona Stanley Hospital, WA
5. Dr Claire Dendle	Member, AIM BT Committee & DPE - Monash Medical Centre, VIC
6. A/Professor Matt Doogue	Member, AIM BT Committee & Member of the Written Examination Committee – Adult Medicine
7. Dr Renee Eslick	Member, AIM BT Committee & DPE - Canberra Hospital, ACT
8. Dr Paul Jauncey	Member, AIM BT Committee & DPE – Sunshine Coast University Hospital, QLD
9. Dr Marc Lanteri	Member, AIM BT Committee & DPE - Werribee Mercy Hospital, VIC
10. Dr Alice O'Connell	Member, AIM BT Committee & DPE - Royal Adelaide Hospital, SA
11. Dr Sajan Thomas	Member, AIM BT Committee & DPE - Alice Springs Hospital, NT
12. A/Prof Michael Woodward	Member, AIM BT Committee & Chair of the Adult Medicine Division Accreditation Subcommittee
Directors of Physician Education	**Hospital and State**
1. Dr Zarrin Allam	Royal Perth Hospital, WA
2. A/Professor Wilma Beswick	St Vincent's Hospital, VIC
3. Dr Andrew Brett	Royal Melbourne Hospital, VIC
4. Dr Yog Chopra	Hornsby Ku-ring-gai Hospital, NSW
5. Dr Bianca Devitt	Box Hill Hospital, VIC
6. Dr Jonathon Fanning	Royal Brisbane and Women's Hospital, QLD
7. Dr James Gome	Warrnambool Base Hospital, VIC
8. Dr Shantha Hewapra Dewage	North West Regional Hospital, TAS
9. Dr Jonathon Hill	Wollongong Hospital, NSW

10. A/Professor Samuel Hume	Royal Melbourne Hospital, VIC
11. Dr Annie Hung	Albury Wodonga Health, NSW
12. Dr Neha Irani	Joondalup Health Campus, WA
13. Dr Cameron Jeremiah	University Hospital Geelong, VIC
14. Dr Shanthi Kannan	Queen Elizabeth II Jubilee, QLD
15. Dr Kenneth Khoo	Calvary Hospital, ACT
16. Dr Soe Ko	Grampians Health Ballarat, VIC
17. Professor Benjamin Kwan	St Vincent's Hospital, NSW
18. Dr Sophia Lam	Cairns Base Hospital, QLD
19. Dr Heather Lane	Sir Charles Gairdner Hospital, WA
20. Dr Ben Larkin	Shell Harbour Hospital, NSW
21. Dr Dayna Law	Logan Hospital, QLD
22. Dr Adrian Lee	Royal North Shore Hospital, NSW
23. Dr Matthew Lee-Archer	Launceston General Hospital, TAS
24. Dr Lauren Lim	Lyell McEwin Hospital, SA
25. Dr Nicole Lioufas	Sunshine Hospital, VIC
26. Dr Michael Low	Casey Hospital, VIC
27. Dr Rajasekar Malvathu	Rockingham General Hospital, WA
28. Dr David Martens	Liverpool Hospital, NSW
29. Dr Rhianna Miles	Greenslopes Private Hospital, QLD
30. Dr Afshin Moghadam	Robina Hospital, QLD
31. Dr Ajantha Narangoda Liyanage	Bundaberg Hospital, QLD
32. Dr Shaun Pandy	The Prince Charles Hospital, QLD
33. Dr Nadia Patel	Princess Alexandra Hospital, QLD
34. Dr Toni Pearson	Northern Beaches Hospital, NSW
35. Professor Jeffrey Post	The Prince of Wales Hospital, NSW
36. Dr Anne Powell	Alfred Hospital, VIC
37. Dr Simon Proctor	Flinders Medical Centre, SA
38. Dr Mohammed Nabil Richi	Geraldton Regional Hospital, WA
39. Dr Georgia Ritchie	Port Macquarie Base Hospital, NSW
40. Dr Anneke Shea	Toowoomba Hospital, QLD
41. Dr Belinda Smith	St Vincent's Hospital, VIC

42. Dr Jessica Stranks	Lyell McEwin Hospital, SA
43. Dr Eddy Tabet	Royal Prince Alfred Hospital, NSW
44. Dr Eleanor Tan	North West Regional Hospital, TAS
45. Dr Spencer Toombes	Toowoomba General Hospital, QLD
46. Dr Corinne Tey	St Vincent's Hospital, VIC
47. Dr Malcolm Turner	Royal Hobart Hospital, TAS
48. Dr Chinweuba Ubani	Bunbury Hospital, WA
49. Dr Belinda Weich	Mackay Base Hospital, QLD
50. Dr Tim West	Campbelltown Hospital, NSW
51. Dr Emily Woolnough	St John of God Midland Public and Private Hospitals, WA

College staff	Role
Professor Inam Haq	Executive General Manager, ELA
Nicole Willico	Manager, Training Services, ELA
Emily Morrison	Manager, Training Accreditation Services
Libby Newton	Manager, Education Policy, Research and Evaluation (EPRE)
Naseem Anwar	Senior Executive Officer, Assessment and Selection
Ella Veness	Manager, Program Implementation
Rebecca Udemans	Head of Education, Development & Improvement
Imogene Rothnie	Senior Project Specialist, EPRE
Sarah Millar	Manager, BT & AT Services Au & AoNZ
Jennifer Gili	Training Program Manager, ELA
David Van Boom	Senior Executive Officer, Basic Training
Victoria Arifin	Executive Officer, Basic Training

Welcome

Dr Andrew Henderson, Chair of the Adult Internal Medicine (AIM) Basic Training (BT) Committee, welcomed attendees to the 2023 AIM DPE Forum comprising of in person attendance in both NSW, VIC and WA as well as virtual attendance from attendees across Australasia. Dr Henderson additionally gave an overview of the Forum's Agenda.

A/Prof Mitra Guha, Chair of the College Education Committee (CEC), welcomed the DPEs present. A/Prof Guha reflected on her tenure with the College including 27 years serving as a DPE. DPEs are the face of the College in each hospital and are the key and central person representing the College. The role of DPEs has evolved over time. Additionally, the number of Physician trainees in Australasia has grown significantly. The increase in trainee numbers and expectations placed on DPEs has introduced challenges. The role of the CEC is to ensure quality is maintained across all College programs while aiming to improve the experience of trainees and educators. The College owes DPEs an immense debt of gratitude for their often unrecognised and unrewarded contribution.

Education, Learning and Assessment (ELA) Update

Prof Inam Haq, Executive General Manager - ELA, provided an update on the following:

Projects in flight

Education Governance

We are undertaking a review of the education committee structure and function to develop and implement a contemporary governance and reporting structure that aligns with College values, prioritises effective decision-making and timely communication, and contributes to a high-quality member/trainee experience.

Expressions of interest are currently open to join the Education Governance Working Group.

Education Technology

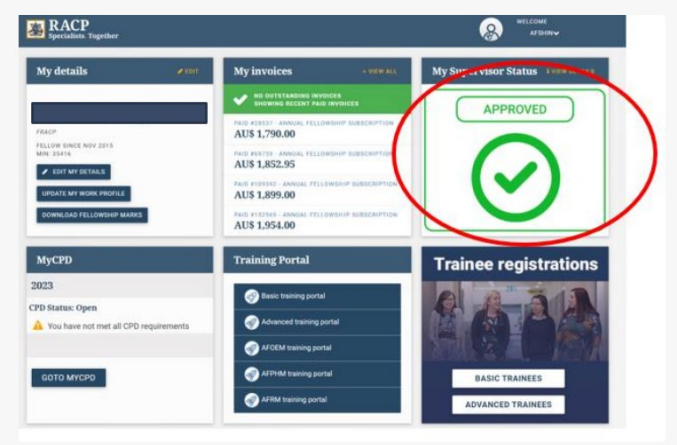
The Board has prioritised education technology in 2024 engaging KPMG to provide a report on a whole of education technology architecture solution. A functional assessment and project integration will take place in 2024 to enable swifter outcomes for members.

Training Enquiry

We recognise we need to improve our response timelines and communications and have commenced a staged program of process improvements, information sharing, technology add-in, training and resourcing.

Supervisor Professional Development Program (SPDP)

Over 200 SPDP sessions were delivered in 2022 to approximately 3000 supervisors. To remain eligible to supervise, you must have completed your SPDP workshops by 31 July 2023. Supervisors who have met their SPDP requirements will have an 'Approved' tick in their MyRACP:



Growing the Indigenous Physician Workforce

- 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.
    - Well-being and performance coaching Māori and / or Pasifika Basic Trainees.
    - RACP online communities (ROC) for both our Aboriginal and / or Torres Strait Islander members via the Deadly Doctors ROC and for Māori and / or Pasifika members through the Māori Caucus
    - An equipment fund to provide a fully equipped physician briefcase for trainees eligible for the 2023 DCE or other relevant clinical assessments.
    - Continued work with AIDA on the cross-medical college initiative, the Specialist Trainee Support Program (STSP). This has included access to a range of opportunities for RACP supervisors to learn about culturally safe supervision, and the provision of on-going culturally safe options for support to our trainees.

Entry into Basic Physician Training (BPT)

- Jurisdiction information about applying for BPT on website
    - To improve consistency of and access to information about applying for training in Australia and Aotearoa New Zealand for both Adult Medicine and Paediatrics and Child Health.
    - Webpages will be promoted through RACP communication channels in 2023 as a resource for potential trainees.

- Pilot of pre-interview assessment tool (online Situational Judgement Test called 'Casper')
    - We're collaborating with five paediatric training settings/networks in Australia and an external test provider to pilot and evaluate a pre-interview assessment tool intended to improve the selection process.
    - Test is intended to measure candidates' ability to reflect on and communicate responses to interpersonal and professional dilemmas, in line with the attributes outlined in the RACP selection criteria and professional practice framework.
    - 278 applicants to the Queensland, Victorian, New South Wales, South Australian and Western Australian Basic Paediatrician Training Networks for BPT 1 in 2023 voluntarily completed Casper during the relevant jurisdiction recruitment and selection timeframes in 2022.
    - Evaluation findings - some good evidence of validity, reliability, and acceptability of the test.

- Next steps - consideration of evaluation findings and development of recommendations to College Education Committee about the use of such assessments for entry into Basic Training.

Training Surveys

Two surveys were conducted, the Physician Training Survey (PTS) and the Medical Training Survey (MTS), between August and November 2022. Trainees in AoNZ, educators in AoNZ and educators in AU took the PTS and Trainees in AU took the MTS.

Response rates of 47% from Australian trainees, 18% from AoNZ trainees, and 13% from all educators.

Overall satisfaction

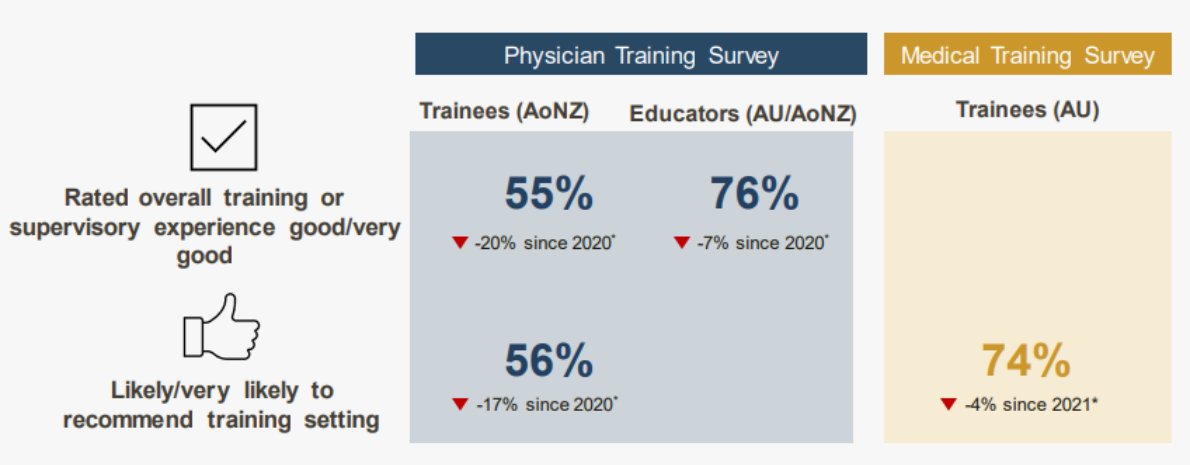


Figure 1: Overall satisfaction

Supervision

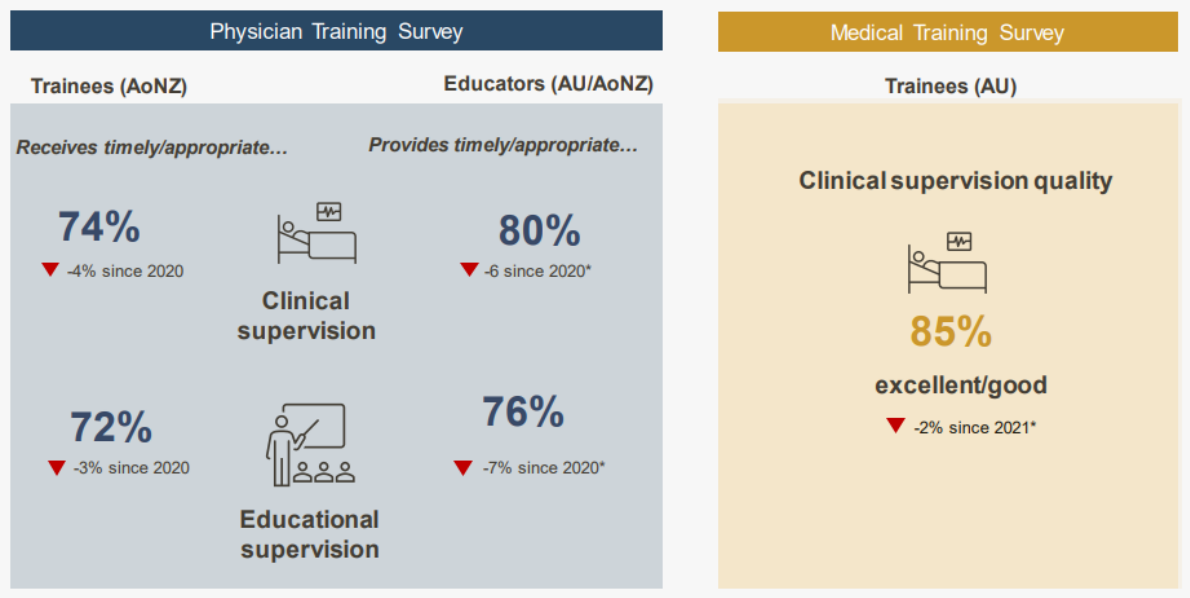


Figure 2: Supervision

Protected Time / Capacity

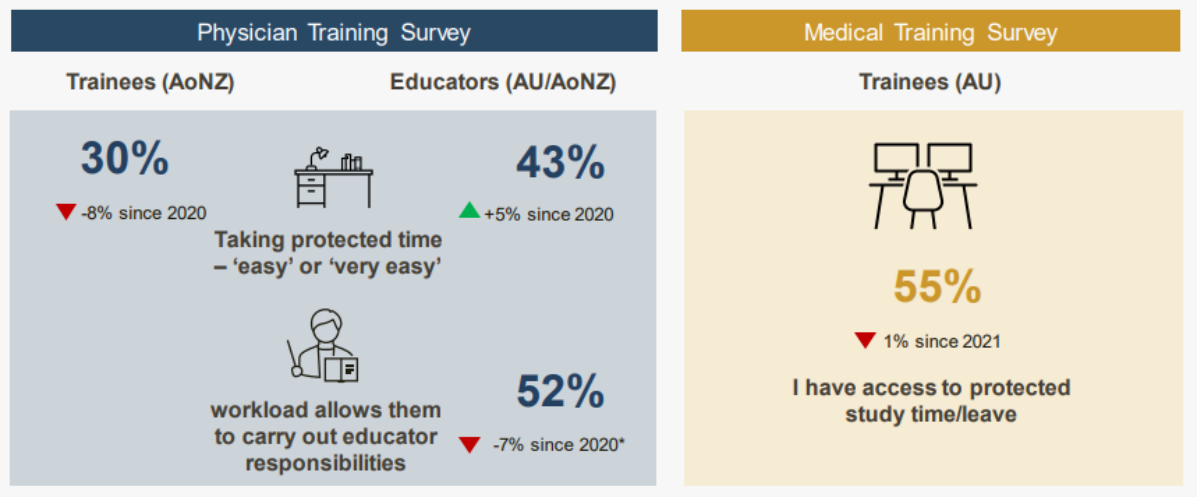


Figure 3: Protected Time / Capacity

The survey findings are used to:

- Inform our work on the following:
  - Education Renewal program
  - New Physician Health and Wellbeing Strategy
  - Safe Training Environments action plan
- Sharing the findings:
  - Interactive reporting dashboard for DPEs with local results
- Following up concerns:
  - Engage with training settings that have stand-out concerns
  - Offer support to educational leaders
  - If warranted, request responses outlining actions to be taken

Participants raised and discussed the following matters:

SPDP

- DPEs may request a list of who has pending SPDP requirements at their setting by emailing Supervisor@racp.edu.au. Supervisors are also able to view their completion status on MyRACP.
- Trainees will be able to view a current list of eligible supervisors via the RACP website. The date this will be available is still to be confirmed.
- Larger settings have a significant number of supervisors and obtaining a list of their completion status can be difficult. Improvements to reporting (i.e. PowerBI) have been implemented to simply and efficiently identify supervisors with pending requirements.

Growing the Indigenous Physician Workforce

- NSW Health has developed a strong program; consideration could be given to cross-credentialing.
- NT Health has their own credentialing with compulsory cultural safety included in the curriculum.
- Most hospitals now have mandatory cultural safety training. However, the definition of cultural safety is evolving and changing so we must continue to be vigilant.

Entry into BPT

- Casper is an additional tool to enhance selection into training by providing further insight into candidates communication, interpersonal and professional skills.

Training Surveys

- Regional vs metropolitan breakdown was requested.
- The College should advocate for defined FTE in supervisory roles and this is often greater than the FTE that is currently in the guidelines.
- Establishing a training program can be very time-consuming and this is not reflected in the suggested FTE.
- Using Accreditation as leverage to ensure training settings are providing appropriate FTE to supervisors is the most effective tool the College can utilise.
- The pro-rata FTE guidelines were created several years ago, the current expectations on DPEs and supervisors need to be considered as these have increased over time.
- Some settings have an expectation that the College should be funding the supervisory roles.
- Supervisors have increasing service delivery expectations due to workforce shortages and this is impacting their capacity to provide training. Some settings do not have enough clinicians willing to supervise in addition to their roles and this further impacts the demand on those willing to supervise.
- Supervisors of other medical colleges have queried why RACP supervisors are allocated FTE for supervision and this has not been provided for their program.
- The College has relied on volunteer educators for a long time, there should be a push to professionalise supervision.
- Review or Training Provider Standard and Accreditation requirements to occur next year. Additionally, Capacity to Train Guidance implementation data should be available next year. This data can be used to inform the review of FTE.
- DPEs should use their Accreditation review to request appropriate FTE as this can be included as a condition. Additionally, this does not necessarily need to wait until re-accreditation, if there is inadequate FTE being provided please inform the Accreditation team by emailing Accreditation@racp.edu.au.
- Active management process in place to deal with settings with serious non-compliance issues.

Divisional Clinical Exam (DCE): 2023 Logistics

Naseem Anwar, Senior Executive Officer, Assessment Services presented to the Forum on the 2023 DCE logistics.

Key Dates

Country	Applications Open	Applications Close
Australia	17 March 2023, 10:00am	27 March 2023, 1:00pm
	Exam Date	**Results Release**
	9 June to 25 June 2023	Week of 3 July 2023
	Applications for Special Consideration are subject to a deadline of 5 business days post examination.	
Country	**Applications Open**	**Applications Close**
Aotearoa New Zealand	17 March 2023, 10:00am	27 March 2023, 1:00pm
	Exam Date	**Results Release**
	9 June to 18 June 2023	Week of 3 July 2023
	Applications for Special Consideration are subject to a deadline of 5 business days post examination.	

Figure 4: DCE Key Dates

Ms Anwar provided an overview of the following items:

- DCE Candidate terms and conditions have increased detail for the 2023 application
- Location of the exam for AU and AoNZ
    - AU exams will be held within another state or territory. Candidates should be prepared to travel to a different state or territory depending on where they're allocated to sit the exam.
    - AoNZ will candidates travel to a different location from where they work to complete their exam. Candidates won't be examined in hospitals where they're trained.
- Contingency plans for significant disruptions:
    - Plan A - The exam proceeds as scheduled on the planned exam date using the planned delivery model.
    - Plan B - The exam will be rescheduled as soon as possible. Impacted candidates may be reallocated to other local available exam sites.
    - If one or more hospitals, States or Territories can't go ahead with an exam on its planned date due to COVID-19 disruptions, those in unaffected areas can still take their exam.
- Examiner feedback process
- Withdrawals and refunds – trainees should provide a medical certificate where applicable.
- Special consideration
- Examination will occur in traditional format
- Exam day schedules and timings
- Composition of examining team:
    - 1 NEP/SEP/SLE (Senior Local Examiner)
    - 1 Local Examiner
    - +/- 1 Provisional Examiner
- Definitions and overviews Long and Short cases.
- Candidate scoring
- Dress code and personal items
- Medications lists
- Stationery & equipment available on the day
- Candidate etiquette and consent form
- Candidate wellbeing and appropriate escalation path for issues on the day
- Changes in 2023:
    - The Committee have advised that the use of ophthalmoscopes during the examination should be at the discretion of the candidate and examiners, as was the case before the pandemic. Fundoscopy should not be essential to achieve a pass standard in any case
    - Sites will be providing a vegetarian lunch option to candidates during the lunch break
    - Candidates will have to check in their mobile phones, but will be able to access them during the lunch break

The participants raised and discussed the following matters:

- The clear rubric for scoring replaced the prior method of using the total mark. The prior method had issues as some trainees who failed all short cases or all long cases would still pass or candidates may fail by one mark. The current system is more fair as it gives a balanced view of their performance.
- There are sufficient AIM exam places for the expected number of candidates. Some AoNZ candidates may undertake their exam in AU.
- PCH exam places are quite tight relative to the number of candidates.
- Feedback is still provided by the NEP. Candidates are advised to include their DPE in their DCE feedback, however, this is not mandated.
- Experienced local examiners interested in becoming national examiners should advise the NEP examiner at their exam setting. Those that meet the eligibility criteria and have performed well as

examiners may be eligible to become a national examiner. Consideration will also be given to ensuring suitable distribution of examiners by hospital and state.
- Hospitals are currently being given tentative DCE dates to work towards. The number of candidates at each hospital will also be provided by the end of March.
- Candidates will require time to arrange their travel and should be advised as soon as possible of their exam date. Candidates receive their allocations a minimum of 6 weeks prior to the exam cycle commencing.
- DPEs that are 2+ years post fellowship may become provisional examiners.
- Exam rooms should have a maximum of three examiners.
- There was some confusion on the process for providing feedback to candidates previously. A session at the NEP calibration session will assist to clarify this process.
- Candidates have continued to practice for their exam virtually and should ensure they are including face-to-face as part of their preparations.

Changes to the Flexible Training Policy (FTP)

Libby Newton, Manager, Education Policy, Research and Evaluation (EPRE) presented to the Forum on the changes to the FTP.

The FTP outlines the provisions for flexible training for all RACP training programs including interruptions, part-time training and returning to training after a prolonged absence. In April 2022 the Gender Equity in Medicine Report launched and in July 2022 the CEC reviewed the GETT submission. In late 2022 FTP revision was brought forward at the request of the RACP Board and CEC.

Consultation

Consultation conducted in November 2022 with feedback collected via consultation survey, written submission or virtual meeting:

- 56 RACP Members and groups responded
- presentations and feedback sessions also held with groups that met during the consultation period

Feedback reviewed by the Education Policy team, appraised need to adjust proposed changes and / or implementation approaches. CEC Chair also provided guidance throughout this work.

Key Changes

1) Removal of 24-month cap on amount of parental leave excluded from maximum time limit to complete training. Trainees may apply to have time retrospectively removed from their time-limit if the exceed the cap prior to 2023.
2) Excluding medical leave from the maximum time limit to complete training. Trainees may apply to have time retrospectively removed from their time-limit if the exceed the cap prior to 2023.
3) Reduce minimum standard full-time equivalent (FTE) for part time training from 0.4FTE to 0.2FTE.
4) Introduction of ‘return to training plan’ concept following prolonged absence

Revised Progression Through Training Policy (PTTP)

To ensure alignment between policies, associated amendments to the PTTP were also approved by the CEC:

- time limits to complete training do not include approved full-time parental leave and medical leave
- irrespective of whether certification decisions are made in units of weeks or months, training periods undertaken will be recognised in one-week increments.

Both the revised PTTP and FTP are on the RACP Education Policies webpage

Next Steps

Timing	Activity
April 2023	Trainee webinar, hosted by College Trainees' Committee with focus session on flexible training
	Development and publication of Flexible Training resources to assist trainees when seeking flexible training options
	Development and publication of a Return to Training plan template and guidelines to be used for trainees seeking to return to training after a continuous interruption of more than 24 months.

Figure 5: FTP Next Steps

The participants raised and discussed the following matters:

- Evidence to support medical and parental leave is required, inclusive of retrospective requests to amend periods of interruption.
- It is a challenge to manage ensuring service delivery for patients while providing flexibility for the workforce.
- The FTP and PTTP are College wide and apply to both BT and AT.
- Trainees undertaking training at 0.2FTE are still subject to the same time-limit to training as those training full-time.
- Trainees on prolonged medical leave are still required to register. Training support may be required for trainees that fail to progress in training.
- Jurisdictional employment issues and training are often conflicting. Trainees who have been out of training for some time may have difficulty securing a position to resume their training.
- The Return to Training Plans are being developed in partnership with the supervisor / DPE and approved by the relevant committee. These plans are in place to support trainees that re-enter BPT.

Selection into Training (SiT) Policy Consultation

Libby Newton, Manager, EPRE presented to the Forum on the SiT consultation.

The SiT policy was developed in 2015 and effective from 2017. The SiT sets out the principles which underpin selection, outlines criteria for eligibility and selection and outlines standards for the process of selection.

SiT Revision

The aim of the SiT revision is to ensure that the SiT policy promotes selection outcomes and experiences that are aligned to the RACP's strategic objectives.

RACP Strategic Plan 2022-2026

Figure 6: RACP Strategic Plan 2022-2026

RACP Professional Practice Framework

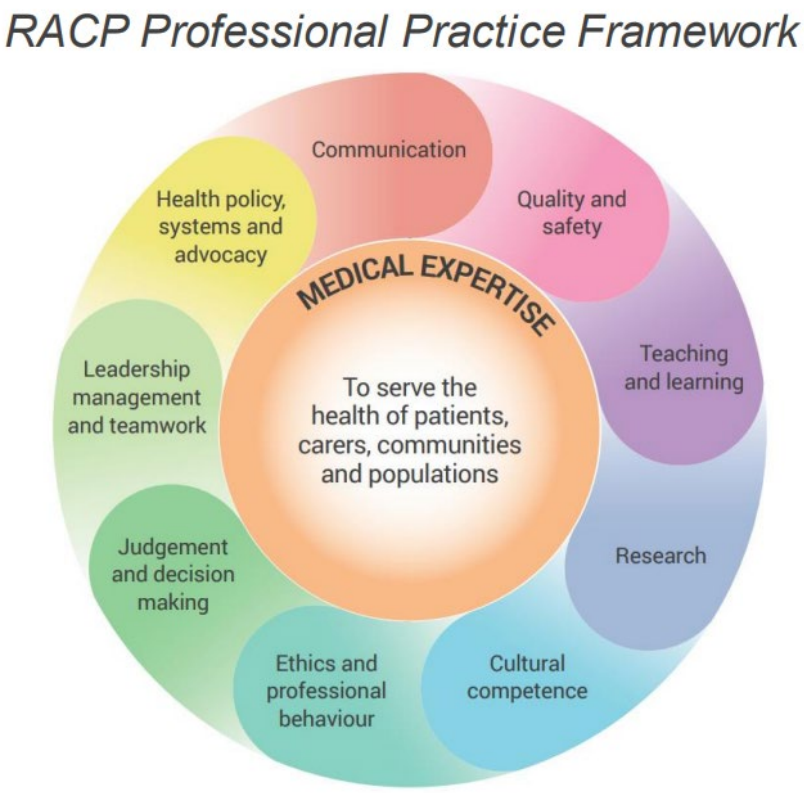


Figure 7: RACP Professional Practice Framework

National Medical Workforce Strategy 2021-2031

Figure 8: National Medical Workforce Strategy 2021-2031

Additional considerations are the RACP Gender Equity in Medicine Report, RACP Indigenous Strategic Framework and AMC Accreditation Standards.

SiT Review Timeline

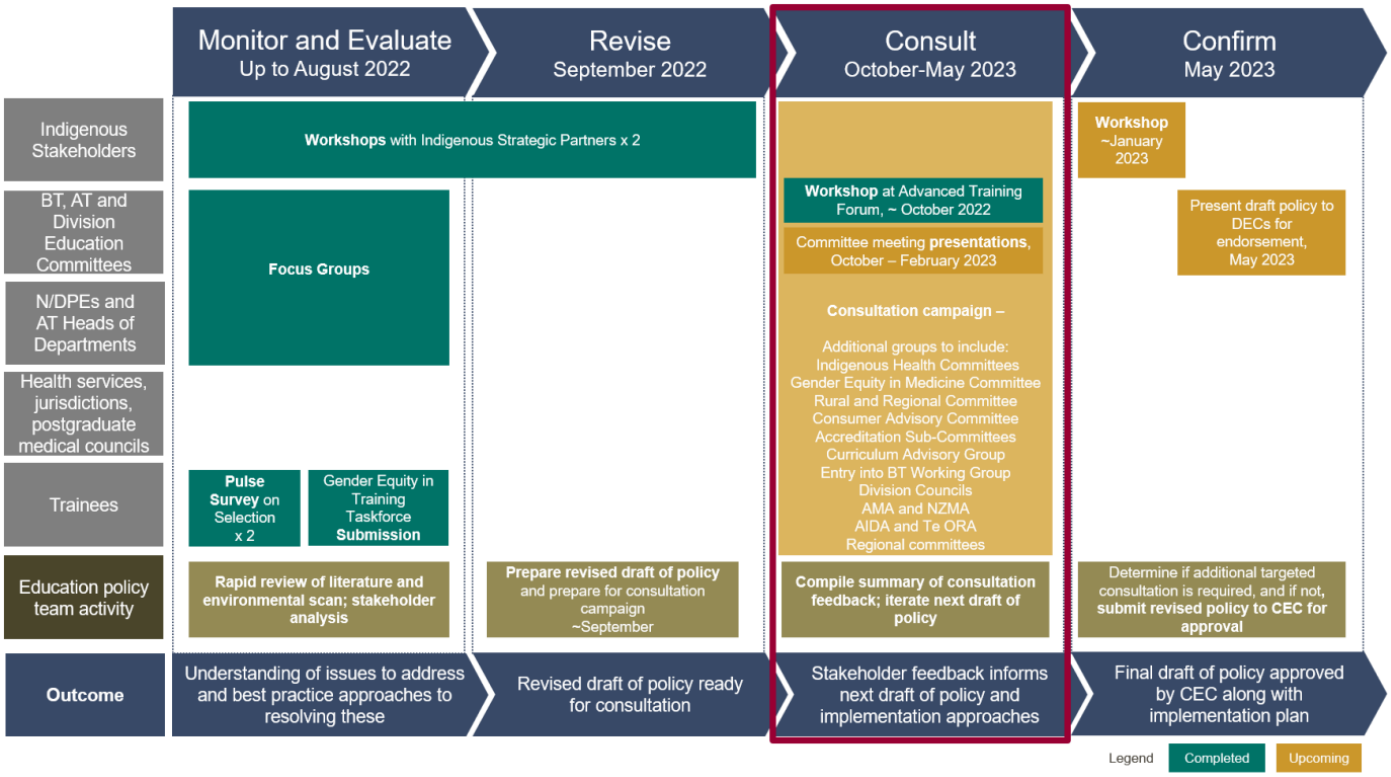


Figure 9: SiT Review Timeline

Key proposed changes

1) Change from Principles to Strategic Goals and shift to Social accountability and Indigenous equity:
    - *Social accountability:* To support the growth of a physician workforce that reflects and is responsive to the diversity and priority health concerns in the communities it serves, including culture, ethnicity, socio-economic status, and geography/rurality of origin.
    - *Indigenous equity:* To support equitable opportunities for Indigenous doctors through strengths-based and culturally safe approaches to selection.
2) Provisions to drive growth of the rural and/or Indigenous health and/or Indigenous physician workforces:
    - 8.5 in addition to the essential selection criteria, training providers must implement criteria for selection of:
        i. Candidates with a demonstrated commitment to rural and/or regional health, and/or;
        ii. Candidates who identify as an Aboriginal and/or Torres Strait Islander person or Māori, and/or;
        iii. Candidates with a demonstrated commitment to, and understanding of, Indigenous health
3) Changes to the Standards for Selection Processes and integration of Standards into the main policy
    - These are a key component of the policy and drive quality while allowing for flexibility in response to diverse contexts

Feedback

Feedback can be provided by emailing EducationPolicy@racp.edu.au by Friday 30 March.

Next Steps

A broad consultation campaign will occur in February and March 2023. In April and May 2023, the second revision of the SiT Policy will occur based on consultation. Additionally, consultation will occur with health departments and external organisations.

Mid 2023, the final revised policy will be presented to the CEC for approval along with implementation recommendations.

The participants raised and discussed the following additional matters:

- Accreditation is the primary lever for ensuring training settings comply with the SiT
- A number of jurisdictions are already establishing similar goals as those included in this refresh. The aim of this revision is for the RACP to set the standard and expectation and highlight areas of concern raised in surveys.
- Selection into Advanced Training requires state-based or a national approach to help mitigate nepotism.
- A recommendation could be that selection criteria for position are pre-published. This was acknowledged as being the proposal for transparency.

Accreditation Renewal

Emily Morrison, Manager, Training Accreditation Services presented to the Forum on Accreditation Renewal.

Accreditation Renewal is currently in Phase 2 of the rollout which runs until December 2024.

Key changes to the Accreditation program are:

- Setting, Program and Network Accreditation

- Setting executive, DPE and NDPE collaboration
- Four-year accreditation cycle
- Nine Standards under Four Themes

Phase 2 includes:

- The introduction of network accreditation
- Tools and processes to support the Monitoring stage of the accreditation cycle
- Tools and processes to support the Reporting stage of the accreditation cycle

Benefits of training networks:

- Diversity of training experiences
- Competency-based training and integrated assessment
- No training gaps
- Trainee experience
- Reduces geographical maldistribution of trainees

Training Network Accreditation Rollout:

- Network accreditation will commence in mid-2023 with an initial rollout of three NSW HETI AIM BT networks.
- These networks will be asked to provide feedback on processes and tools which will inform further refinements ahead of full rollout of network accreditation in 2024.
- An initial rollout of NSW HETI PCH BT Networks will be undertaken in early 2024.

Training Network Principles

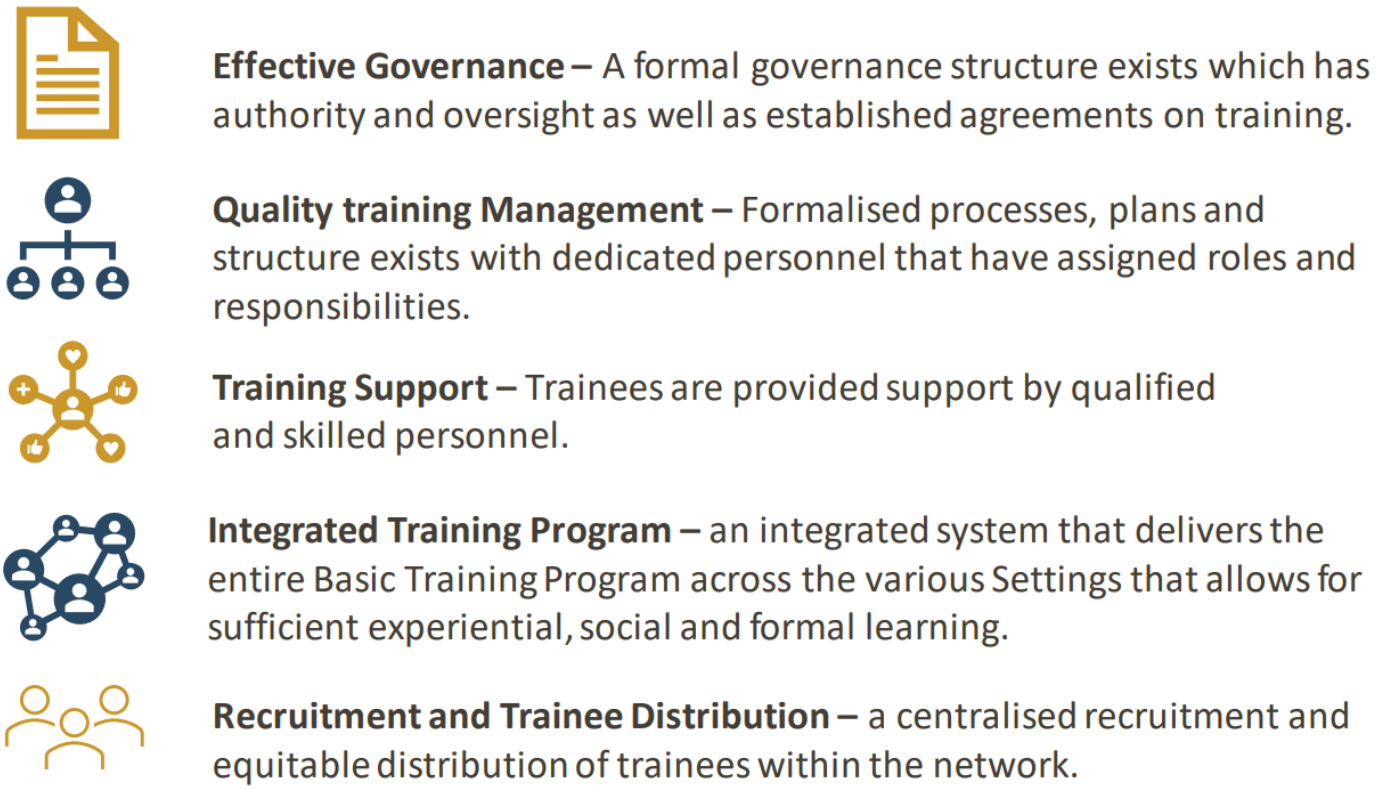


Figure 10: Training Network Principles

Network Accreditation Review Logistics

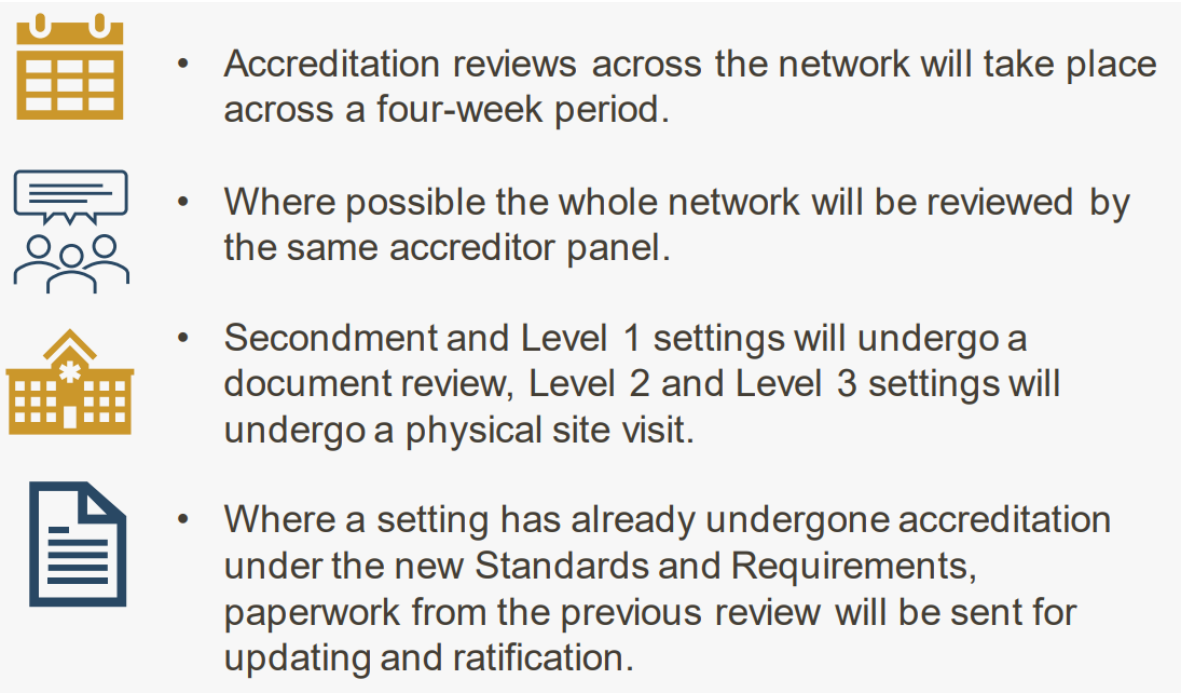


Figure 11: Network Accreditation Review Logistics

Training Provider Standards Responsibility Matrix

Responsible stakeholder	Roles
Network Director of Physician Education (NDPE)	Is responsible for the governance of a Network and its integrated Training Program.
Setting Executive	Is responsible for the training environment at a Setting. The senior management team of a health service.
Training Program Director of Physician Education (DPE)	Is responsible for the delivery of the Training Program at the Setting.

Standard Component	Number	Statement	Responsibility - part of a Network
Theme	**1**	**Environment and Culture**	
Standard	**1**	**Safety and Quality**	
Criterion	1.1	The Setting has a high standard of medical practice, evaluates its practices, and improves the quality of its service	Setting
BT AIM and PCH Requirement	1.1.1	A Basic Trainee is involved in patient safety and health quality care activities undertaken by the training setting.	Training Program
Criterion	1.2	The Setting has a system and culture that enables issues to be raised about the standard of care without fear of consequence.	Setting
Criterion	1.3	A trainee receives an orientation to each new Setting and rotation.	Setting
BT AIM and PCH Requirement	1.3.1	A Training Setting ensures a Basic Trainee completes an adult advanced life support course and is oriented to the setting's life support protocols.	Training Program
Criterion	1.4	Trainee and educator work arrangements enables the delivery of high-quality care and optimises learning and wellbeing.	Setting
Criterion	1.5	Handover occurs when there is a transition in care.	Setting
BT AIM and PCH Requirement	1.5.1	Consultant supported handover occurs at least daily.	Training Program
Standard	**2**	**Learning Environment**	
Criterion	2.1	Physicians embody the professional standards set out in the RACP Professional Practice Framework and are prepared to be involved in the training, education, and assessment of trainees.	Shared Network & Setting
Criterion	2.2	The Training Provider seeks and responds to concerns about training from trainees and educators.	Shared Network & Setting
Criterion	2.3	The Setting has a learning environment and culture which values, supports, and delivers equitable physician training	Setting
Criterion	2.4	The Setting provides a safe, respectful learning environment and addresses any behaviour that undermines self and/or professional confidence as soon as it is evident	Setting
Criterion	2.5	The Setting maximises the educational value of tasks assigned to a trainee	Setting

Figure 12: Training Provider Standards Responsibility Matrix

Accreditation Self-Assessment Form

The form has now been split into three parts:

1) Part A – Setting - *to be completed by setting executive*
2) Part A – AIM BT Program (Part of a Network) – *to be completed by Network DPE*
3) Part A – Training Network AIM – *to be completed by DPE*

Monitoring

Monitoring includes:

- Managing Conditions and Recommendations that arise through an accreditation review
- Undertaking Focus reviews on any conditions and recommendations placed on a Training Provider or Training Program as part of the accreditation review
- Managing a Change of circumstance that affects the delivery of training at any point during the four-year accreditation cycle
- Managing a Potential breach of Standards at any point during the four-year accreditation cycle

Reporting

- Executive summary template under development.
- All accreditation decisions will be published on the RACP website.

Next Steps

- Continued stakeholder training and support for network accreditation.
- Self- assessment forms are due back from initial rollout networks in July.
- First network accreditation visits will be undertaken from September.
- Publish our active management process as part of monitoring.
- Finalise tools and processes to support reporting.
- Accreditors calibration day to be held in Q3.

The participants raised and discussed the following additional matters:

- The Accreditation team is currently recruiting new accreditors.
- The aim of Accreditation is to improve the quality of training.
- The Accreditation team wish to develop case studies of best practice by training settings.
- Accreditation can place conditions or recommendations to settings to provide protected teaching time. This condition is commonly placed if there is insufficient evidence to support that the teaching time is being provided and trainees are available and feel comfortable to attend.
- Settings due for re-accreditation under the new standards have been given sufficient notice.
- The accreditation process can be somewhat ominous for a new DPE; however, the process is there to ensure the setting is meeting the standards and the training program has the necessary support. The Accreditation team run regular webinars to assist settings in completing the required forms. Areas that DPEs wish to see improved at their setting should be highlighted during the process so this can be highlighted for action by the setting.
- The DPEs are working with the College to improve the training program at their settings. The College is there to support the DPE and is aware some settings will not meet all of the standards and requirements with their first assessment.
- It was queried if there are trainees expected to do one clinic every term or an average of this through their training. It was advised the expectation is that two of the three clinical experiences are met through clinics.

- When a new hospital is being built it would be optimal for the DPE or the College to be involved to clarify what is required to deliver the Basic Training program.
- The FTE provided in the guidelines are a minimum standard and if additional FTE is required the DPE should work with the hospital executives to increase this allocation.
- Most hospitals are reliant on a small percentage of supervisors who do the bulk of the supervising. The College should introduce more matrices to ensure the workload is split more evenly. Additionally, FTE for Educational Supervisors and Rotation Supervisors need to be more consistently provided.

New Basic Training Program Update

Ella Veness, Manager, Program Implementation provided an update to the Forum on the New Basic Training Program.

2023 New Basic Training program Early Adopters

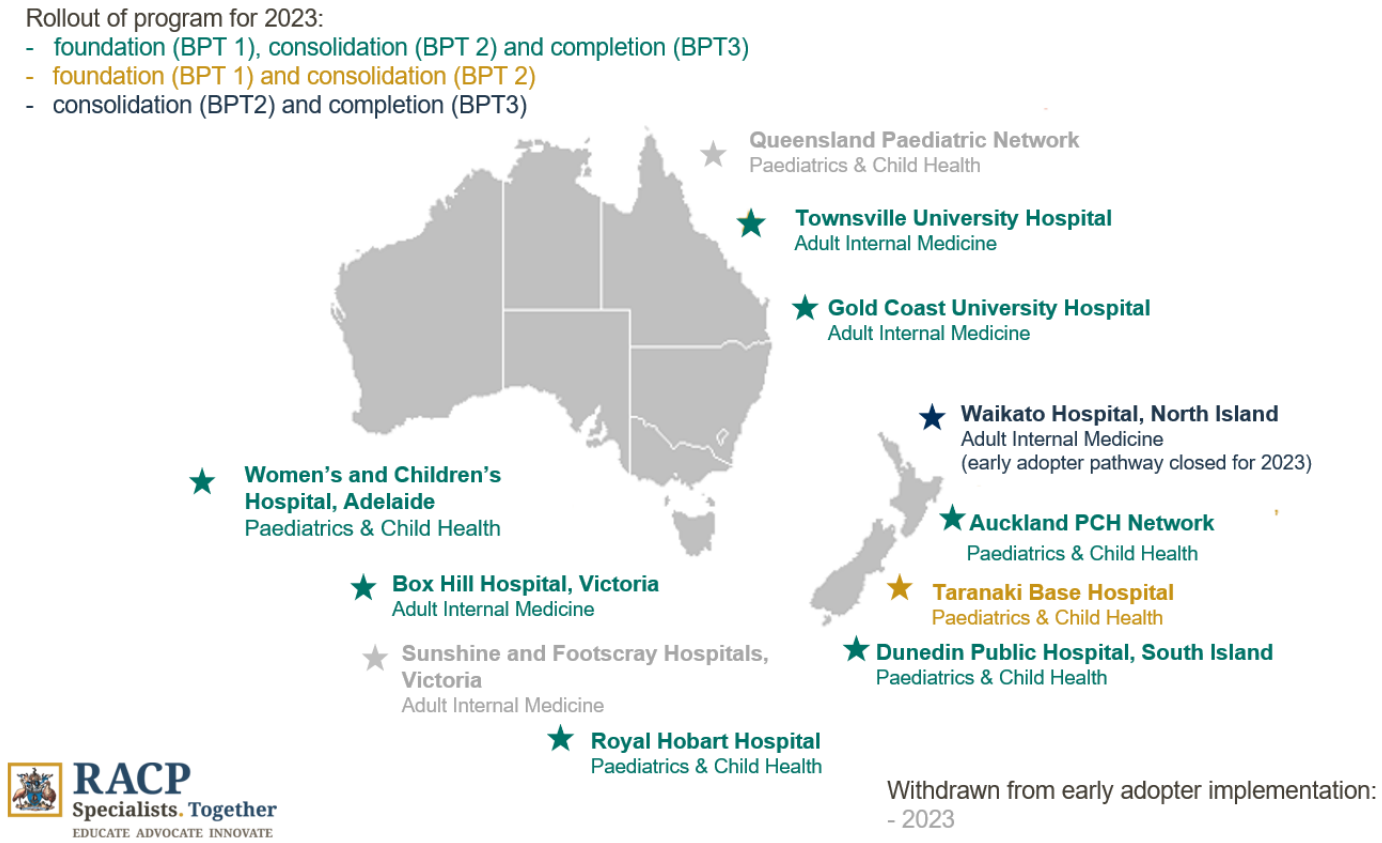


Figure 13: New BT Program Early Adopters

Due to delays with the supporting software, Tracc, full implementation has been further delayed until 2025.

Some of the consideration to proceeding with further implementation of the new program are:

Capacity of DPE/Setting:

- In scoping additional implementation options, we are seeking feedback on feasibility and usefulness of implementing mid-year with new trainees only
- Are there any current barriers to supporting implementation of the new program that should be brought to our attention

Supporting technology readiness:

- With Tracc features still in development, a stable system will be necessary to support implementation across settings.

The Curriculum team requested feedback on the feasibility of mid-year implementation from the Forum participants.

The participants raised and discussed the following additional matters:

- Tracc needs improvement to become more user-friendly before full implementation could occur. A decision on whether Tracc will be ready is set to occur in March.
- Mid-year implementation was deemed to be undesirable.
- Once of the key benefits of the new program are the progress review panels. These panels have improved the monitoring of trainee progress and identifying trainees that require additional support earlier in their training.
- Having trainees on both PREP and the New BT program is difficult to manage.
- Managing the input of trainee rotation information into Tracc is labour intensive. This is currently being managed by College staff; however, it was estimated this would require 4-5 days of effort for a program administrator.
- The structure of the new curriculum is excellent; however, it requires functional software to support it as the assessments are labour intensive when completed manually.
- Trainees receiving feedback that they need additional supervision would be discussed at a progress review panel. The panel may then determine if structures need to be put in place to support the trainee.
- Balancing supervisory requirements with provision of nights rosters can be challenging, particularly for trainees that are cited as requiring greater supervision. Trainees that enter BPT as PGY3 are more experienced and likely more capable of managing a nights rotation with less supervision.

Trainee and Supervisor Burnout

Dr Andrew Henderson, Chair, AIM BT Committee and Dr Claire Dendle, VIC DPE Representative on the AIM BT Committee, lead a discussion on trainee and supervisor burnout.

Results from the Physician Training Survey and the Medical Training Survey show COVID-19 has had an adverse effect on personal health and wellbeing, access to supervision & teaching, the quality of training experiences and workload. Workload in particular has led to increased feelings of fatigue and burnout.

Rates of bullying, harassment and discrimination held steady while declines in morale were reported.

Additionally, trainees in New Zealand reported a 13% decrease in flexible working arrangements since 2020.

Question 1: What do you perceive as the key drivers to burnout for trainees, supervisors and DPEs?

Participant responses / discussion:

- Inadequate time to do perform the DPE role.
- Acting solo in the DPE position and unable to provide support for leave cover.
- Staff shortages more generally.
- Disparity between hospital workforce requirements and capacity to train.
- Inadequate resources to deliver quality training in some settings. This varies by training setting and jurisdiction and is dependent on their response to Accreditation requirements.
- Difficulty in obtaining volunteer support for exam preparation and delivery.

- COVID-19 increased random impacts felt by trainees, supervisors and DPEs. For example, the number of staff away sick seemed to increase leading to greater potential workload each day. Additionally, changing mitigation measures required constant adjustment to work practices.
- A/Prof Anne Powell is completing her PhD in DPE Burnout, and this may assist in identifying potential factors that could be addressed.
- 1 in 3 trainees are reporting bullying or harassment. Trainees may not feel empowered to raise this issue directly with their supervisor and/or training setting. Additionally, how bullying and harassment are defined should be clear to survey participants.
- DPEs should advise the College if they feel they are being bullied by their training setting executives.
- DPEs are often wearing 'multiple hats' in their roles and this can be difficult to manage the complexities due to conflicting interests. Consideration should also be given to DPEs not having excessive involvement or influence in other College programs. Trainees may experience additional stress during the Advanced Training selection process due to their perception the Basic Training DPE may be on the selection panel and be involved in the recruitment decision.
- Improving response times to enquiries, ensuring easy access to support, and providing clear communication from the College will reduce trainee stress.

Question 2: What program or online resources has your training setting implemented to address trainee and supervisor well-being?

Participant responses / discussion:

- After a recent incident a debrief occurred for the impacted trainees providing psychiatric support. This support was so successful it was later expanded to be available to all trainees in the health network. The service is confidential and trainees can either self-refer or be referred by a supervisor.
- Trainees have provided feedback that they would appreciate medical workforce staff being considerate of their training requirements and the impact these have on their ability to perform a full-time Medical Registrar role. Unrealistic expectations lead to burnout and resignations which further impacts the stress on the trainees and supervisors that remain.
- Holding training settings to account to ensure trainees are being rostered fairly and compensated appropriately for any overtime is essential.

Question 3: What key points would you like this Forum to feedback to the RACP Health and Wellbeing Committee?

Participant responses / discussion:

- Benchmarking the required time allocations for fulltime trainees and physicians to undertake patient care, quality assurance, teaching and any other typical tasks would be invaluable. Benchmarking of responsibilities in position descriptions could also provide further insight.
- Consideration should be given to what other Colleges and medical bodies in Australia and overseas are doing to address workforce health and wellbeing. The Australian Medical Council should also be providing guidelines as the regulator.
- Physician trainees are often used to fill gaps in the workforce including after-hours care across many areas of the hospital. It is important to be aware of this distinction when comparing Basic Trainees to Advanced Trainees, as Advanced Trainees are more specialised.
- Clear consultant to patient ratios are important.
- Staff shortages leading to an overworked workforce are an ongoing issue.

Supporting Rural and Regional Settings

Prof Martin Veysey, Member, Rural and Regional Physician Working Group (RRPWG) 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 and established the RRPWG 18 months ago.
- 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.

The issue faced by regional, rural, and remote residents in AU

Median age at death, mortality rate and rate ratio, by sex and remoteness area (2020)

	Major Cities	Inner Regional	Outer Regional	Remote	Very remote
Median age at death (males)	79.6	78.7	76.8	73.1	65.7
Age-standardised rate (deaths per 100,00) (males)	545.9	630.7	668.1	703.3	712.7
Rate ratio (males)	0.94	1.09	1.15	1.21	1.23
Median age at death (females)	85.2	84.3	82.7	78.3	66.2
Age-standardised rate (deaths per 100,00) (females)	388.6	435.9	461.0	468.7	569.5
Rate Ratio (females)	0.95	1.07	1.13	1.15	1.40

Figure 14: The issue faced by regional, rural, and remote residents in AU

11.6% of RACP Members in Australia and 0.6% of RACP Members in AoNZ live in Regional and Remote areas. The ratio of physicians to the general population is reduced in Regional and Remote areas and this is leading to adverse outcomes for the population.

Draft Recommendations

1. Prioritise regional, rural, and remote (RRR) healthcare at the RACP.
2. Build capacity and capability to provide physician training in RRR areas.
3. Improve the attraction and retention of RRR physicians.
4. Collaborate to improve RRR healthcare provision.
5. Respect, promote and acknowledge Indigenous people.

A detailed breakdown of the rationale for each recommendation can be found in the draft Regional, Rural and Remote Physician Strategy.

Feedback on the draft strategy is still being considered for incorporation into the final version. There will be several town halls to discuss the strategy and aid in anticipating any barriers or issues that may result from the strategy. Feedback or questions can be submitted via email: council@racp.edu.au.

Once the final draft is confirmed, the draft strategy will be submitted to College Council for endorsement and the College Board for approval.

The participants raised and discussed the following additional matters:

- 25% of medical students originate from rural and remote areas. As physician training is very metro-centric, this leads to trainees establishing themselves in urban areas as part of their training. Evidence suggests that trainees who are from rural and remote communities who undertake their training in that community are more likely to remain in that community.
- Mandating 6 months of Advanced Training in rural or regional areas may assist to address the issue.
- Training quality is paramount. As such, smaller rural and regional settings require additional support to ensure standards are being met.
- Specific rural pathways could be established (i.e. Rural General Medicine) which could be supported by legislation to ensure there are clear and guaranteed positions available for trainees.
- Trainees require logistical support to relocate to rural and remote areas as securing housing and moving family and possessions can be difficult. Additionally, there may be other barriers to relocation such as access to schooling for dependents and concerns regarding available infrastructure. The College should be advocating for these issues to be addressed so trainees can more easily relocate.
- Trainees who undertake rural and remote training gain a broader understanding of the issues faced in these areas and this can lead them to providing a higher standard of care.
- Rural hubs for rural networks are in development in partnership with the College of Surgeons. The aim would be to rotate trainees out of a rural or remote are rather than rotating them in. DPEs will be invited to express their interest in participating in a pilot of the program later this year.
- Rural and remote settings are often staffed with a greater percentage of locum staff, as a result, it can be more difficult to ensure adequate supervision for trainees and to obtain RACP Accreditation. Fellows of the College would need to commit to relocating to rural and remote areas to provide supervision.
- Mandating time in rural and remote settings for Fellows and trainees may be the most effective means to address the inequity in health outcomes for the population.

Presidential Address

RACP President, Dr Jacqueline Small, thanked the DPEs present for being an essential and often unrecognised part of the College's delivery of education and training to the highest standards for medical specialists across the 33 specialties of the RACP.

Dr Small particularly welcomed new DPEs and encouraged them to feel at home in the College walls.

The last few years have been particularly challenging and DPEs have been at the front line. The AMC commended the RACP for maintaining progression for trainees despite the many headwinds faced. Sincere gratitude is extended to the DPEs for supporting the College through this difficult period.

Questions and Open Discussion

There were no additional questions or comments raised.

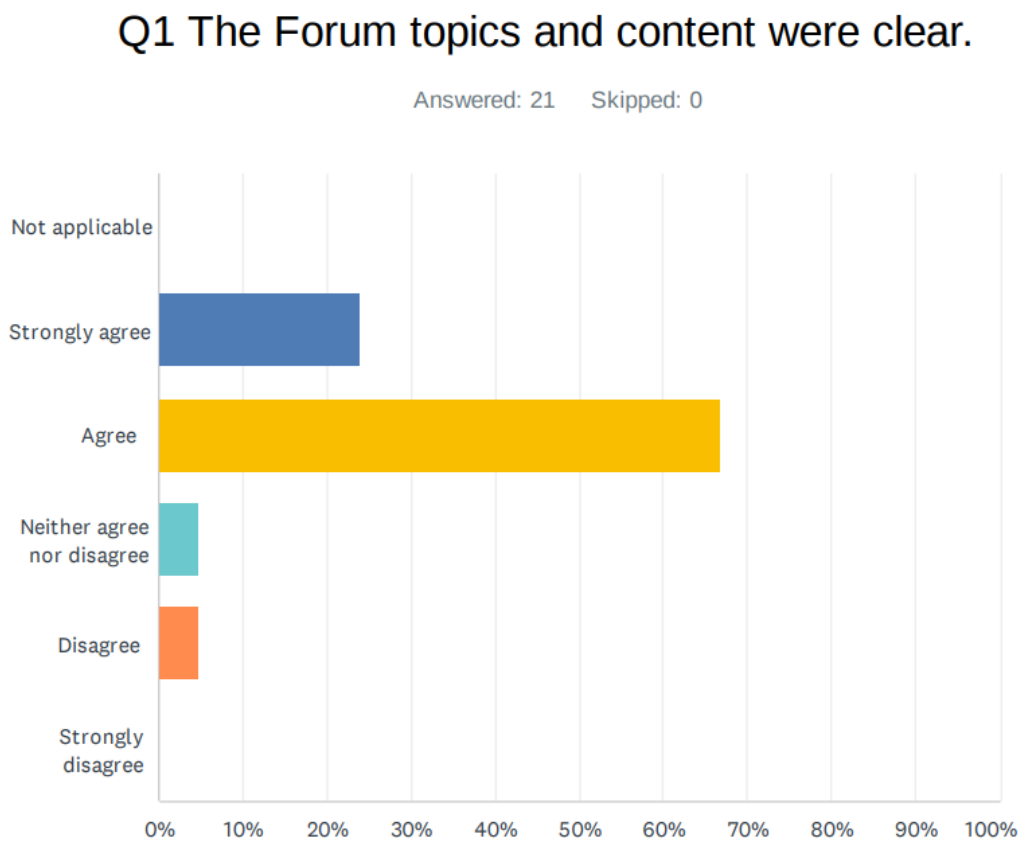
Conclusion

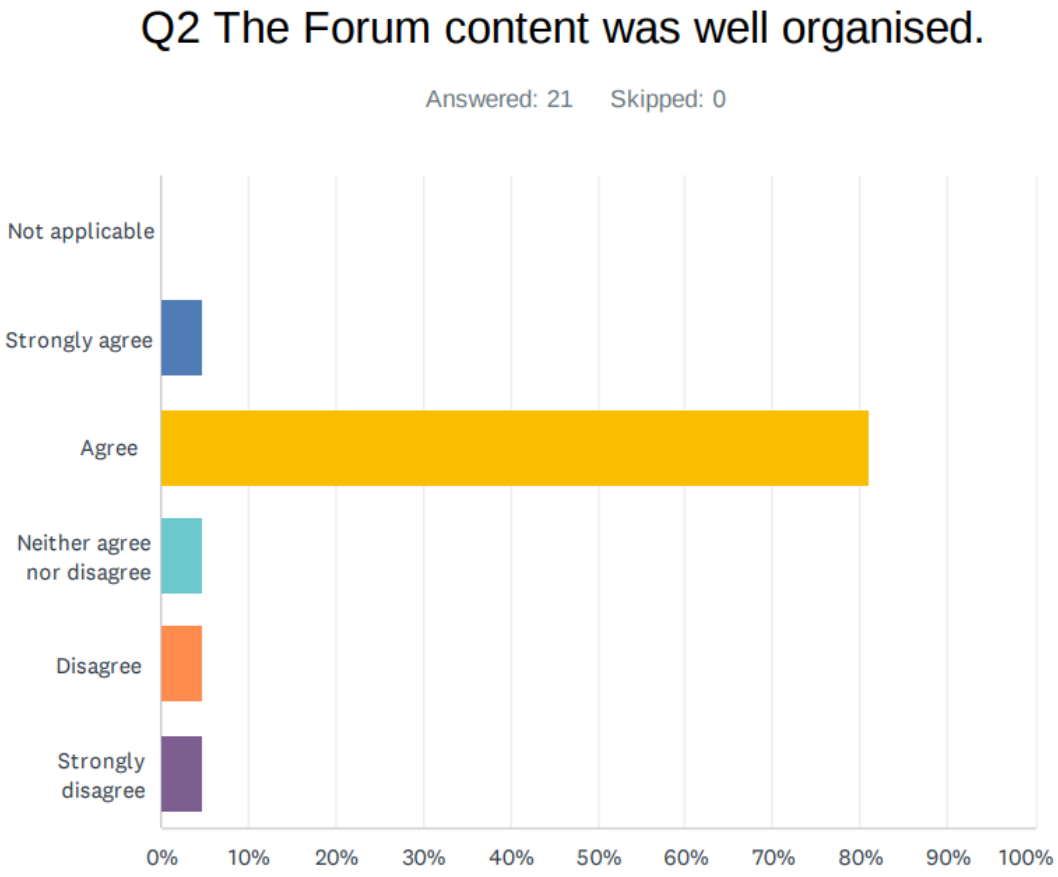
Dr Andrew Henderson thanked the presenters, College staff and those in attendance for a successful Forum.

DPEs were encouraged to reach out to the AIM BT Committee at any point by emailing: BasicTraining@racp.edu.au

The 2023 DPE Forum concluded at 4:00pm AEST

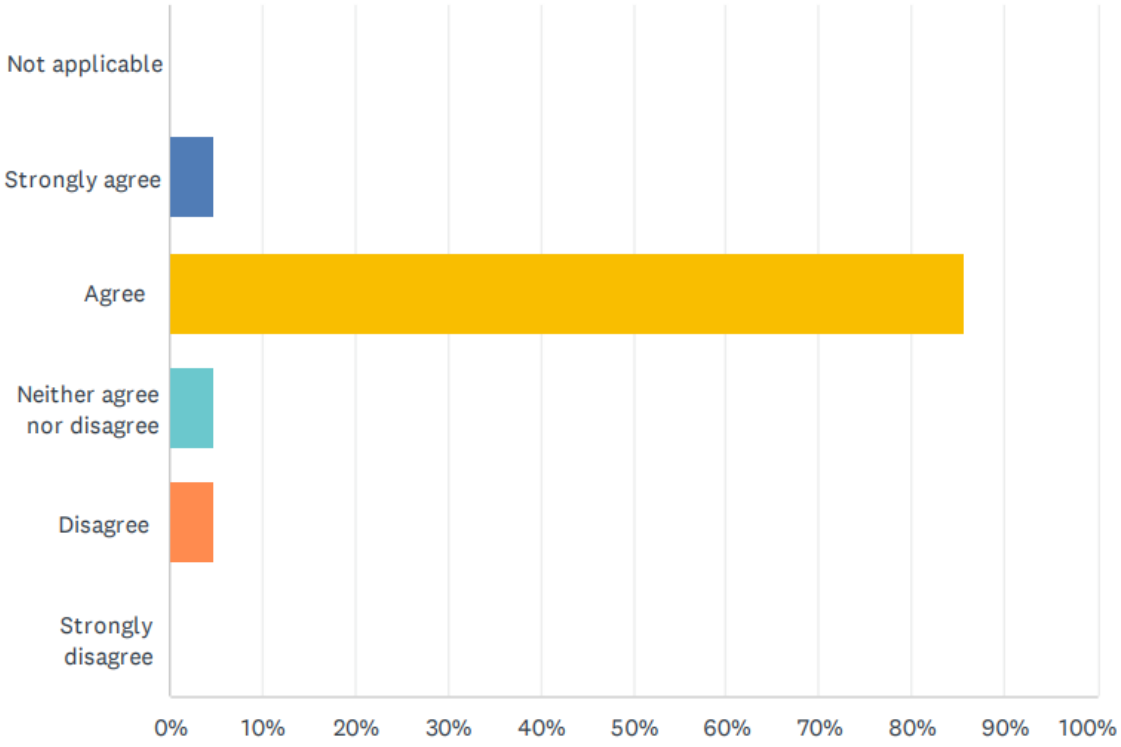
Appendix 1: Meeting evaluation





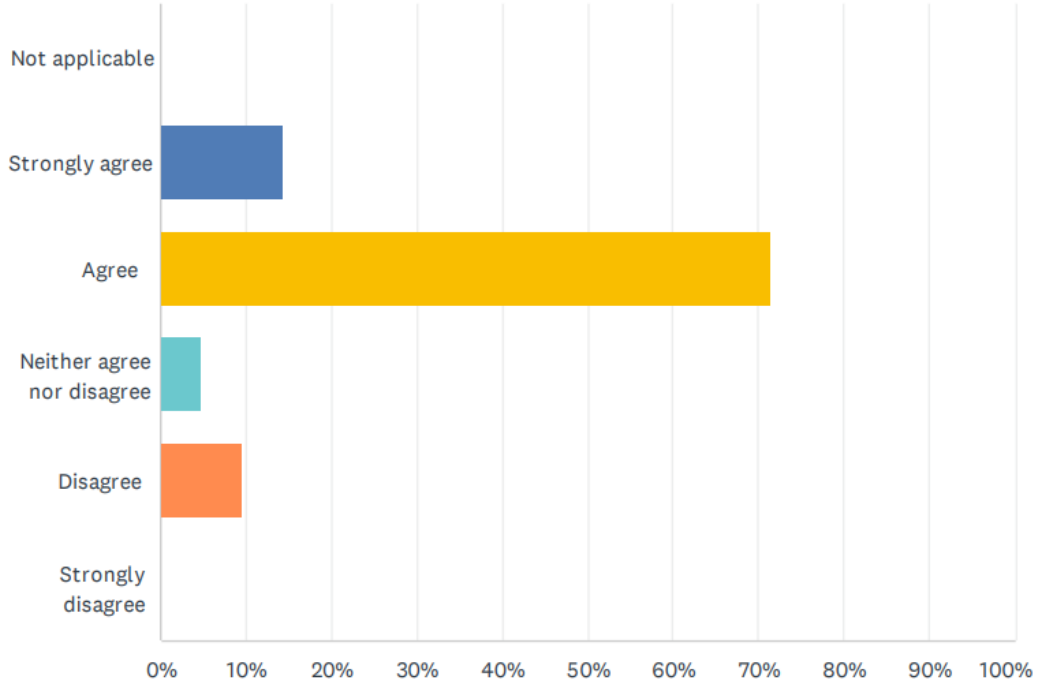
Q3 The length of the Forum was sufficient.

Answered: 21 Skipped: 0



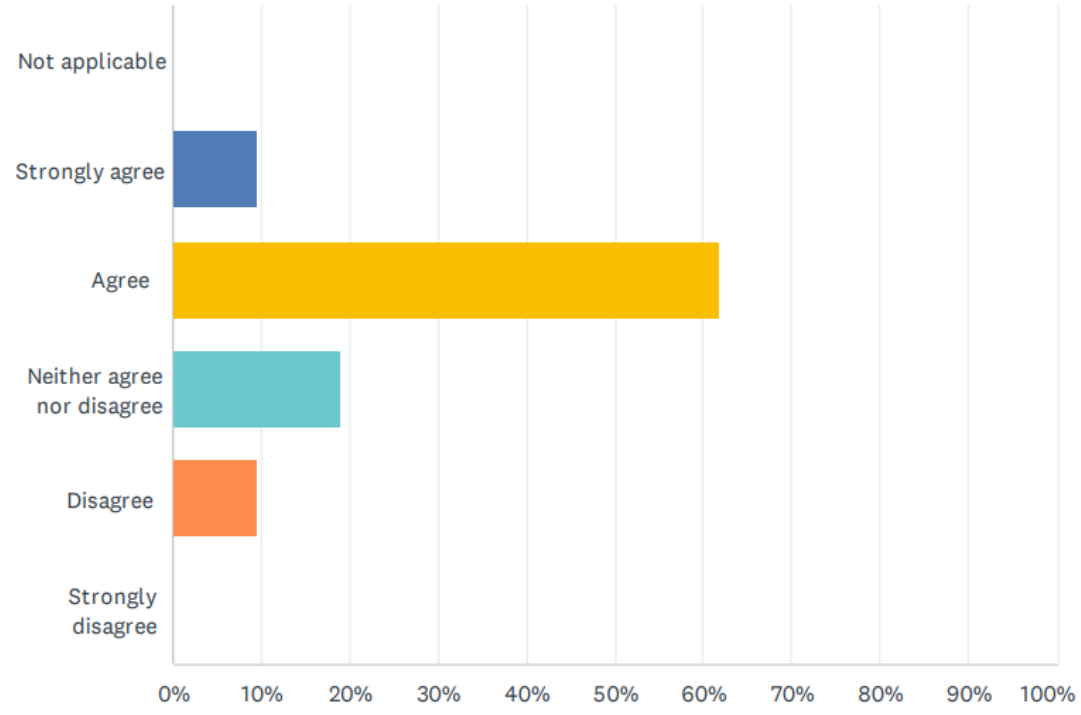
Q4 Questions were encouraged at the Forum.

Answered: 21 Skipped: 0



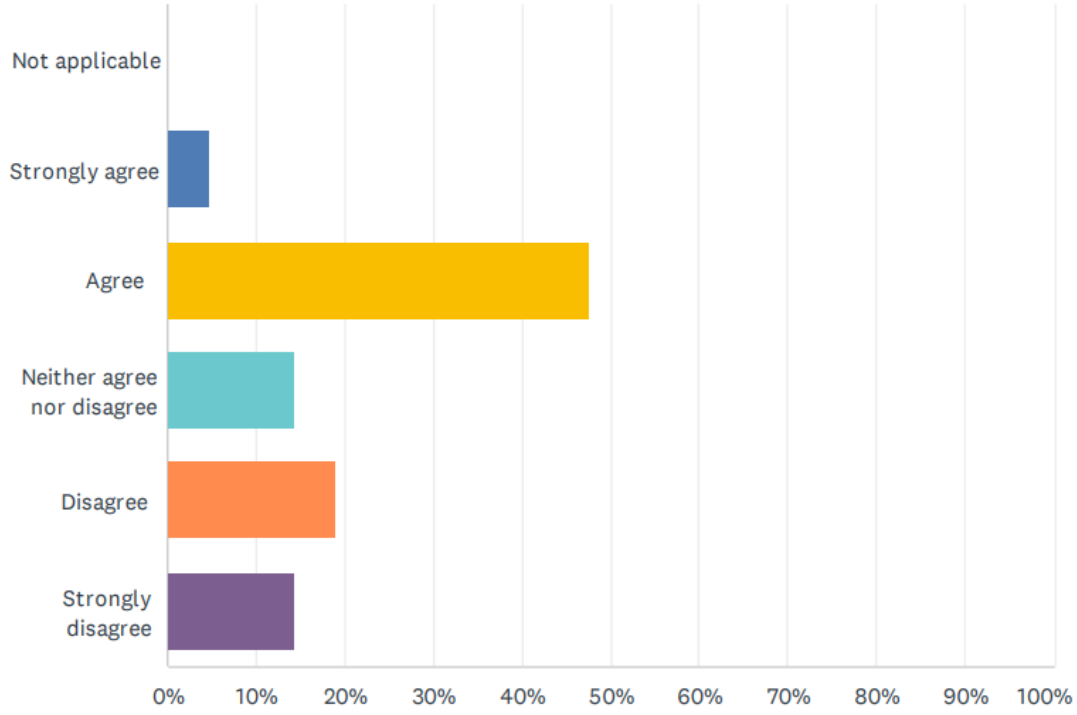
Q5 Questions asked were clearly answered.

Answered: 21 Skipped: 0



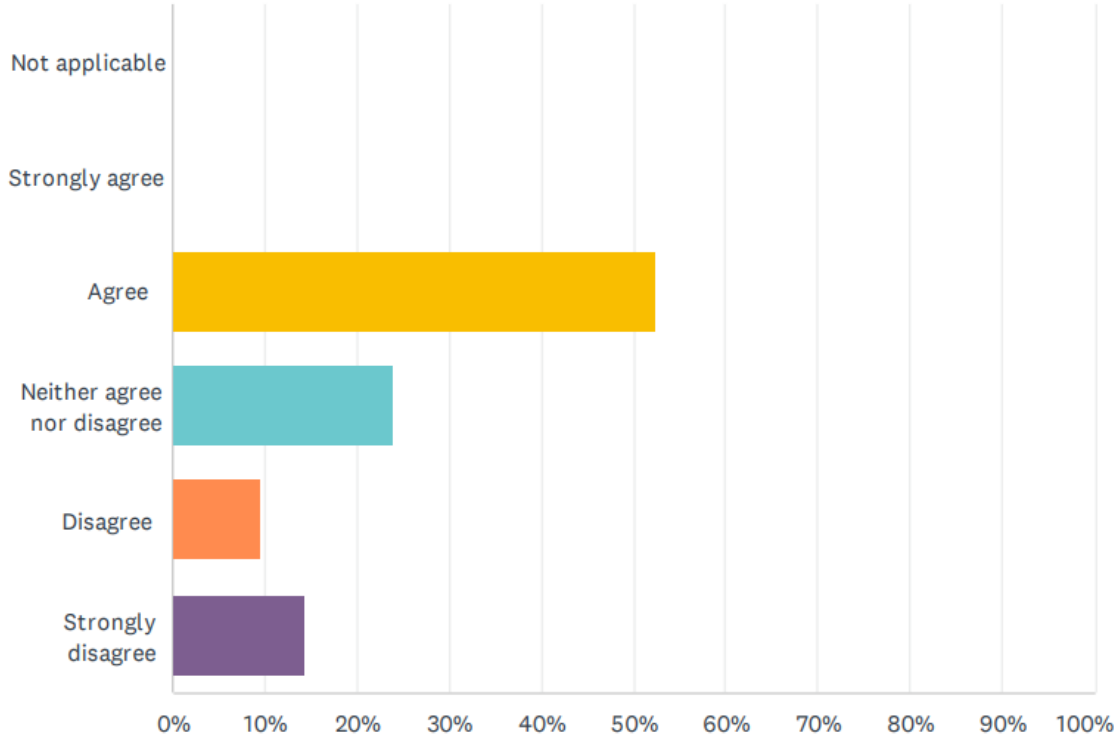
Q6 Participants had ample opportunity to present ideas and opinions.

Answered: 21 Skipped: 0



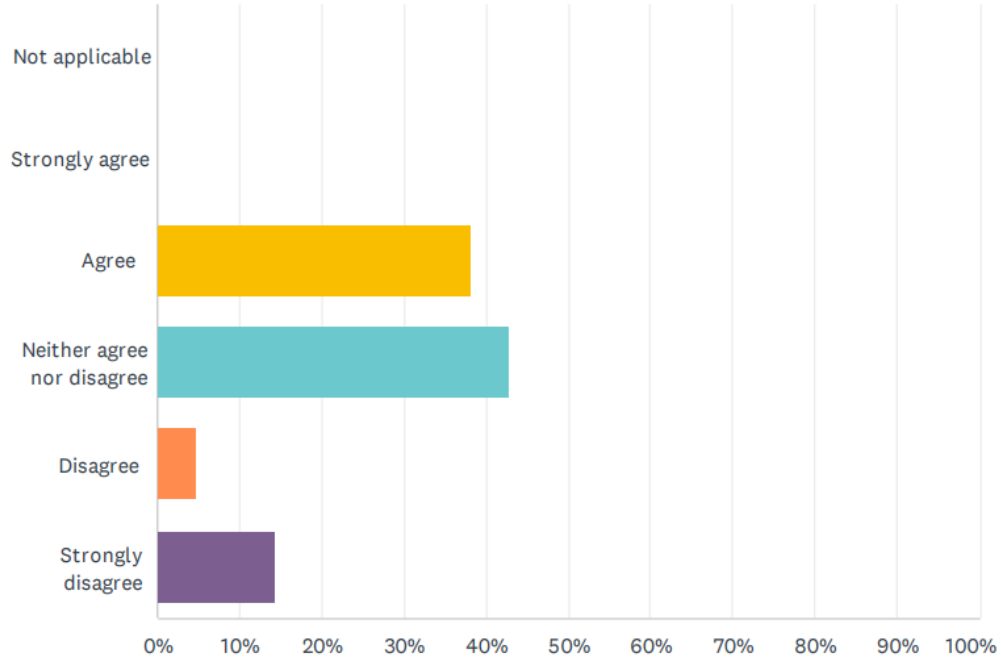
Q7 Forum structure helped the group to consider complex issues

Answered: 21 Skipped: 0



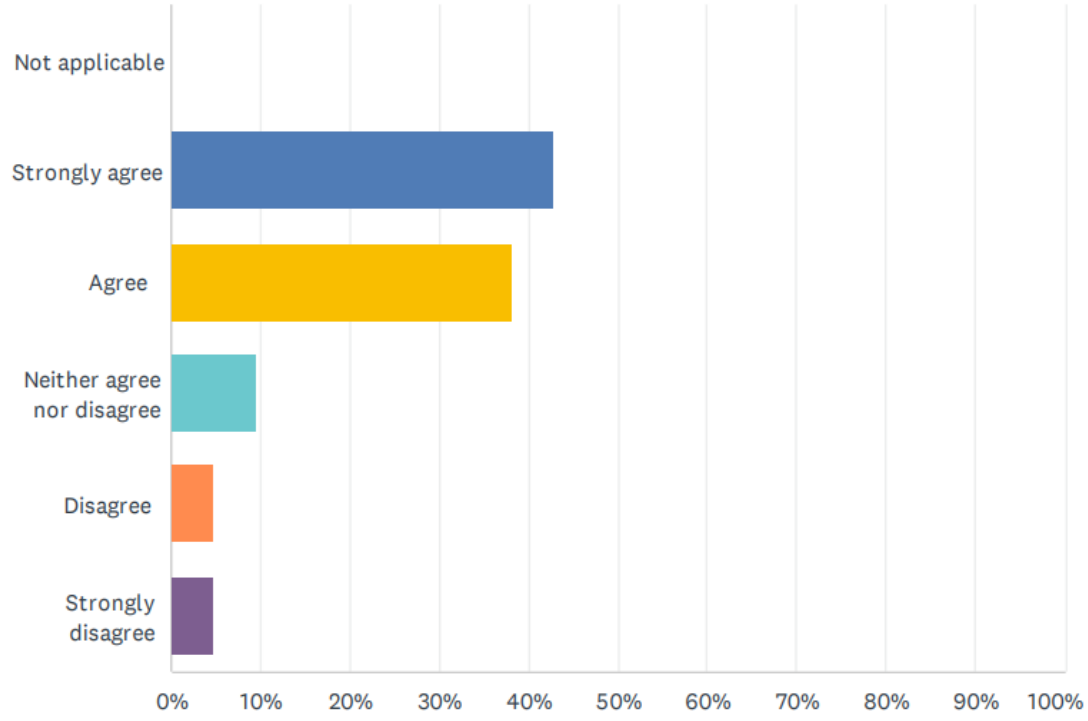
Q8 Forum structure helped the group to make effective recommendations.

Answered: 21 Skipped: 0



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

Answered: 21 Skipped: 0



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

- Social connections with other DPEs.
- Examination discussion.
- Clarification of 2023 DCE plans. Ongoing discussions around capacity train (limited but interesting).
- Open discussion between DPEs.
- Networking with colleagues. Updates on critical issues, e.g. accreditation.
- Meeting colleagues from across the country.
- The RACP proposals for Regional, Rural and Remote training for the medical workforce in these areas and the subsequent discussion among the presenter and the attendees both physical and on-line.
- The new BPT program updates.
- Challenges with TRACC.
- Interactions and being able to answer questions in real time.
- Discussion around FTE for DPEs.
- Covered the relevant topics and issues, e.g. changes coming up.
- Zoom available, discussion about exam preparations.
- Networking & update on requirements.
- The Victorian DPE breakfast prior - lots of practical suggestions and sharing of ideas.
- The Trainee & Supervisor Burnout session was interactive and encouraged participation.

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

- Greater in person attendance would be positive.
- There was an intimation from a presenter that we should be all meeting together centrally in one location. This is not practical nor appropriate (i.e. time, environmental concerns) given the amount of travel required. I was interested to see the Victorians and West Australians had a separate central meeting Hub – this seemed to strike the balance of having a shared space and discussion.
- More time for open discussion.
- Disappointing that nobody from TRACC available to answer questions - key infrastructure for new curriculum roll-out and nothing but crickets to hear! Audio for the offsite participants - although this should encourage more on-site participants in the future!
- The forum was very soon after the written exam where our state performed unusually poorly - it would have been nice to have some written exam discussion. The sound was clearly a problem for those that didn't attend in person - perhaps in person attendance could be more widely encouraged.
- Audio visual aspects as it was difficult to hear the presenters clearly.
- More general discussion at the end.
- Sending out agenda earlier.
- Greater opportunity for DPE's to lead agenda.
- Openness to questions - actual discussion of challenging issues. The exam section was not useful - we can all read the details on the internet.
- Participants discussing very specific situations that were not relevant to most of us.
- The style of the forum. Firstly, the vast majority of the information imparted could have been in an email with a page for critical summary of changes. This would leave time for the DPE to share issues and ideas.
- Having a professional facilitator and break out groups would work really well in this setting. You could separate out the f2f and those online for the breakout groups.
- The sound was very distracting online - running hybrid is very difficult and some additional IT support would be good - I have found attending many of the college meetings in hybrid format extremely challenging due to sound - other hybrid formats i.e. within my health network - have worked much better.
- Can we make the forum in the latter half of the year. This time of year is very busy for many DPEs - we all commented on the timing in Victoria.
- RACP updates can be very brief or sent in an email. The forum would be better served to make recommendations on issues that arise or provide us with teaching. It would be great to have

sessions where we can understand how different health services teach their trainees. Provide avenues to partner and network with each other in teaching etc.

Suggested topics for discussion at the next DPE Forum:

- Some more practical sessions = problems DPEs have encountered and how they have solved them.
- Updates around written exams in October.
- An update regarding the College's stance on regional and rural training for APTs would be of interest.
- Exam refresh - both written and clinical exam: ideally both an update from the refresh group and a workshop to help modify their recommendations. Practical session on establishing progress review panels.
- Written exam session as above.
- How the RACP can support DPEs educationally including protected time for their supervisory role.
- Update regarding Regional, Rural and Remote medical training.
- Best practice to ensure accreditation.
- A review of the difficulty and relevance of the written exam. Value vs. wellbeing of our registrars.
- Managing struggling trainees - always worthwhile.
- Discussion around new 2-year internship in Victoria and when entry point into BPT - will it be PGY2 (current situation) or PGY3 (like NSW)? Good to have uniform agreement on this from RACP perspective.
- How does the RACP advocate for education with the jurisdiction departments of health.
- Integrating with networks.
- I'd like to look more at the intersection of accreditation with the DPE group. Particularly in regard to what we all think we need in regard to resources (FTE / admin support) to do the job in a sustainable and high-quality manner.