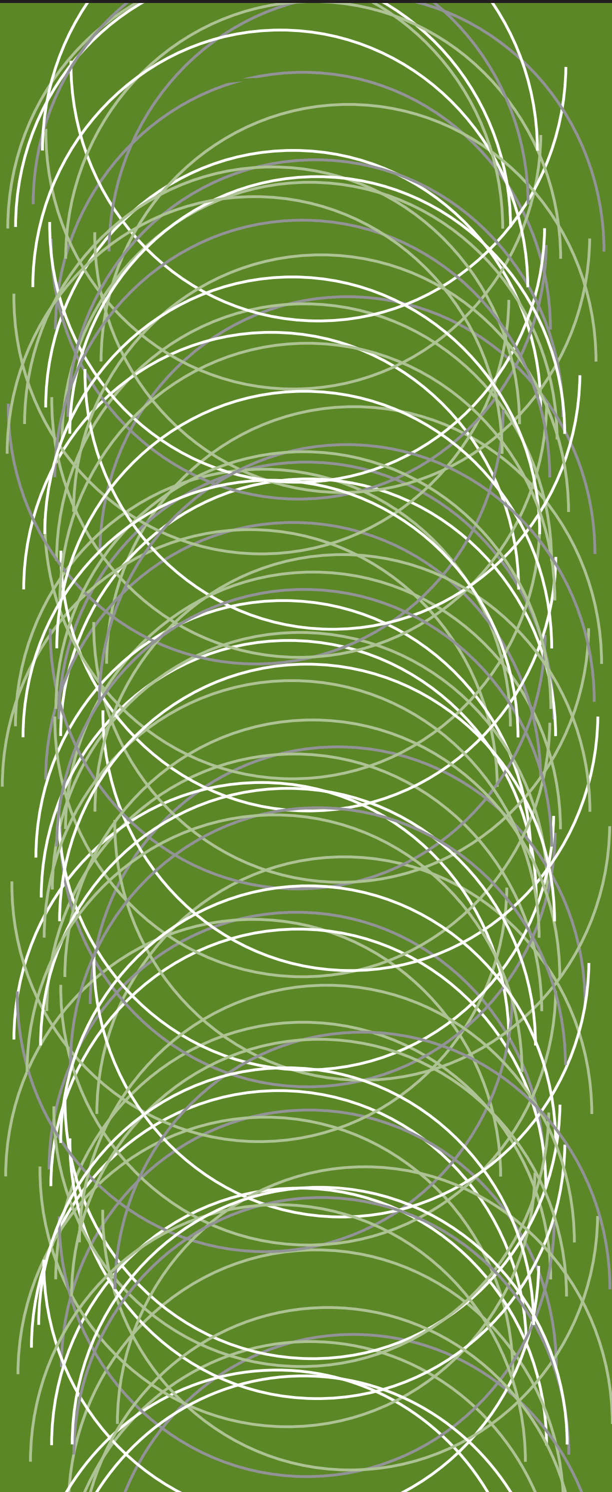
Australian Medical Council Limited

Report
AMC Workshop: Training Program Evaluation and Trainee Feedback

AMC



John B Reid Theatre, AGSM Building,
The University of New South Wales, Sydney
Saturday 13 November 2010

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Executive Summary

On 13 November 2010, the Australian Medical Council held a Workshop on Confidential Trainee Feedback Mechanisms.

The workshop was an initiative of the Specialist Education Accreditation Committee, which oversees the process for assessment and accreditation of Australian specialist medical education programs and professional development programs. In reviewing progress reports by accredited specialist medical colleges, the Committee had noted that a number of colleges were having difficulty addressing recommendations made in AMC accreditation reports concerning the accreditation standards relating to Monitoring and Evaluation, and in particular accreditation standard 6.1.3, which states, 'Trainees contribute to monitoring and to program development. Their confidential feedback on the quality of supervision, training and clinical experience is systematically sought, analysed and used in the monitoring process. Trainee feedback is specifically sought on proposed changes to the training program to ensure that existing trainees are not unfairly disadvantaged by such changes.'

The workshop, in which 75 trainees, college staff and jurisdictional representatives participated, provided an opportunity to discuss current processes for trainee input into program monitoring and evaluation within colleges, as well as processes for addressing complaints and appeals.

The Australian Medical Council also commissioned a literature review and survey of appropriate institutions, which was provided to workshop participants, to determine good practice for conducting trainee feedback on their training experiences, with particular focus on confidentiality. This research was then incorporated into the program evaluation.

This report summarises the workshop's sessions and presentations. It also captures the outcomes of the workshop's small group and panel discussions.

Introduction and Context

Since the AMC established the process for assessing and accrediting specialist medical training programs ten years ago, it has recognised the importance of providing opportunities for those completing programs of study, the doctors in training, have opportunities to contribute to the assessment of these programs. Similarly, in setting its accreditation standards, it has recognised that trainees are affected by the way in which the education providers, the colleges, manage their training program and also the role trainees play in AMC's own processes and committees. Over this period, recognition of trainee issues within the colleges has changed, as have the AMC's accreditation standards in regard to these matters. The AMC monitors colleges program against the accreditation standards and the AMC Workshop for Training Program Evaluation and Trainee Feedback, held on 13 November 2010 at the University of New South Wales, Sydney, was developed to assist organisations, including specialist colleges, deal with trainee issues, and to inform possible changes to the AMC accreditation standards.

The workshop addressed two themes:

- Obtaining feedback from trainees, with a focus on improvement.
- Trainee concerns, complaints, and appeals.

The workshop aimed to be useful, educative and useful at a practical level, to form a sense of whether current practices are sufficient. The workshop was structured into sessions including presentations, small-group discussions, and a panel discussion. This report captures the outcomes of the sessions.

The AMC published a website with supporting information prior to the workshop. The website included:

- AMC accreditation standards relevant to the workshop and information on the accreditation process (Attachment 1).
- A literature review on best practice for obtaining and using trainee feedback, commissioned for the workshop (Attachment 2).
- A list of suggested pre-reading papers. (Attachment 3).

Presentation Sessions

The workshop included four presentation sessions with seven presenters from a variety of disciplines. This section presents a brief summary of each session. Biographies of presenters are included in Attachment 4 and full presentation slides for each topic are available in Attachment 5.

AMC standards and accreditation findings

This session was presented by Associate Professor Jill Sewell AM, chair of the AMC Specialist Education Accreditation Committee.

Presentation

Associate Professor Sewell provided an overview of the AMC standards and how trainees have been involved in the accreditation process over time. The AMC began accrediting specialist colleges in 2002 after a two-year pilot program. The accreditation standards and peer review process, which ensure high training program standards, are approached in a collegiate manner. Assessment teams consult widely and, during the process, give feedback to the organisation under review.

When the AMC accreditation process began, many of the colleges defined stakeholder input narrowly. The AMC, however, wished for a broad definition, and included site visits and invited submissions into the accreditation process. Accreditation processes include a confidential survey of trainees and supervisors, and a specialist medical trainee from another specialist training program is included on the assessment team. Site visits allow assessment teams to focus on issues identified in surveys. However, the process is not ideal. Survey response rates are often low and at least one college has suggested that the AMC survey may create barriers in the college's own feedback mechanisms. The AMC therefore tries to work in complement to college processes.

From 2000-2006, the AMC had few standards that addressed trainee contributions to quality monitoring. Some trainees had suggested that the AMC create an ombudsman to resolve issues, but ultimately this was considered difficult to set up and perhaps inappropriate in the context of the purpose of the overall process. Instead, the AMC opted to strengthen accreditation standards around trainees. A reference group including trainees and senior college staff and office-bearers developed the new standards draft in 2006, with the revised standards completed in 2007. These made the expected role of trainees more explicit, including contributions to training policy development, and monitoring and feedback processes. This has led to more specific recommendations from AMC assessment teams in the years since.

Colleges have recognised the importance of feedback, but it often lacks framework. Colleges have involved trainees in their internal processes and boards, but sometimes as observers only. In some cases, trainees have formed groups outside the college to fulfil their representation needs. Some colleges still seek feedback from trainees but not other stakeholders, and some from neither.

Finally, surveys and other AMC consultation processes reveal disjuncture between trainee expectations and reality, including:

- Work safety, especially working hours. These are not set and managed by the college but by the health service employer.
- Women in medicine issues. There is still concern around representation and the opportunity to provide feedback on issues for women in training.

- Anonymity, especially in smaller training programs. In these situations, trainees fear being branded troublemakers if they give negative feedback.
- An appeals process, which may favour supervisors and be burdensome to the trainee.

Questions

Questions from the audience after the presentation included:

Are there other ways that trainee bodies can contact and interact with the AMC to address any ongoing problems?

The AMC does not have one way of dealing with the issues. The AMC is not and cannot be an appeals body. We need to discuss today if a mechanism is needed for facilitating interaction. Andrew Perry's presentation will discuss this area further.

Does the AMC assist with 'filling the gap' if a recommendation has been made?

AMC offers individual assistance around a whole range of issues in accreditation, in a confidential but good information-sharing way. But the main legal role is assessing whether accreditation standards have been met.

Has the AMC done any benchmarking on trainee feedback? Such as types of trainee feedback and the effectiveness of them.

There is a benchmark of 'experience over time'. The literature review pulls together some of the wider understanding.

Trainee perspectives and expectations

This session was presented by Dr Andrew Perry, immediate past chair of the Australian Medical Association (AMA) Council of Doctors in Training and chair-elect of the Australasian College for Emergency Medicine (ACEM) Trainee Committee.

Dr Perry presented the trainee perspective. He reflected that no system is perfect. The AMA, through its role as an independent advocate receiving both formal and informal information, can offer insight. Informal methods to deal with problem situations were usually best and formal processes are seen as a 'last resort'.

Dr Perry gave the workshop the first report of an AMA specialist trainee survey completed in April-May 2010. This was independent of colleges processes and designed to take a snapshot of all specialty colleges. The survey was electronic and distributed to Doctors in Training members and trainee committee chairs with a request to distribute more widely. In addition, in the week before the workshop, Dr Perry conducted an informal anonymous electronic survey of trainee committee chairs with results broadly mirroring the AMA survey. Results for both surveys are given on Dr Perry's slides in Attachment 5.

Dr Perry outlined the most common trainee concerns in terms of their type, frequency, and motivation.

- Type. Concerns can come from any level in the training tree and it is important to determine which level is involved. At the college level, the most frequent complaint is the cost of training, which could be better explained to trainees. Other common issues are outlined in the presentation slides. At a local level, the common issues are accessing flexible training, safe hours, supervision, harassment, and bullying. Dr Perry stated the colleges can be the best advocates for trainees in these areas.
- Frequency. There is no register and no precise figures. Dr Perry's experience is that concerns vary widely year to year and are issue dependent, typically <10 separate major issues a year. Anecdotally, the frequency has diminished in the last five years.
- Motivation. Many training-related rulings are high-stakes for the trainee, or where violation of natural justice is seen to have occurred. The AMA experience is that concerns are almost never vexatious, but occasionally under-informed.

Finally, Dr Perry outlined key issues in obtaining trainee feedback:

- A primary reason is to minimise appeals and discontent, but also as an investment in the future leaders of the college and to identify improvements.
- Feedback should be requested on the right issues at the right time and by asking the right people. For example, representatives are efficient, but sometimes all the trainees need to be involved.
- Trainee committees are almost universal and an efficient means of obtaining feedback. However, to be effective, they must be able to communicate with the people they represent.

Overall, Dr Perry considered the AMC standards were adequate, but could be improved with explanatory notes. He suggested a number of 'best practice' examples within the colleges:

- Appeals process: RANZCOG (details on website).
- Involving trainees in governance: RACP.
- Surveying the training environment: ACEM.

Feedback to enable program improvement – possibilities, practicalities, and examples of current approaches

This session contained three presentations:

- Associate Professor Tim Shaw and Dr Linda Klein from The University of Sydney.
- Ms Mary Lawson, Director of Education at the Australian and New Zealand College of Anaesthetists (ANZCA).
- Dr Karen Owen, CEO of the Royal Australasian College of Medical Administrators (RACMA).

Presentation 1: Program evaluation and gaining feedback and input

Associate Professor Shaw reflected on the period of enormous change in medical training and education over the last ten years, including changes in roles, funding, programs, and rules that have led to more responsibility and less time. He concluded that in this environment, two points are critical:

- Get the fundamentals right. The foundations of program evaluation matter because otherwise it is easy to be purely reactive, rather than proactive.
- Take everyone with you.

Associate Professor Shaw began with the foundations of program evaluation:

- Are all the stakeholders really on the same page? Program Logic Models are an example of good practice: they show how a program intends to produce outcomes and links resources, activities, outputs, short- and long-term impacts, and outcomes. This can be represented as a flow diagram to facilitate understanding. Without a shared understanding, you cannot further develop an evaluation plan and gather needed information.
- Do you have an integrated evaluation plan? Program Logic Models also allow mapping of evaluations onto the outputs/outcomes and identify information needed. Evaluation has a life cycle and the most important part is to disseminate the report and implement changes. Plans are negotiated with stakeholders, who will have different perspectives.
- Has the plan been communicated to all stakeholders?

Connecting with trainees is fundamental to meaningful feedback, and also appropriate as they are the next generation of college officeholders. Among trainees, colleges are still viewed as a bastion that needs storming. Associate Professor Shaw presented ideas to increase trainee

connection (see slides, Attachment 5), including taking on trainees as associate fellows and spending time in hospitals with trainees. The most important principle is to **close the loop** – make sure trainees understand what is done with data collected. Dr Klein commented that under this principle, they have posted survey results and proposed actions on student websites, and have kept response rates >90%.

Dr Klein outlined the long history and evidence base of participatory evaluation. The method chosen (survey, direct methods, focus group, etc.) depends on the questions being posed, the available sources of data, and people and time resources. She provided tips for questionnaires (content validity, format, and measurement scales) and focus groups and interviews (should both be conducted by an independent person to improve data reliability). Further details are contained in the presentation slides in Attachment 5.

In summary, the following points were 'take home' messages:

- Get everyone on the same page and get the basics right.
- Develop an evaluation plan.
- Set focus depending on information sought.
- Program logic is a useful tool to develop plan and set questions.
- Evaluation methods must be appropriate to the questions asked.
- Engaging trainees on multiple levels will improve feedback.
- Need to be creative in how you bring trainees 'on board'.

Presentation 2: Trainee involvement in quality improvement at ANZCA

Mary Lawson's presentation outlined both the formal and informal evaluation systems within ANZCA:

- Formal. ANZCA accredits training sites, not individual posts. This process involves a cycle of review with online data collection appraised by an independent team who makes recommendations. Trainees are asked to complete two surveys, one on opinions and the other on workload. The assessment team follows up with trainee interviews and the committee has a trainee representative. In addition, ANZCA has periodic initiatives that has included a curriculum review cycle (www.anzca.edu.au/edu/projects/curriculum-review) in which trainees were involved in submissions, surveys, and the review working group. The submissions from the review process continue to be valuable.
- Informal. Trainees themselves initiate some surveys. These are annual in some regions and are being progressively rolled out by the Trainee Committee. This is an anonymous online process and the Trainee Committee reviews the data. There is no college management, which is both positive and negative. In addition, there are some issues with anonymity, highly variable response rates, and potential for overlap with college formal processes.
- Other input mechanisms. In addition, information can come from committees (including trainee, education and training, and accreditation) or from the trainee member on the college council. In education working groups, the college has recognised the need to have two trainees due to power imbalance. This includes working groups for clinical teacher development, distance education, and curriculum review and redesign.

ANZCA applies John Owen's work on evaluation steps, which requires thinking about evaluation at each stage of development. Issues that are relevant now are to:

- Develop existing online capacity.
- Consider workload implications.
- Coordinate to augment rather than replicate existing activity.

- Negotiate priority at college level, e.g. for required level of IT support.

Questions ANZCA uses to guide the evaluation process include:

- How do we collect meaningful data?
- How seriously do we take results?
- What impact will this have on patient care?
- Do we have systems in place to act on results?

Presentation 3: Trainee feedback – RACMA program improvement

Dr Karen Owen spoke on trainee feedback and program improvement at RACMA. She firstly set the context that RACMA tends to have older trainees with more experience, and often with another specialty. Therefore, they use more RPL and specialised training plans mapped to the program curriculum.

RACMA uses a framework to collect information similar to McGahan (2004)[1]:

- Retrospective or reflective events that generate progressive changes. This includes surveys, forums, evaluations for particular tasks, informal conversation and individual stories, and trainee presentations at workshops.
- Prospective events that intermediate or shift relationships for change. The Candidate Advisory Committee (a sub-committee of the college board since 2004) and trainee members of college committees, including education and training, curriculum, and training sub-committees.
- Reactionary or radical events that generate disruptive or innovative change. Changes driven by complaints and appeals.

RACMA surveys from 2006–2009 indicated the main issues for candidates were:

- Cost of workshops.
- Need for interstate travel.
- Length of some workshops.
- Desire for more trial exam cases with clearer information on what is a good answer.
- More interactive sessions (but needing to understand what was meant by this).

Candidates for several years wanted a secure online forum, but now the college has provided it, the forum is not used. It has been hard to engage trainees this way. Two feedback-driven changes in recent years both involved assessment.

Dr Owen provided a learning example where RACMA decided to introduce a new assessment task and apply the change retrospectively. This attracted severe push-back from candidates. This was a lesson in governance and led to a regulation for implementing changes to the training program. Trainees believed they were listened to as a result.

In RACMA, most feedback goes to governance structures in the college. The college publish results if appropriate. Trainees make contributions to the college journal *The Quarterly*, which also published the trainee survey this year. Letters of feedback to trainees are used where appeals are going on (for individuals involved). Program changes have occurred as a result. For example, the college will cease publication of reflective case studies from 2011. Challenges and issues remain, as detailed in the slides, Attachment 5.

College review and complaints

This session was presented by Mr Michael Gorton AM, Principal at Russell Kennedy Pty Ltd.

[1] McGahan, A. (2004). How Industries Change. HBR. Harvard Business School Press.

Presentation

Mr Gorton presented the legal perspective on trainee complaints. He reflected that for every one appeal or significant review, there are likely more issues below. Therefore, colleges need processes in place to reduce the impact of potential issues. Careers are involved; this translates into dollars and can lead to substantial legal claims if people are delayed or prevented entering a college.

Mr Gorton gave a brief outline of the Australian Competition and Consumer Commission (ACCC) review[2], of the specialist medical colleges. One of the issues constantly arising is the confusion of 'two hats' people may wear – one hospital (e.g. industrial, workforce) and one college (e.g. supervisors, unit heads). In response, colleges have moved to better selection processes, but all the colleges are still subject to challenge if processes are not done properly. The Brennan principles say processes must be fair, transparent and allow appeals; not all colleges had these in place at the time of the review.

Mr Gorton took some time to discuss the term *natural justice* in its legal meaning, which is most relevant to understand when making decision to delay or dismiss a candidate. The components include:

- a decision made objectively (criteria assessment)
- considering relevant material (e.g., not gossip, material outside selection criteria, or discriminatory material. Also avoid 'local knowledge', which can be a backdoor way to introduce gossip into the process.)
- with opportunity to be heard
- provides notice of adverse material (be careful of anonymous comments, and still need to disclose substance of the issue when information comes from confidential referees)
- avoids bias by using impartial selectors (not those with a relationship to the candidate or who have made a prior decision involving the candidate)
- has a review mechanism (appeal).

Colleges actually enter into a contract with the trainee, that is, to supervise at a certain level of quality and to deal with candidates in accordance with stated processes. For example, a Western Australian decision found a college made a misrepresentation when it provided inadequate feedback to a candidate while having a policy that detailed feedback would be provided.

In the overall colleges processes for appeals, decisions may first be reconsidered by the same committee. Following this:

- The decision can be reviewed by a different committee. This allows fresh eyes, but may only be considered if an error of process occurred in the first consideration. Colleges often struggle with feeling such reviews are a criticism of the previous decision maker, and may be reluctant to criticise as a result.
- Following this, the decision may be considered by an independent review of training. Triggers may include bad rotations, and rulings against a candidate. This is a constructive exercise to see if decision made is appropriate and what can be done at a local level to improve the situation.
- Following this, the matter proceeds to the appeals committee. In some colleges, this is a natural part of the process, in others, difficulties on criticism occur as previously outlined. The appeals committee is, however, the last chance to avoid the issue progressing to court, which is time consuming and costly. Though informal, appeals can be a very

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[2] Australian Competition and Consumer Commission (ACCC) and Australian Health Workforce Officials' Committee (AHWOC) 2005. *Report to the Australian Health Ministers: review of Australian specialist medical colleges*, ACCC Publishing Unit, 7/05. Available from: http://www.accc.gov.au/content/index.phtml/itemId/699578

intimidating process for the trainee. Appeals are a good opportunity to fix the issues before they progress to court.

- Issues in this process include:
  - Ensuring natural justice occurs at all levels.
  - Careful documentation.
  - Procedural error is often the basis for trainees' appeals to be upheld. This is the way a court would find also, so important to get process right.
  - Exclude new information in appeals that was not available to the original decision maker. Some colleges may include it depending on the situation.
- Outcomes from the process include:
  - No change.
  - Accept the recommended change (usually in merit-based cases).
  - Send the issue back for another hearing (especially in process-related cases).

Final recommendations were:

- Ensure clarity of process, criteria, and roles.
- Ensure clear guidelines, processes, and policies exist. Use templates (letters, information sheets, explanations) to helps make processes more consistent and manageable, especially where people are doing the process for the first time.
- 'Centralise' oversight of review and appeal processes (especially dismissals) to ensure the process is handled by people who regularly perform it.
- Differentiate the role of the college and the employing hospital and be clear so that people are not confused as to 'who' is speaking to the trainee.
- Support selectors and supervisors, for example, with training programs.
- Maintain insurance and ensure it covers these issues. For example, insurance may cover financial claims but not administrative remedy claims, which are often the type of claim brought.

Questions

Questions from the audience following Michael Gorton's presentation included:

Can you clarify privilege of documents – how can the college avoid these being discovered later for another purpose once the trainee is fully qualified?

This might arise where an allegation of incompetence is made. There's no way to protect the training records as part of such a process. The college can have a records destruction policy that to avoid unnecessarily holding documents once a person is qualified, but this can be problematic because defence is often also in the documents.

A follow-up. The concern amongst fellows is not that they would be sued, but that the information would be used for a purpose other than what it was intended for. For example, a person reflecting on their own deficiencies as a trainee.

Commonwealth protection may be possible for the reflective part of the CPD program because without such protection, people may be less frank about themselves.

On patient safety: colleges have large responsibility to the general public as well to remove someone from training if there is a major issue. How does this relate to the processes described?

Many colleges have as part of their rules a proviso that says they can suspend a doctor immediately if there is a patient safety issue. But mandatory reporting should also be

considered in these circumstances, because then college may have obligation to report the trainee to the medical board.

Do you think we are passing the buck if a trainee is given a bad report because they are moving hospital because of fear of litigation?

Yes. This is why evaluations have moved towards extracting more information than just 'satisfactory'.

Small-group Discussion Sessions

The workshop broke into six groups to enable participants a forum to discuss the experiences of individual colleges in more detail. Two discussion sessions were guided by a set of prompt questions (see Attachment 6), one relating to obtaining feedback for program improvement, and the other to focus on college review and complaints. These small-group discussions also provided questions for the panel discussion presented later in this report. This section summarises the notes taken in the panel sessions under the prompting question.

Obtaining feedback to enable program improvement

Due to time constraints on the day, each group chose a single question to discuss. The questions and discussion outcomes are listed below.

Question 1: *In practice, what information should medical colleges be seeking from trainees in order to assist with program evaluation and improvement? Of this, what is most important? Which type is most difficult to gather?*

Key areas for trainee feedback discussed in groups included:

- More process feedback, such as on delays or difficulties. Exams and teaching are probably the topics trainees are most interested in but trainees are generally not asked about wider college processes, such as policy directions.
- Access to curriculum, progression of training, supervisor quality, what is taught 'on the ground', fairness and transparent of exams, and decision making consistency.
- Satisfaction (but needs unpacking), gaps, and what works.
- Usefulness of resources for learning.
- Preparedness for next level of training.
- Perceptions of learning environment.
- Relationship with College.
- In the early stages of training, whether needs are being met and safety.

Difficulties in giving feedback for pro-bono supervisors was discussed.

Question 2: *In your experience, what have been the more effective methods for gaining feedback from trainees/students on their education programs? What were the key elements that made these effective? What factors are less effective and how can these be addressed?*

- Best feedback is achieved face-to-face.
- The group suggested a trainee advocate act as a feedback agent, and that the advocate should know the college, have specific skills, and perhaps be a new specialist. They think a trainee advocate should be considered, though some colleges may not think it is appropriate or fit within their current structure.
- Need to make clearer that roles on committees need feedback in both directions, and suggested putting this information in a handbook for committees. Recognised the feedback mechanism through trainees is, however, sometimes difficult.
- Discussion occurred on whether term evaluation should be mandatory. Further, the group discussed that feedback should be mandatory on training terms, teaching and

supervision; the possibility of a national tool; the culture of workplaces and connecting curriculum with clinical work, teaching, and assessment. Suggestions were made to have external mediators (or tools) assist with term evaluation.

- Finally, the need for colleges to have a process for and show they can 'close the loop' on feedback. Survey design has a role in making sure the trainee knows their feedback will result in change.

Question 3*: In what circumstances is it more appropriate to seek feedback from groups of trainees (such as a trainee committee)? When is it more appropriate to seek feedback from individual trainees?*

The group responded that:

- Where information was sought on curriculum/assessment or related issues of change, feedback should be sought from a group (training committee etc).
- Where information was sought on effectiveness of attachments or delivery of training, feedback should be from individuals, ensuring they are de-identified.
- Induction or guidelines to assessment are needed for trainees providing individual feedback (including limitations and privacy legislation).

Question 4: *What is the role of an effective trainee feedback process in program evaluation and improvement? What are the consequences of not collecting and addressing trainee feedback effectively?*

The group listed their key points for effectiveness of trainee feedback in evaluation and improvement were:

- Structure of the evaluation to determine what happens to the feedback.
- Demonstrating a change/outcome.
- Involving trainees early (not just as respondents) to identify the issues and feedback purpose, and to design questions.
- Closing the loop – acting on results, targeting information to relevant groups, and promoting the changes.

Key consequences for not addressing feedback effectively were:

- AMC dissatisfaction.
- Loss of 'buy in' and no shared understanding: not acting on feedback given is worse than not taking feedback.
- Inability to evaluate value and type of change.
- Assuming one-size-fits-all.
- Lack of standard/benchmarks for respondents.

College review and complaints procedures

Question 1: *Given the number of trainee/supervisor or trainee/college interactions that may lead to complaints or reviews of decisions, how does a college prepare supervisors/colleges and trainees, including informing them of their rights and responsibilities?*

The group discussed the following ways to prepare supervisors and trainees, and inform them of their rights and responsibilities:

- Guidelines and templates.
- Clear, open, and collegiate processes that are communicated to all.
- Trainee induction (e.g. RCPA).

- Trainee agreements and charters (e.g. RACP developed in response to AMC recommendations, RACDS) or memoranda of understanding (e.g. ACEM, RANZCOG). Need for a supervisor charter was also raised.
- Encouraging trainees to participate in the college, including on review committees.
- Supervisor training courses and supervisor accreditation.
- Educating both trainees and supervisors on feedback expectations, and using common feedback forms.
- The use of an ombudsman for independent review.

Through the discussion, the groups recognised challenges in this area, including:

- Dispersed supervision making communication more difficult.
- Delineating the responsibilities of the college and the employer not always easy – these 'jurisdiction' issues are complex and can lead to duplication or miscommunication.

Questions asked by the groups included:

- Why can't colleges work together to achieve common goals and outcomes?
- Do we need to educate trainees and supervisors in the expectations for feedback?

Question 2: *In your experience, what are the characteristics of effective mechanism for dealing with complaints and/or reviews in educational institutions such as the specialist colleges? What characteristics of ineffective mechanisms have you experienced?*

The groups discussed a number of characteristics of systems that effectively deal with complaints of reviews:

- A clear, open, and transparent process, including documentation and excellent communication to the trainee. The clarity of the process also includes knowledge of who to contact, which affects expediency. One group specifically cited that a single point of contact is needed.
- Ensuring the responsibility is passed (or delegated) to the most appropriate level in the organisation, and, equally, providing informal mechanisms prior to the a formal complaint, such as mentors or advocates. This can be a challenge in a decentralised environment and highlights importance of communication.
- Clearly defined grounds for complaint (objective criteria) and demonstration of natural justice.

Ineffective mechanism characteristics discussed included:

- Poor communication between the college and the 'periphery'.
- Impacts on the trainee for raising a complaint.
- Non-empathetic processes.

Question 3*: What role does an effective process for dealing with trainee complaints/reviews of decision play in assisting program evaluation? What are the consequences of not having an effective method for dealing with complaints and/or reviews of decisions?*

Groups viewed the role of the complaints/reviews process in program evaluation as:

- Identifies improvement areas, and often provides impetus for change.
- Evaluation itself a protection mechanism for trainees.

Consequences for not effectively dealing with complaints/reviews included:

- Lost opportunity to improve.
- Loss of college reputation.

- Financial (and other) consequences for the trainee.
- Invoking legal avenues.

The groups noted:

- No formal process in most colleges.
- Much is resolved at the local level and never known to the colleges.
- Appeal information and outcomes need to be de-identified.

The groups queried:

- Is there a role for an external body to provide a third party avenue?
- Are databases/registers of complaints reviewed and used for broader trend analysis?

Question 4: *What can organisations such as the specialist colleges do to minimise complaints and/or reviews of decisions?*

Consistent themes in group discussion were:

- Good communication with employer, supervisor, and trainee (misinformation is an issue).
- A good process which is clear and is always followed.
- Empowering trainee representation (including committees) in governance structures, for example, ability for trainee committees to table agenda/policy for consideration.
- Having mechanisms in place for trainee feedback, including on governance structures. Both formal (e.g. focus groups) and informal processes of value.

Other discussion reflects a need for:

- Change management to minimise issues and to sell the change.
- Ensuring link between educational objectives and assessment.

Panel Discussion

The panel discussion took questions both generated from the small-group discussions and direct from the audience. The panel members were: Professor Barry Baker, Dr Linda MacPherson, Dr Andrew Perry, Associate Professor Jill Sewell and Associate Professor Tim Shaw.

Question 1: *Tim mentioned specialist training has an impact on patient care – do you think patients have a stake in the trainee education?*

The panel said they did not think consumers are used enough in education (where the term 'consumer' was used lightly). Experience from oncology was discussed where consumers are involved in the education process and this is found to be extremely valuable. The panel also recognised the issue of consumer participation not defined in the AMC standards, and is an issue the AMC is wrestling with. The main issue seems to be getting the right people involved; not just informed and productive people, but representative.

Question 2: *Who do we say a consumer is? What does this mean – someone who has had an (any) interaction or a significant interaction with the health system?*

The panel discussed this with input from the audience. Meanings included, 'someone who had lived experience of receiving the type of service being delivered at that time'. Also discussed was the potential for other people associated with care offering their experiences. One audience member commented on their system where trainees are evaluated by patients, other health professions, and administrators. Interestingly, no statistically significant differences are found in ratings from different parties. The panel also mentioned the Australian Consumer Council who can provide representatives, and that the AMC processes always have consumer representation.

Question 3: *I got a sense from Dr Perry's talk that concerns can arise and founder at the sub-specialty level and that this level can call the shots despite the college having overriding authority. How much of a problem is the sub-specialty group with trainee concerns?*

Within large colleges, the subspecialties not always knowing the college processes can be a problem, including in areas such as selection, training location, and natural justice principles. The AMC is aware of and discussing this issue. The panel commented that structures in the larger colleges have changed a lot. The panel clarified the AMC holds the overall college accountable to the standards, and expects the college would ensure standards through its subgroups, but has recognised a need to address this further.

Question 4: *One of the group ideas was trainee agreements – almost quasi-contracts – comments?*

The panel discussed their individual experiences, including trainee agreements where both trainees and the college sign for what they will and will not do. RACP is drawing up a training charter to recognises trainee and college expectations. The panel discussed the role of the hospital in charters. The panel experience is where the hospital signs to say they will provide the listed facilities. The panel also suggested further discussion on agreements with supervisors, and the audience commented that agreements may disadvantage some trainees if their college cannot negotiate particular conditions that another college can. Overall, the panel recognised the actual implementation of the on-paper agreement is the key.

Question 5: *What is the general feeling about how communication to trainees is done on the purpose of evaluation and expectations for trainees?*

Communication is difficult where people are distributed. In a university model, trainees could be addressed as a group but a college model, this is difficult. New technologies and approaches may provide some answers, but information overload has to be avoided. The face of the college is the supervisors, and if they do not understand the processes, then the trainees may not either. Associate Professor Shaw suggested short cycle feedback using online tools could be used.

Question 6: *Is there enough commonality between the colleges that we could draw upon a common template or framework?*

Information sharing was encouraged. Common questions and benchmarks can exist no matter how the questions are asked. The panel commented that it would make sense for someone to be a clearing house for these ideas.

Question 7: *Is there a chance to move back to the model where we had maybe 15 years ago where a person in the hospital setting was available?*

Funding for this arrangement is a major issue, which ultimately may come back to trainees. Local employers may also miss information if feedback goes directly back to the college.

Question 8: *Panel question (Dr Perry): How do you involve trainees in evaluation? We have discussed whether a trainee should be involved in every college accreditation visit. But then we run into issues where trainees have to do this in their own time and there needs to be some addressing this commitment.*

Discussion acknowledged the trainee's own time is often involved, and strategies to avoid compromising the trainee, such as not evaluating sites in their own state.

Question 9: *Panel question (Professor Baker): I'm interested to know the point of view of other trainees on utility of recent graduate rather than trainee representation?*

The panel discussed, with audience input, the pros and cons for involving recent graduates compared with trainees – overall, opinion was a trainee was preferred. Concerns were raised about long-term sustainability of commitments for trainees and consultants in evaluation processes.

Outcomes

Themes emerging from discussions included that:

1. 'Closing the loop' is critical to the integrity of any feedback system. Trainees must understand what happens to the data they provide and what changed as a result.
2. Communication difficulties are a major limitation where trainees and supervisors are widely distributed. This needs to be addressed, possibly through online technologies. Specific issues within this theme included:
   - Communication to trainees explaining the costs of training, particularly when fees rise.
   - Communication between trainees and the trainee committees representing them.
   - Communication between the college and the 'periphery'. Trainee agreements and charters may have a role in closing any expectation gaps.
   - The need for supervisors to be informed on college processes, being the local 'face' of the college. The potential for supervisor charter or agreements was floated.
   - The need for a clear point of contact for trainees, especially for sensitive complaints.
3. Many systems already exist that appear to be working well. Reinvention is not desirable, so possibilities for colleges to share resources or work together need investigation.
4. Both trainee and college are concerned about long-term sustainability of trainee feedback and program evaluation, which require high levels of responsibility and time commitment. Expectations for trainees expected to give feedback to multiple authorities may need setting out.
5. Anonymity is a significant issue for trainees, particularly for those in programs with small numbers. Strategies are available to improve anonymity and reduce perceived consequences.
6. Clear, transparent processes within the college are critical, especially for concerns and complaints.

Attachment 1

AMC Standards and Accreditation Process

Description of Australian Medical Council accreditation process 2010

Australian Medical Council

- *Independent* national standards body for medical education and training.
- Ensure that standards of education, training and assessment of the medical profession promote and protect the health of the Australian community.
- Major functions: standards setting, assessing, accrediting, informing.

History of AMC accreditation

- 1985 - AMC set up to accredit medical school courses
- 1998 - Commonwealth asks AMC to develop standards/procedures for medical specialties. AMC consults stakeholders and runs a pilot
- 2002 – AMC agrees to accredit specialist medical training + continuing professional development programs
- 2002 - standards and procedures published
- 2006 - AMC standards revised in relation to college trainees
- 2008 - AMC completes first cycle of accreditation of programs of all established colleges
- 2008 - Full revision of AMC standards after extensive consultation
- 2010 - National Registration and Accreditation Scheme commences, accreditation of specialist medical training covered by the Scheme.

Aims of process

- To assess and recognise specialist medical programs and organisations that satisfy standards of educational quality.
- A collegial process based on self and peer assessment for public accountability and improvement of academic quality.
- Is intended to be constructive and to respect the expertise and autonomy of training organisations.
- Supports and fosters educational initiatives.
- Diversity of approach is a strength of postgraduate medical education and training in Australia. The AMC aims to support diversity, innovation and evolution in approaches to medical education.

2008 AMC accreditation standards

Some 60 standards, grouped under the headings:

- The context of education and training
- The outcomes of the training program
- The education and training program – curriculum content
- The training program – teaching and learning
- The curriculum – assessment of learning
- The curriculum – monitoring and evaluation
- Implementing the curriculum – trainees
- Implementing the training program – delivery of educational resources
- Continuing professional development

Accreditation processes

AMC Specialist Education Accreditation Committee

- Develop standards, policy and procedures.
- Implement & evaluate process and policy, set work program.
- Encourage improvements in medical education and training - workshops.

Assessment teams

- Set up to assess a specific training programs or programs of a specific college.
- Work within AMC guidelines and processes.
- Reports to the committee.

Process in Detail -1

- AMC chooses assessment group:
  - Related disciplines; health admin; junior doctor; health consumer; educators; maybe an overseas expert.
  - Mix of regions, gender, age, experienced/inexperienced.
  - College has opportunity to comment in proposed membership
- Applicant lodges submission based on AMC standards.
- *Team* reviews documents, formulates questions, plans review, decides on members' roles.
- AMC seeks stakeholder submissions, including trainee and supervisor feedback.

Process in Detail - 2

- Review: an intense 1-2 weeks. The *team*:
  - Visits training sites/practice sites
  - Meets committees, staff, trainees, etc
  - Holds own debriefing and planning meetings
  - Agrees on draft findings and debriefs applicant.
- *Team* prepares report with recommendations.
  - All members contribute
  - Commendations and recommendations agreed by team.
  - Recommends a period of accreditation

Accreditation options

- AMC may grant accreditation if reasonably satisfied
  - that a program of study, and the provider meet accreditation standard; or
  - that the provider and the program of study *substantially meet* accreditation standard, *and* the imposition of conditions will ensure the program meets the standard within a reasonable time.
- AMC may decide not to accredit.
- Maximum accreditation = 6 years. May grant shorter periods when it imposes conditions.
- AMC advises the Medical Board of Australia of its accreditation decision. Board makes decision on the approval of the program of study for registration purposes.

Progress reports

- Once accredited, specialist colleges provide annual progress reports to the AMC
- Reports address recommendations made in AMC accreditation reports and AMC standards

Attachment 2
Literature Review

Medical training providers obtaining feedback from their trainees: what is *best practice*?

Charlotte Nash-Stewart

Prepared for the Australian Medical Council (AMC) workshop: Training Program Evaluation and Trainee Feedback, 13 November 2010

Abstract

Continuous evaluation and improvement in modern medical education requires trainees to give feedback on their supervision and training programs. Feedback approaches vary: methods include surveys (paper-based or electronic), interviews, focus groups and direct peer reporting. Feedback may be taken by the training provider or a third party, and may be anonymous or open. Despite the frequency and the variety of approaches, published literature contains no clear consensus on what constitutes *best practice*. This paper reviews the literature and presents a summary of best practice knowledge on obtaining feedback from medical trainees. This is presented in three parts: selecting or developing a feedback tool, administering the tool (confidentiality and safety), and using feedback data. More research is still required to provide evidence for best practice in many areas, but most sources agree quality feedback requires careful development of a reliable and valid feedback tool, a confidential administration process, ability and commitment to take action on the findings, and follow-up to assess the success of changes.

Introduction

One of the principles of modern medical education is continuous evaluation and improvement.[1,2] As consumers of this education, trainees are key stakeholders and many organisations, including accreditation bodies and colleges, acknowledge this principle by seeking feedback from trainees on satisfaction,[3-6] training program quality,[3,5,7,8] and areas for improvement.[4,7,9] Published literature reveals a variety of methods and tools for taking trainee feedback, but no clear consensus exists as to *best practice*.

The Australian Medical Council (AMC) commissioned this literature review to examine the question of *best practice* in taking feedback from medical specialty trainees. The information supports the AMC workshop in Training Program Evaluation and Trainee Feedback to be held in Sydney in November 2010, and is relevant to standards set by the AMC in accrediting specialist training programs:

6.1 Ongoing Monitoring

6.1.1 The training organisation regularly evaluates and reviews its training programs. Its processes address curriculum content, quality of teaching and supervision, assessment and trainee progress.

6.1.2 Supervisors and trainers contribute to monitoring and to program development. Their feedback is systematically sought, analysed and used as part of the monitoring process.

6.1.3 Trainees contribute to monitoring and to program development. Their confidential feedback on the quality of supervision, training and clinical experience is systematically sought, analysed and used in the monitoring process. Trainee feedback is specifically sought on proposed changes to the training program to ensure that existing trainees are not unfairly disadvantaged by such changes.

6.2 Outcome Evaluation

6.2.1 The training organisation maintains records on the outputs of its training program, is developing methods to measure outcomes of training and is collecting qualitative information on outcomes.

6.2.2 Supervisors, trainees, health care administrators, other health care professionals and consumers contribute to evaluation processes.

7.2 Trainee Participation in Training Organisation Governance

7.2.1. The training organisation has formal processes and structures that facilitate and support the involvement of trainees in the governance of their training.

8.1 Supervisors, Assessors, Trainers and Mentors

8.1.3 The training organisation routinely evaluates supervisor and trainer effectiveness including feedback from trainees and offers guidance in their professional development in these roles.

8.1.5. The training organisation has processes to evaluate the effectiveness of its assessors/examiners including feedback from trainees, and to assist them in their professional development in this role.

The meaning of feedback has been discussed in published literature, but usually definitions are given in the context of feedback to trainees.[10] This review focuses on the complementary situation: trainees giving feedback on their training experiences. The definition of feedback in this setting, however, is essentially the same: feedback is specific information comparing observed performance [of a training program, supervisor, etc.] to a standard, given with the intent to improve performance [of the training program, supervisor, etc.]. As such, high quality feedback in clinical education settings:

1. covers observable tasks and competencies

2. contains highly specific information

3. measures against an explicit standard

4. reports feedback items that the respondent observes first-hand

5. is given to a party able to act on the feedback

6. is obtained as part of a plan to re-observe.[10]

Best practice is taken to mean the most efficient (least effort) and effective (best results) method for trainee feedback, as far as established by research evidence.[11] This paper addresses current knowledge in three parts:

7. best practice in selecting (or developing) a feedback method/tool

8. best practice in administering the method/tool (confidentiality and safety)

9. best practice in using the information gathered.

The reader should be aware that good quality research evidence is lacking in many areas; trials to evaluate the strengths and weaknesses of particular feedback methods are rare. Much of

what is presented in this paper is a summary of consensus, and agreement between many researchers in the absence of rigorous testing may constitute only most common practice, rather than best practice. Despite this, the review identified some key papers that contain excellent summaries of relevant research, or extensive details of feedback tool development. These, listed below, are advised as further reading:

10. Maniate,[12] detailing the development of the Canadian resident program evaluation (RPE) surveys.
11. de Olivera Filho,[13] detailing reliability and validity processes for survey development.
12. Bienstock et al,[14] summarising giving feedback *to* trainees, a subject complementary to this paper.
13. Kogan and Shea,[15] summarising current knowledge in medical course evaluations, including feedback.
14. Alfonso et al,[16] one of the first studies of anonymous vs. open evaluations.
15. Beckman et al,[17,18] who summarise available feedback tools and comment on validity.
16. Porter et al,[19] who reviews literature related to 'survey fatigue'.

Methods

To obtain material for this review, PubMed, Medline, Google Scholar, and Web of Science databases were searched for articles with various combinations of: *trainee OR student OR postdoct* OR learner OR apprentice OR cadet AND feedback OR evaluat* OR opinion OR judgement AND confidential* OR anonymous OR secret OR closed.*

Paper references were also examined and highly relevant papers were checked for prospective citations using Web of Science. The AMC also contacted two overseas organisations known to conduct large-scale trainee surveys—The London Deanery, whose surveys are now used nationally in the UK, and the Royal College of Physicians and Surgeons of Canada (RCPSC)—for their input.

Discussion

Best practice in selecting or designing a feedback tool

Published literature shows a variety of qualitative and quantitative methods for taking trainee feedback, including surveys/questionnaires, interviews (independent or with trainers), focus groups and direct reporting.

Surveys and questionnaires

Surveys/questionnaires are the most common feedback method and are used both to answer one-off research questions[4,6,9,16,20-23] and to measure changes.[3,7,12,24-26] Surveys are highly flexible: they can be small- or large-scale; on paper or electronic; and can measure quantitative ratings (e.g. Likert scales: *strongly disagree, disagree, neither agree nor disagree, agree, strongly agree*) or collect qualitative data (e.g. open questions).[20] Electronic surveys allow rapid data processing (including for 'red flag' issues), flexibility to change information flow,[2] may reduce administration cost,[26] and allow tracking of respondents while preserving confidentiality.[26] The reviewed literature does not evaluate whether taking feedback

electronically or on paper changes response quality, however efficiency gains for large-scale surveys make the electronic format part of current best practice. Examples of existing, large-scale surveys of medical trainees include:

17. Canadian resident program evaluations (RPEs) used in the RCPSC and College of Family Physicians of Canada (CFPC) programs.[12] Both were developed using input from residents and first used in 1983. RPEs are currently confidential paper-and-pencil surveys, but will be transitioning to online format, though a timeframe for the change is not given.

18. Learners' Perceptions Survey (LPS) used in Veterans Affairs (VA) teaching facilities in the United States.[25,27] The LPS has been used annually since 2001 with more than 70,000 completed surveys (not all are specialty trainees). The 57-item LPS was developed from a comprehensive literature review and subsequent focus groups, pilot testing, and statistical analysis. Its primary goal is to describe trainee satisfaction with various aspects of their program.

19. Accreditation Council for Graduate Medical Education (ACGME) (USA) Resident/Fellow Survey.[3,28] The ACGME surveys each core specialty every year, and makes aggregated reports available to programs with four or more residents if 70% response rate is achieved.[13,28]

20. UK General Medical Council National Training Surveys,[29] which are discussed later, and the London Deanery Foundation Programme, which conducts multiple surveys of its doctors.[30,31]

Development

Published literature shows studies taking feedback from trainees often re-use or adapt existing questionnaires that were developed by accreditation bodies, specialist colleges, or other researchers.[20,21,23,24,26,32] In cases where researchers develop a new questionnaire, they often omit specific details about how this was done.[7,9] However, the literature does contain examples of detailed survey development, and most (but not all) researchers present a copy of their questionnaire in their paper.[3,6-9,13,16,22,23,32-37] If a survey tool is being developed, a data analyst should be involved early to address design issues[38] and surveys should be specific about items on which feedback is required. For example, if a survey asks a general question about social environment, it should not be assumed that specific issues such as harassment will be reported.[22]

Two development processes are used by a number of researchers:

1. Developing an initial survey version using benchmarks for quality in the survey's subject. For example, if the survey is to address supervision, initial questions would reflect research-supported features of good (or poor) supervision. Researchers have used literature reviews and models,[16,27,33,37,39,40] trainee opinion surveys,[12,13] expert input,[8,12,27,33,37,40-42] task forces and working groups,[26,27] or a combination of these, to establish benchmarks. Important considerations include developing questions for a specific purpose[15] (e.g. questions targeted at specific program areas) and ensuring changes can be made in the areas that the questions address should poor performance be reported.

Pilot testing of the survey and refining questions, which may involve a cycle of testing, refining, retesting, and further refining.[6,8,12,22,27,33,39,41,42] Survey pilot testing can identify both problems with question wording, and technical aspects of the survey such as web-access. Developers theorise this process ensures critical accreditation issues are covered using clear language. Good examples of this process include Maniate,[12] who describes the 2006 RPE questionnaire update which used a multi-stage iterative process (Figure 1); Keitz et al,[27] who

describe the LPS survey development; and Roff et al,[8] who describes the development of the Dundee Ready Education Environment Measure (DREEM).

Thorough development of a new survey involves substantial consultation, expert input, time, and cost. When these resources are not available, existing validated surveys can be used (or adapted, recognising this may affect validity) and question banks also exist.[43] Examples of validated and widely-used tools include:

21. the DREEM Inventory,[8,44,45] developed in the UK in response to rapid changes in medical education, and a refinement of earlier instruments. Development involved iterative design and pilot testing. Although developed for medical students, it has been shown as useful in resident feedback.[46]
22. the Course Evaluation Questionnaire (CEQ),[34] designed to monitor quality of teaching in higher education. This has been applied to undergraduates, recent graduates, and validated for medical students, though not specialist trainees.
23. The Stanford Faculty Development Program (SFDP) clinical teaching framework,[35] developed to reflect components of effective clinical teaching and validated for medical students, though not specialist trainees.

Other tools used to evaluate resident teaching by medical students are summarised by Coverdale et al.[47] Beckman et al[18] presents a similar review of instruments with a focus on validity. Such summaries are a helpful starting point for those wanting to obtain trainee feedback using (or adapting) an existing validated instrument.

Validity, reliability, and bias

The goal of the development process is to produce a survey that generates meaningful data, which is valid, reliable, and free from avoidable bias. Survey design affects results; factors studied include: the number of points on the rating scale, descriptors on the rating scale, the order of questions and reversing questions, forced choice, and positive rating skew (halo effect).[15,48,49] Survey design requires knowledge of these issues, which is beyond the scope of this paper. Specialist advice is desirable; however, guidance can also be sought from survey design texts and guides, pro-forma questionnaires, and several researchers who comment on the key issues.[15,38,50-53]

Validity of a feedback tool concerns whether the tool generates a true measure of what the developer intended it to measure. Some researchers have used 'face' or 'eyeball' validity, but this has been criticised as 'unscientific'.[54] Statistical tests are preferred,[13,16,22] but Beckman et al[17,18] conducted reviews showing measures of validity are highly variable in research of trainee feedback surveys. They provide definitions and examples of different validity evidence, and propose a new rating system. Kogan and Shea,[15] in a review of medical course evaluations, conclude little research exists to support decisions made in designing evaluation forms. However, they do report that consensus is to use multi-item forms, and to keep the evaluator anonymous.

Evaluating particular aspects of a program (including individual supervisors) requires a minimum numbers of evaluations. Researchers have variously reported this minimum as 10 – 23 evaluations, depending on what aspect is being assessed and the method used.[33,55] This can allow sampling from large groups of students or trainees in the same program.[56]

A review by Kogan and Shea[15] points out that educational terms used on surveys (e.g., *independent learning*, *feedback*, and *integration*) may not be understood by students, and a

reasonable extension says many trainees may have similar difficulties. Some studies make reference to the increasing numbers of overseas-trained doctors working and training in health systems,[7,21] where English as a second language and local colloquialisms may add to difficulties interpreting survey questions. This is not addressed in the surveyed literature, but general survey design advice suggests using plain language, avoiding jargon and colloquialisms.[57]

Biases in feedback data may appear from a number of sources, including the design of the survey itself, response rates, and respondent withholding information. Even validated, reliable surveys have been reported to contain 'halo error': a strong tendency for raters to think of a person in general as good or inferior, and for this thought to colour separate qualities they are being asked to rate.[13,58] (This study relates specifically to feedback on supervisors, but as halo error is a cognitive bias, similar problems may occur with wider program attributes in surveys). This study called for further research to identify the type and magnitude of these biases to improve interpretation of results. Albanese[51] raised similar issues of 'generosity' bias, highlighting that surveys often fail to identify serious deficits or discriminate between performance levels (i.e., the highest rated and lowest rated supervisor could differ by only fractions of a point). Reasons for these problems included survey tool design issues (already stated), and inherent rater judgements. Albanese made ten recommendations to minimise these problems, which neatly capture the research consensus[10,51]:

24. Create surveys to serve an intended need, and know about good design

25. Standardise forms (i.e. minor changes can have large effects and reduce comparability)

26. Maximise response rates

27. Make the rating task as easy as possible

28. Maximise reliability and validity of the survey used

29. Maintain anonymity (minimise 'pain' to the rater if they choose a negative response)

30. Ensure the raters have enough exposure to what they are rating

31. Get multiple perspectives (more than one rating) and combine approaches

32. Establish clear expectations – which includes showing the rating form ahead of time

33. Interpret results being aware of biases.

Response rates affect data quality. Voluntary surveys in medical settings often achieve low response rates (50% or less),[22,59-61] which can introduce bias and reduce reliability.[62] Therefore, best practice should include setting a minimum response benchmark, in consultation with a data analyst, prior to administering the survey. For example, Canadian RPE survey results are only used if at least 50% of RCPSC residents have completed the survey, 60% for CFPC.[12]

Substantial research has considered how to increase response rates, though most studies are not specific to feedback from trainees.[59] The research is definitively summarised by Edwards et al[62] in a Cochrane Review that considered methods to increase responses for both postal and electronic questionnaires. Table 1 shows a summary of the results. In addition, the London Deanery, who developed the system now used as the UK National Survey of Trainee Doctors, has achieved >85% response rates using a suite of methods, including:

34. obtaining endorsement and active support of trainee leaders and college representatives
35. advertising widely at hospital level
36. making the survey an annual event and publicising the results
37. making the survey web-based and providing proof of completion for respondents' portfolios
38. requiring proof of completion at annual reviews
39. reporting to hospitals with information at hospital and unit level
40. ensuring confidentiality by limiting reports to units with at least three respondents
41. inviting open text comments and following them up
42. requiring action plans where problems were identified
43. inviting trainees to suggest questions
44. a competition for research ideas drawn from data
45. up to 12 reminders to non-responders.[63-65]

Other feedback methods

Other feedback methods are largely qualitative and include interviews,[66] focus groups,[9,15] and direct reporting,[30] either alone or combined with surveys.[7] Interviews and focus groups both provide opportunity for gathering more detailed information, but are limited by group size and confidentiality issues, discussed further in following sections. There is some research evidence that trainees give more favourable feedback when the in presence of an authority figure.[67] Therefore, for the best chance of uninhibited feedback, interviews and focus groups should be facilitated by a person who is not an authority figure in the training program.

Feedback can also be given by representatives of a trainee body directly to committees or boards. This can allow a large body of opinion to be distilled and reported efficiently. However, experience from the London Deanery has shown lack of awareness, limited communication between trainees, unwillingness to disclose sensitive issues, and confidentiality may undermine this process.[30] These comments are made in the context of an accreditation

process report, rather than a research study. No studies addressing these issues were found in the surveyed literature.

Administering the feedback tool

Confidentiality

Research shows preserving confidentiality for trainees giving feedback is critical for data integrity. Trainees exist in a power imbalance with their supervisors, and research suggests negative experiences are less likely to be reported if the trainee can be readily identified.[15,16,23,32,62,68,69] Meta-analysis of multiple trials has also found assuring confidentiality increases response rates in paper surveys.[62] Fear of reprisal or damaging a working relationship are repeated themes undermining feedback when confidentiality is not preserved, and there is some evidence (though not universal) that concern about consequences of negative feedback may increase as trainees advance in their program.[15,16]

The reader should note that confidentiality is not the same as anonymity. Anonymous feedback cannot be traced to the respondent. Confidential feedback may collect identifying data, but not disclose it to the end feedback recipient.

Among the important studies are Cunningham and Aquilina[68] who identified disadvantages of feedback systems relying on face-to-face interviewing with senior peers: infrequent feedback, reluctance of trainees to relay problems which may brand them as 'troublemakers', and results of feedback not being made known to the trainees. More recently, Afonso et al[16] report the first study to evaluate the difference between open (identity of the trainee known to the evaluated teacher) and closed (anonymous) evaluations provided by medical students. They demonstrate that open evaluations may artificially inflate ratings. They also gathered trainee perceptions on barriers in open evaluations, which included fear of retaliation or destroying relationships with the clinical teacher.

Most authors agree that anonymous evaluation systems are preferred to open feedback.[15] However, hybrid systems can exist where data handlers can identify respondents (for tracking, to identify comments of concern) but the data given out anonymously. Rosenberg et al[26] report such a web-based evaluation system where confidentiality was achieved by: assigning security levels; allowing only certain people (such as the program director) access to all information; and submitting composite resident evaluations to supervisors (rather than individually). They also allowed respondents to submit indirect comments only to the program director, and found both faculty and residents used this for negative and positive comments. Where electronic systems are used that clearly identify the respondent, even if the intention is to hold information confidentially, strong reassurance may be needed.[65]

Safety

Confidentiality in large surveys/questionnaires is achieved by the respondent not being identified on the survey and large numbers of respondents in a particular site or discipline. What happens when the target group is not large? Willett et al[32] captures the problem of a single trainee giving feedback or relating difficulties: *evaluation within a one-to-one learning context cannot simultaneously offer confidentiality to the student and individualised feedback to the preceptor*. Where there are small numbers of trainees in particular programs (or interviews and focus groups are used), maintaining confidentiality requires additional measures, such as results collected by a person not associated with the program[9,66,68] or a number of responses aggregated before being passed to the supervisor or included in reports.[15,26,39,70] For example, the UK National Surveys of Trainee Doctors intend to report on a

tri-annual basis for small specialties with just one trainee per unit [64]. This may defeat the need to give prompt feedback to the supervisor and both these methods cannot preserve confidentiality where a trainee experiences difficulties requiring intervention, such as bullying and harassment.[20,21,69] In these cases 'safe' environments for trainee feedback must be addressed,[21] where 'safe' means an environment in which the trainee feels free to raise the issues without fear of reprisal.

Willett et al[32] suggest protected avenues of communication are needed, even if infrequently used, and that providing both open and confidential evaluations may address the different needs of program providers (for evaluation), trainees (to have problems addressed), and trainers (to receive specific feedback for improvement). Best practice therefore suggests multiple approaches and avenues for feedback.

Incorporating feedback into program evaluation

Research indicates feedback should be taken with a pre-determined purpose; that is, used to evaluate the specific areas for which the process was designed. From this follows that thresholds for action should also be established prior to results being received. For example, Clarke[39] describes setting a threshold of two *unsatisfactory* ratings before taking action on particular items of their supervisor-focussed survey; and Keitz et al[27], analysing the large LPS survey results, limited their discussion to items with statistical significance $p < 0.001$.

Published literature shows trainee feedback is used to assess the effects of program changes,[7,9,24] which allows benchmarking to compare before and after. For example, Edgren[71] describes using the DREEM Inventory to assess the educational climate during a curriculum review. Several researchers also report trainee feedback is used to assist in staff promotion/retention and faculty development needs.[32,72]

Feedback from trainees forms a key part of accreditation programs in many jurisdictions. For example, the Canadian RPEs are completed three to four months before the accreditation visit. Results are distributed depending on the College: for RCPSC, only the resident(s) on the accreditation team receive the results; for CFPC, the results go to the entire accreditation team. Similarly, the AMC accreditation process typically includes trainee surveys of each college approximately three months before accreditation visits. Surveys are standard instruments aligned with accreditation standards and are reviewed and customised by each assessment team depending on the college to be surveyed. Feedback is sought from the college on wording and surveys are mailed to trainees to ensure privacy. Qualitative and quantitative data from surveys is collated and used to further inform the accreditation process, including the extent of stakeholder consultation. This process has been in place since 2000.

Trainee feedback can be used to identify and address problematic behaviours (such as from supervisor or peers). Addressing the behaviours may occur through feedback to the person of concern. Research reviews suggest this type of feedback can have effect on undesirable behaviours, but that feedback must be intense and immediate to have the best chance of success.[73,74]
In other cases, training providers seek feedback to identify improvement areas, especially over the long term.[3,12,20,25-27,30,33,45] Some tools used for this purpose have trainees fill them out twice: once for the 'as is' ratings, and once for their perceived 'ideal'.[45] Typically, these studies publish the survey results and state the feedback is useful for strategic planning and resource allocation. However, papers often lack details as to how the feedback data is used in decision making, what remedial strategies were chosen, what subsequent changes occurred and to what

level of success. The paucity of these details makes determining best practice in incorporating feedback difficult. In fact, Willett[32] found medical students held the opinion that feedback does not lead to program change, and other surveys suggest this opinion may be widespread.[75] Willett called for investigation of this perception. Among those who do describe action taken, Jasper[70] detailed feedback forming part of formal reports given to decision makers in the Royal Australian College of General Practitioners[6,40,76]; and Clarke[39] presented combined survey data to clinical supervisors to encourage reflection and discussion. Individual feedback was provided only on request, but no data was available to show improvements as a result.

Research suggests feedback repetition is essential after interventions or to track progress.[68,77] This is reflected by Clarke[39], who expresses the process of improvement as:

> *(i) the 'customer' defines quality; (ii) 'quality' is measured; (iii) the results are presented and reflected upon; (iv) ways to improve performance are considered and implemented; and (v) the 'quality' measures are repeated.*

These steps, including the final and critical re-measure or audit step, are essentially the same as processes described in risk management standards, if quality deficiencies are substituted for 'risk'.[78,79] Trainee feedback therefore supports both 'ends' of the overall improvement process, identifying underperforming areas, and assessing the success of any implemented changes.

The timing of surveys is an area of little research with conflicting findings[15]; however, those seeking trainee feedback should consider potential effects timing could have on results. For instance, before examinations, trainees may be reluctant to disclose problems; after examinations, trainees may inflate ratings. The frequency of taking feedback from trainees must also be considered, acknowledging the large number of surveys that medical trainees may be asked to complete in a given period. This 'survey fatigue' has been reported as adversely affecting response rates and data quality.[80,81] To address the issue, Porter et al[19] reviewed the literature and conducted experiments on survey fatigue. The little available research mostly addresses university students, but several guiding principles emerged:

46. Multiple surveys are likely to reduce response rates, with the worst effect being for back-to-back surveys

47. Surveys requiring large time commitments are more likely to induce survey fatigue

48. Surveys with interesting or relevant content are less likely to induce survey fatigue.

The paper does not comment what survey frequency might be optimal, except to imply multiple surveys in one academic year may be enough to affect results. Such problems force the survey administrator to consider what other surveys their target population are asked to complete, and when. Porter et al[19] captured this issue when they state, "... the growing pressures for assessment from outside groups such as legislatures and accrediting agencies, and internal pressures from individual offices trying to show performance results, and the pressure to administer multiple surveys can be intense."

Lessons from other professions

Kogan and Shea[15] draw lessons from research on higher education feedback tools and relate these to medical education. They discuss research findings favouring global evaluations (i.e., students are asked to rate their experiences generally) or multi-dimensional evaluations (i.e., students are asked specific questions in a number of different areas). They conclude that research supports both approaches.

The legal education field contains two papers of note. Abel[82] explores the pitfalls of asking students for only quantitative ratings when the reasons for a low rating may be student preference rather than effective teaching methods. This echoes earlier conclusions that qualitative and quantitative methods should be combined. Further, Ho and Shapiro[83] report on changes made to the Stanford Law School's survey process. The changes involved transitioning from paper to online format, and subtle wording changes, which had an unexpectedly large effect and made comparing old and new surveys difficult. The authors conclude that any reform to survey process must calibrate the old and new scales, and keep timing the same. These conclusions broadly align with principles already discussed.

The training and practice of doctors is often compared to that of airline pilots, on the basis that 'high-stakes' decisions are required of both professions. Therefore, attempts were made to locate information on trainee feedback in the aviation industry. However, preliminary searches did not identify any studies on feedback from trainees (there were some dealing with feedback *to* trainees). Searches were also frustrated by dual meanings of terms; for example, *feedback* also meaning tactile response of controls in a trainee pilot's hands.

Conclusions

Feedback from trainees is frequently used to identify underperforming aspects of training programs. Further research is required to understand the complexities that influence the process, quality of data and use of feedback obtained from trainees. Best practice is currently more consensus than evidence, but broad critical themes in the process of taking trainee feedback can be summarised:

General principles

49. Combine qualitative and quantitative measures

50. Provide trainees with an explicit standard against with which to compare their experience

(this may include the survey form itself if seen ahead of time)

51. Set minimum numbers/response rates for reliable data before gathering feedback

52. Make results of feedback known.

Surveys and questionnaires

53. Use validated surveys and questions where possible

54. If developing a new survey, involve a data analyst from the beginning

55. Write questions using principles of survey design (design affects responses)

56. Conduct research (pilot survey or literature review) to inform the questions

57. Use plain language

58. Test the survey questions before widespread use

59. Evaluate the survey for validity, reliability, and bias.

Interviews, focus groups, and direct peer reporting

60. Facilitate interviews and focus groups with an independent person

61. Compare direct peer reporting with other confidential approaches.

Confidentiality

62. In cases where small numbers of trainees work under one supervisor, aggregate feedback before giving it to the supervisor

63. Provide protected avenues for feedback that do not include immediate supervisors

64. Inform trainees how confidentiality will be achieved.

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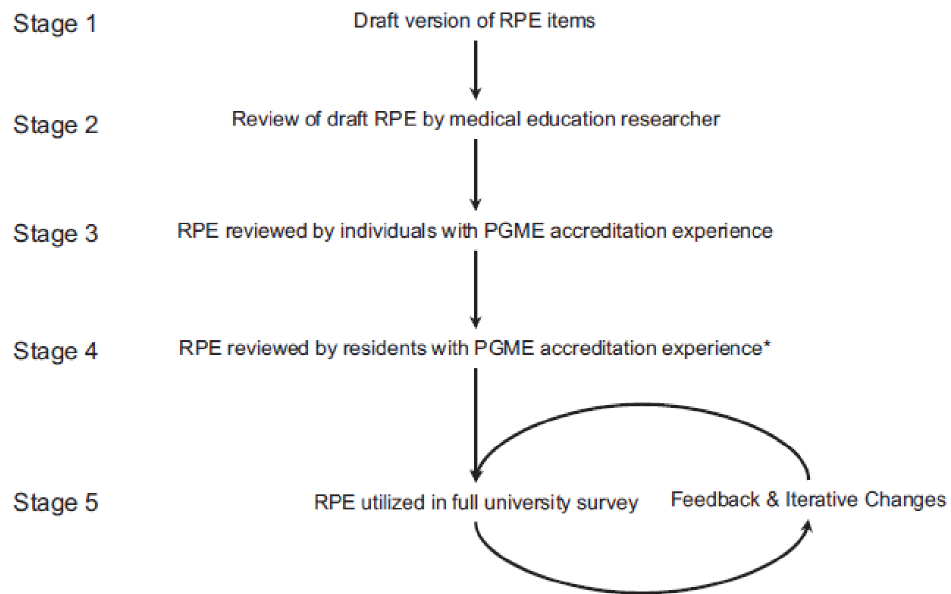
Table 1: Methods to change response rates to postal and electronic questionnaires [62].

Postal/Paper		Electronic	
Method	Odds Ratio	Method	Odds Ratio
Teaser of benefit on envelope	3.08	Including a picture in the email	3.05
More interesting topic	2.00	More interesting topic	1.85
Monetary incentives	1.87	Shorter questionnaires	1.73
Recorded delivery	1.76	Non-monetary incentives	1.72
Shorter questionnaires	1.64	Statement that others have responded	1.52
Unconditional incentives	1.61	Lottery with immediate result notification	1.37
Mentioning obligation to respond	1.61	Offering survey of results	1.36
Provide second copy at follow-up	1.46	Using a white background	1.31
Pre-notification of survey	1.45	Personalised questionnaires	1.24
Follow-up contact	1.35	Using a simple header	1.23
Assurance of confidentiality	1.33	Textual representation of response categories	1.19
University sponsorship	1.32	Giving a deadline	1.18
Hand-written addresses	1.25	Mentioning 'survey' in the subject line	0.81
Stamped return envelope (not franked)	1.24	Email signed by a male	0.55
Non-monetary incentives	1.15		
Personalised questionnaires	1.14		
First class mailing	1.11		
Questions of sensitive nature	0.94		

Figure 1: Process of survey development for the Canadian RPEs. From Maniate (2010)[12]



Attachment 3
Recommended Reading

The following papers offer a selection of research in the field:

Afonso N, Cardozo LJ, Mascarenhas OAJ, Aranha ANF, Shah C. Are anonymous evaluations a better assessment of faculty teaching performance? A comparative analysis of open and anonymous evaluation processes. Fam Med. 2005;37(1):43-47.

Beckman TJ, Cook DA, Mandrekar JN. What is the validity evidence for assessments of clinical teaching? J Gen Intern Med. 2005;20:1159-1164.

Beckman TJ, Ghosh AK, Cook DA, Erwin PJ, Mandrekar JN. How reliable are assessments of clinical teaching? J Gen Intern Med. 2004;19:971-977.

Bienstock JL, Katz NT, Cox SM, Hueppchen N, Erickson S, Puscheck EE, et al. To the point: medical education reviews - providing feedback. Am J Obstet Gynecol. 2007 Jun;196(6):508-513. This paper is a review on giving feedback to trainees, a subject complimentary to the workshop.

de Oliveira Filho GR, Dal Mago AJ, Garcia JHS, Goldschmidt R. An instrument designed for faculty supervision evaluation by anesthesia residents and its psychometric properties. Anesth Analg. 2008 Oct;107(4):1316-1322.

Maniate JM. Redesigning a resident program evaluation to strengthen the Canadian residency education accreditation system. Acad Med. 2010;85:1196-1202.

Porter SR, Whitcomb ME, Weitzer WH. Multiple surveys of students and survey fatigue. New Directions for Institutional Research. 2004;121:63-73.

Attachment 4
Presenter and Panel Member Biographies

Professor Barry Baker

Professor Barry Baker became a Director of Professional Affairs for ANZCA in July 2006. He graduated MBBS from the University of Queensland in 1963 and with a Doctor of Philosophy from Magdalen College, Oxford University, in 1971. He has held a number of academic positions in Australia and New Zealand as well being active in academic publications.

He has served on a number of boards and councils including as Dean of the Faculty of Anaesthetists of the Royal Australasian College of Surgeons (FRACS), which later became the Faculty of Intensive Care, ANZCA. He is the author of more than 200 publications in the academic and scientific literature on anaesthetic, physiological and historical topics, and the recipient of a number of distinguished awards including the Ben Barry medal.

Mr Michael Gorton AM

Michael Gorton currently is a Principal of Melbourne-based law firm Russell Kennedy. Michael provides advice in health, administrative and intellectual property law and in company, contract and commercial law.

He holds a Bachelor of Laws and Bachelor of Commerce from the University of Melbourne. Mr Gorton holds an Honorary Fellowships of the Royal Australasian College of Surgeons and the Australian and New Zealand College of Anaesthetists. He is the Chairperson of the Victorian Equal Opportunity and Human Rights Commission and a Board Member of Melbourne Health (Royal Melbourne Hospital). He is also past President of the Health Services Review Council, former Chair of the Victorian Biotechnology Ethics Advisory Committee and currently Deputy Chair of the Infertility Treatment Authority.

Dr Linda Klein

Dr Linda Klein is a Senior Lecturer in Evaluation at the Office of Medical Education at Sydney Medical School, a position she has held since 2008.

She graduated with honours and a Bachelor of Science from the University of Iowa in 1975, a Master of Science from the School of Psychology, University of New South Wales in 1989, and a PhD from the School of Public Health and Community Medicine, University of New South Wales in 2009.

Linda has held a number of research and teaching positions at the University of New South Wales. She also serves as a freelance consultant in research/evaluation methods and data analysis for the public and private sector, and for honours and postgraduate students. She is a registered Psychologist with the NSW Psychologists Registration Board, and a Member of the Australasian Evaluation Society.

Ms Mary Lawson

Mary Lawson is the ANZCA Director of Education and leads educational projects within the ANZCA Education Development Unit (EDU). She has worked in the field of medical education for almost 20 years, at both the undergraduate and postgraduate levels. Her research and work interests in this area have included emphasis on curriculum redevelopment and the development of clinicians as educators.

Prior to her role at ANZCA Mary held a senior position at Monash University where she developed a suite of postgraduate programs in health professional education and has coordinated national research projects in both the UK and Australia.

Dr Linda MacPherson

Dr Linda MacPherson is currently Medical Adviser to the Workforce Development and Leadership Branch at the NSW Department of Health.

She has had extensive experience in managerial and policy officer roles across several health departments and hospitals in NSW including the South Eastern Sydney Illawarra Area Health Service and Western Sydney Area Health Service. Linda has also been a psychiatry registrar at the Hornsby Hospital. She holds a MBBS and a Master of Health Administration, both gained from the University of New South Wales.

Apart from her involvement on AMC Committees, the most recent of which is on the Specialist Education Accreditation Committee, Linda sits on a number of others including the NSW Psychiatry Network Oversight Committee and the NSW Physician Training Council.

Dr Karen Owen

Dr Karen Owen is the Chief Executive of The Royal Australasian College of Medical Administrators. She has extensive experience in senior executive positions in charge of operation portfolios in the health services, community services in central and regional offices of Victorian government and higher education. Previous appointments have included Director of Services Epworth Health Care, Deputy University Secretary Deakin University (Melbourne Campuses), Deputy Directorships in Programs, Planning and Technology in TAFE, and corporate planning in education and community services in government departments.

In 2006, Dr Owen completed her doctorate on management in the construction of inter-organisational relationships. Her background in education underpins her use of a learning approach to managing ‘deep’ and sustainable change in organisations.

Dr Andrew Perry

Dr Andrew Perry completed his medical degree at the University of Adelaide in 2004 and, after completing his internship at The Queen Elizabeth Hospital has gone on to undertake training in emergency medicine at the Royal Adelaide and Lyell McEwin Hospital, where he is currently a registrar.

Formerly the chair of the AMA(SA) Doctors in Training Committee, and immediate past president of the AMA's federal Council of Doctors in Training, he is the chair-elect of ACEM’s Training Committee. He has long been a strong advocate for the training and other needs of medical students and junior doctors.

Dr Perry has received a number of honours including the AMSS Patrons Plate, AMA(SA) Student Medal, inaugural honorary life membership of AMSA (Australian Medical Students Association), and AMA(SA) Presidents award.

Associate Professor Jill Sewell AM

Associate Professor Jill Sewell is a consultant paediatrician and is Deputy Director of the Centre for Community Child Health at the Royal Children’s Hospital in Melbourne. She is responsible for clinical services in developmental and behavioural paediatrics and runs the Victorian Training Program in Community Child Health for advanced paediatric trainees.

She gained her MBBS from the University of Melbourne Medical School in 1971, and became a fellow of the Royal Australasian College of Physicians in 1984. She has since gained a number of honorary fellowships from colleges across Asia and the UK.

She is a past President of the Royal Australasian College of Physicians, and was previously President of the Paediatrics and Child Health Division of the College, and has served on a number of government and research councils. She was made a Member of the Order of

Australia in January 2005, for services to child health and is Chair of the Alfred Health Quality Committee.

Associate Professor Tim Shaw

Associate Professor Tim Shaw is currently Associate Professor in Workforce Education & Development Group (WEDG), Sydney Medical School, at the University of Sydney. He has managed the development of the Australian National Patient Safety Education Framework, surgical training online for the Royal Australasian College of Surgeons and Cancer Learning for the Commonwealth Government.

He was a co-author of the WHO Patient Safety Curriculum Framework for Medical Schools and the Patient Safety Education Project (PSEP) in the United States. He has also acted as an advisor and consultant to the Institute for Healthcare Improvement Open School Project, Partners Harvard Medical International and the Joint Commission in the United States. He focuses on the governance of professional health education, blending practice and education and flexible learning.

Professor Richard Smallwood AO

Professor Richard Smallwood is an Emeritus Professor of Medicine at the University of Melbourne. He has held a range of academic positions, has had over 30 years involvement in the teaching, and published over 250 clinical and scientific papers, primarily in the field of the liver and its diseases.

In November 1999 he was seconded to Canberra as Australia's Chief Medical Officer, a position he held until July 2003. Professor Smallwood has also had extensive involvement with numerous Australian and international health bodies including the National Health and Medical Research Council, Australian Health Ministers Advisory Council, National Influenza Pandemic Advisory Council, and National Blood Authority. In 2000, he was a Vice President of the World Health Assembly in Geneva.

His present appointments include President of the Australian Medical Council, Member of the Boards of the Victorian Health Promotion Foundation, Vision 2020, the National Stroke Foundation and the Murdoch Children's Research Institute. He was made an Officer of the Order of Australia in 1997 for services to medicine, and in 2006 he was made a Fellow of Trinity College, the University of Melbourne.

Attachment 5
Small-group Discussion Questions

Session 4 – Obtaining feedback to enable program improvement

- In practice, what information should medical colleges be seeking from trainees in order to assist with program evaluation and improvement?
  - Of this information, what is most important?
  - Which type of information is most difficult to gather?
- In your experience, what have been the more effective methods for gaining feedback from trainees/students on their education programs?
  - What were the key elements that made these methods effective?
  - What factors make feedback methods less effective, and how can these be addressed?
- In what circumstances is it more appropriate to seek feedback from groups of trainees (such as a trainees committee)? When is it more appropriate to seek feedback from individual trainees?
- What is the role of an effective trainee feedback process in program evaluation and improvement? What are the consequences of not collecting and addressing trainees' feedback effectively?
- Trainees are one of many groups/stakeholders interested in contributing to feedback on training programs. In your experience, is more or less attention given to trainees' feedback than from other stakeholders? Is it more or less difficult to obtain?

Session 6 – College review and complaints procedures

- Given the number of trainee/supervisor or trainee/college interactions that may lead to complaints or reviews of decisions, how does a college prepare supervisors/colleges and trainees, including informing them of their rights and responsibilities?
- In your experience, what are the characteristics of effective mechanisms for dealing with complaints and/or reviews in educational institutions such as the specialist colleges? What are the characteristics of ineffective mechanisms that you have experienced?
- What role does an effective process for dealing with trainee complaints/reviews of decisions play in assisting program evaluation? What are the consequences of not having an effective method for dealing with complaints and/or reviews of decisions?
- What can organisations such as the specialist colleges do to minimise complaints and/or reviews of decisions?