EFFECTING REFORMS TO AUSTRALIA'S SPECIALIST MEDICAL TRAINING AND ACCREDITATION SYSTEM POST COVID-19

REPORT 5: BARRIERS AND ENABLERS OF EQUITABLE ACCESS TO LEARNING AND TRAINING IN SPECIALIST MEDICAL PROGRAMS IN AUSTRALIA

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EXECUTIVE SUMMARY

As the accreditation authority for medicine, the Australian Medial Council (AMC) has been assessing specialist medical programs in Australia for 20 years.

In that time, specialist medical programs and the specialist medical colleges have evolved in response to changed community and government expectations of medical education and medical practice, international developments in medical education, and the developing accreditation standards used by the AMC to assess programs and colleges.

The COVID-19 pandemic has highlighted some of the challenges and barriers to delivery of specialist medical training but also presented opportunities for change and shared learning. Some of the impacts on medical training and accreditation of specialist medical programs include:

a. Disrupting training pathways, e.g. by interrupting exams, clinical placements and access to other learning
b. Creating challenges for workplace supervision, e.g. by expanding the need to cross skill in telehealth and critical care, reallocating roles and revising scopes of practice
c. Interrupting doctor-in-training rotations, creating uneven workforce capacity, particularly in rural areas
d. Requiring new streamlined reporting approaches, flexible accreditation assessment approaches, and flexible regulatory requirements.

In addition, COVID-19 has led to increased collaboration between specialist medical colleges, peak professional bodies, and accreditation and regulatory authorities to share learning and address common challenges.

The Health Workforce Division of the Australian Government Department of Health contracted the AMC and the Council of Presidents of Medical Colleges (CPMC) to undertake a joint project to contribute to identifying, reviewing and considering more broadly and for the long term, opportunities to improve and enhance the medical training and accreditation system in Australia.

This report presents a review of accreditation findings regarding equitable access to training and resources. It documents the AMC's analysis of specialist medical programs before and since the COVID-19 pandemic through the lens of the *Standards for Assessment and Accreditation of Specialist Medical Programs and Professional Development Programs*. It considers barriers and enablers of equitable access to learning opportunities and resources, and policies that support recognition and accreditation of learning.

The report presents (in section 3 and 4) the methods for and findings from a review of AMC accreditation findings on barriers and enablers of equitable access to learning opportunities and resources (pre-COVID-19), and how COVID-19 disruptions and the move to online learning has impacted on this area of concern, particularly for trainees and health services in regional and rural locations.

The AMC has used a mixed methods analysis to investigate the barriers and enablers of equitable access to learning opportunities and resources for specialist medical trainees. The AMC undertook a

thematic analysis of AMC accreditation findings and college submissions from 2016 to 2020, which covers the period the current accreditation standards have been in use. AMC COVID Change Forms and Department of Health COVID college questionnaires were the data source for analysis of COVID-19 disruptions. The thematic analysis was informed by AMC staff analysis of other documents used in accreditation processes. Qualitative findings of the thematic analysis were triangulated quantitatively using the results of the Medical Training Survey and, where relevant, AMC accreditation survey results.

The findings are written up as thematic narratives under the main headings of 'enablers' and 'barriers'. The themes identified were:

Enablers

- Investment and funding esp Specialist Training Program, IRTP
- Training material and policies online
- Policy robustness and flexibility
- Policy transparency and communication
- Collaboration with health sector organisations
- Consistent assessment and resource access
- Explicit commitment to rural health and flexible training

Barriers

- Training policy inconsistency & rigidity esp flexible training and recognition of prior learning
- Uneven resource access including specific requirements e.g. simulation
- Culture of specialist medical training and specialist medical programs
- Lack of stakeholder collaboration
- Facility inaccessibility
- Colleges not addressing issues (e.g. Indigenous and rural trainees needs)
- Colleges adapting to service and workforce needs and structures

The AMC found that, to continue to provide training during the COVID-19 pandemic, specialist medical colleges accelerated some changes to training processes and resources. In some cases colleges introduced innovations that are likely to be retained in some form longer term, for example putting assessments online. Additional flexibility in college training policies, for example leave, recognition of other learning, and extensions to time, was also identified. At the time of completing the report, colleges were responding to some new challenges as well as the ongoing challenges of delivering and managing training during the COVID-19 pandemic. New issues include addressing the cumulative effect of delays to assessments on trainee progression, and managing, and enabling trainees to track changes to policy and completion requirements that apply to them.

Section 5 explores AMC actions and functions relevant to this project that are levers for development in medical education and practice standards and medical programs. It also outlines how AMC strategic priorities and actions link to the themes of the National Medical Workforce Strategy.

The report concludes (section 6) with a summary of potential next steps for the AMC in responding to the findings of this report.

1. INTRODUCTION

The medical training system in Australia and internationally has been changed significantly by the COVID-19 pandemic. In early 2020, the Australian Medical Council (AMC), the Council of Presidents of Medical Colleges (CPMC) and the Health Workforce Division (HWD) of the Australian Government Department of Health all began considering the impacts of the COVID-19 pandemic on Australia's specialist medical training and accreditation system, and all began to capture information about changes being made. The AMC has also had a focus on flexibility in, and guidance on, the accreditation of specialist medical programs during the pandemic.

The project, *Effecting Reforms to Australia's Specialist Medical Training and Accreditation System Post COVID-19,* funded by the HWD, captures the results of AMC and CPMC investigations into the impact of the pandemic on training and stakeholders across the medical education and training system, as well as how they responded and innovated, to inform recommendations for improvements and futureproofing.

The overarching project objective is to investigate the impact of COVID-19 on Australia's medical training and accreditation system and innovations in response.

The project outcomes are to provide recommendations for improvements to the national system of medical education, training and accreditation and to inform the development and implementation of a National Medical Workforce Strategy.

This report is AMC report 5 for the project. The report presents a review of AMC accreditation findings on barriers and enablers of equitable access to learning opportunities and resources, and policies that support recognition and accreditation of learning, including analysis of all findings relevant to accreditation standards. The review consider how COVID-19 disruptions and the move to online learning has impacted on this ongoing area of concern, particularly for trainees and health services in regional and rural locations.

1.1 THE AUSTRALIAN MEDICAL COUNCIL –THE AMC

The AMC's purpose is to ensure that standards of education, training and assessment of the medical profession promote and protect the health of the Australian community.

It is the accreditation authority for medicine under the *Health Practitioner Regulation National Law Act 2009* (National Law). It assesses medical programs in New Zealand in collaboration with the Medical Council of New Zealand. The AMC develops and applies accreditation standards across all phases of the medical education continuum. It has accredited specialist medical programs since 2002, and this accreditation process covers the 16 colleges that provide specialist medical programs in recognised medical specialties (including one medical and dental college). As the accreditation authority for medicine, the AMC also sets standards for and conducts assessments of international medical graduates seeking to practise in Australia.

1.2 PROJECT DELIVERABLES

The project consists of AMC-led and CPMC-led project deliverables:

- Literature Review: COVID-19 impacts on postgraduate medical education (CPMC)
- Project Report 1: COVID-19 impacts, responses and opportunities (CPMC)
- Project Report 2: Determination of training places (CPMC)
- Project Report 3: Policy recommendations (CPMC)
- Project Report 4: Preliminary report following the 2021 AMC assessment workshop series, Conducting Assessment in a Changing Environment incorporating the results of a survey of stakeholders engaged in the workshops (AMC)
- Project Report 5: A review of AMC accreditation findings on barriers and enablers of equitable access to learning opportunities and resources and policies that support recognition and accreditation of learning (AMC)
- Interactive website development: to provide curated material on assessment, including good practice case studies and videos as well as a repository of material covered at relevant stakeholder workshops and events (AMC)
- A summary article (CPMC and AMC).

Figure 1: AMC project deliverables

The complementary strengths of the AMC and CPMC has meant that diverse aspects of the education and training system have been explored. This collaboration also recognises how impacts on medical training flow on to the accreditation standards and requirements that guide medical education and training.

The AMC and CPMC have a long history of collaboration, including in the design and development of the accreditation process for specialist medical programs and their providers[1]. CPMC nominates members to AMC accreditation committees for this accreditation process.

[1] The National Law uses the term education provider to cover organisations that may be accredited to provide education and training for a health profession. The term encompasses universities; tertiary education institutions, or other institutions or organisations that provide vocational training; or specialist medical colleges or other health profession colleges. The AMC uses this in accreditation standards and guidelines.

1.3 AMC LENS

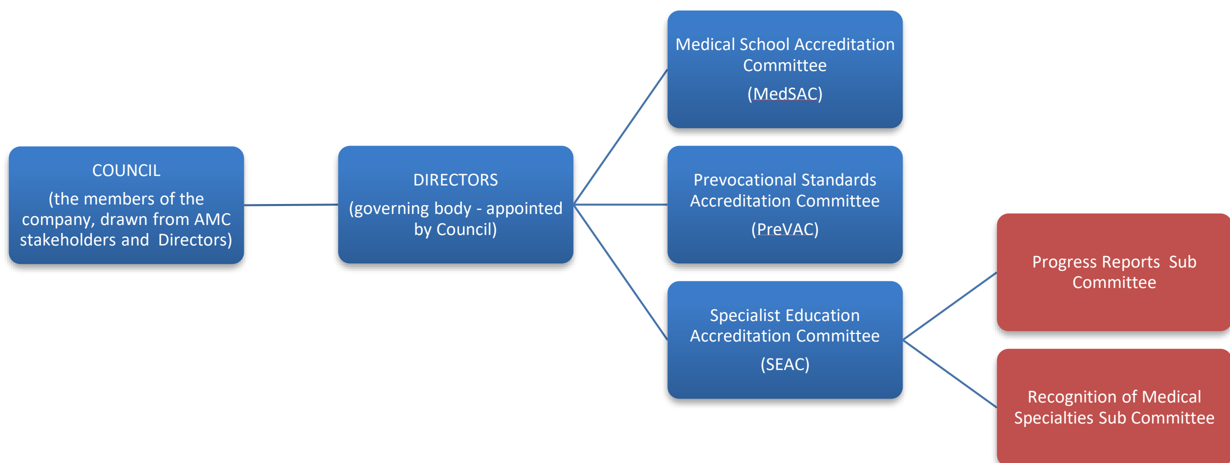
This project links to and builds on the AMC's work as the accreditation authority for medicine under the National Law. As both AMC reports in this project link to and build on the AMC's work as an accreditation authority, the AMC has provided a detail summary of its accreditation role, and the accreditation standards and accreditation procedures in Appendix 1 to both AMC reports.

The funding provided by the HWD, Australian Government Department of Health provides an opportunity to extend the AMC's work and analysis beyond its accreditation assessments and monitoring of accredited programs, and to share learnings from that work to inform broader policy, resources to support innovation and improvements in medical education and accreditation, and the future review and development of accreditation standards and tools.

The AMC's accreditation governance structure brings to all levels of accreditation assessment, decision-making and policy the input of stakeholders including jurisdictions, education providers, medical students, junior doctors and doctors in training, health services, community and consumer members, and the input of Indigenous people and Indigenous health sector organisations.

The AMC project draws on inputs from AMC accreditation assessment teams, the Progress Reports Sub Committee, which monitors accredited specialist medical programs and the Specialist Education Accreditation Committee (SEAC) which performs functions in connection with the standards of medical education and training, specifically specialist medical education, education and training for endorsement of registration, continuing professional development, and specialist international medical graduate assessment.

Figure 2: AMC accreditation governance structure



SEAC will consider the outcomes of these projects and make recommendations as relevant for future changes to AMC-developed accreditation standards and processes. These AMC processes are outlined in sections 5 and 6.

2. SPECIALIST MEDICAL EDUCATION AND TRAINING

This section provides background information on specialist medical training and accreditation. It supplements the detailed description in Appendix 1 of how the AMC assesses and accredits specialist medical programs and their providers, the specialist medical colleges, and the accreditation standards, outputs and outcomes.

2.1 ORGANISATION OF SPECIALIST MEDICAL EDUCATION AND TRAINING

There are 16 specialist colleges in Australia, which sets the standards for and deliver specialist education and training in the 23 recognised medical specialties and 64 fields of specialty practice. Thirteen of these also oversee specialist medical training in New Zealand. Two specialist medical colleges set the standards for education and training in the specialty of general practice in Australia.

There is no single entry point to vocational training. Specialist medical programs can start in the second or third postgraduate year, but entry to vocational training may also be delayed. To gain entry to a specialist medical program in their chosen specialty, doctors must succeed in a competitive selection process for a fixed number of college-accredited training positions or posts, or a place in an accredited facility or training program. The number of trainee positions offered is also dependent on the capacity of the health services or facilities to accept trainees.

The time required to complete specialist medical programs varies from about three to seven years, depending upon the specialty.

Programs may be structured as a combination of basic and advanced training, with barrier assessments between the stages, or in other phases or stages. Specialist trainees (usually called "registrars" in the workplace) work in a series of training positions in which they are supervised, mentored and assessed by appropriately qualified specialists. The combination of training positions, education courses and structured assessment of progress constitutes the individual's training program.

Supervision of junior registrars is usually undertaken by a specialist and/or a senior registrar in association with a specialist. Over time, the registrar takes increasing responsibility for decision making about patient care and management, and learns a wider range of practical skills.

Specialist vocational training for most clinical specialties, apart from general practice, has traditionally been undertaken in teaching hospitals but, over more than 10 years, there has been a sustained focus in Australia on expanding training in regional, rural and remote settings and private facilities to better reflect where healthcare is delivered, to meet medical workforce needs and to satisfy curriculum objectives.

Most specialist colleges require registrars to take written and practical exams testing their knowledge, clinical and practical skills. Increasingly, colleges include other formative and summative in-training assessments, such as workplace based assessment so that the full range of skills and behaviours, including communication, team work and other forms of professional behaviour, can be assessed.

2.2 AMC ACCREDITATION

Accreditation is a cyclical process of assessment of education and training programs against set standards. An accreditation assessment results in an accreditation decision by the AMC, which states the length of period of accreditation granted, whether the AMC has found the program and provider to meet or to substantially meet the standards, and sets conditions on the accreditation where standards are found not to be met or only substantially met.

The purpose of the AMC accreditation process to recognise specialist medical programs and education providers that produce medical specialists who can practise unsupervised in the relevant medical specialty, providing comprehensive, safe and high quality medical care that meets the needs of the Australian and New Zealand healthcare systems, and who are prepared to assess and maintain their competence and performance through continuing professional development, the maintenance of skills and the development of new skills.

The *Standards for Assessment and Accreditation of Specialist Medical Programs and Professional Development Programs* focus significantly on the external context, training environment and relationships to support education and training. Since the last revision, in 2015, they are grouped into 10 major areas, as follows:

Standard 1	The context of education and training
Standard 2	Purpose and outcomes
Standard 3	Specialist medical training and education framework (the curriculum)
Standard 4	Teaching and learning
Standard 5	Assessment of learning
Standard 6	Monitoring and evaluation
Standard 7	Trainees
Standard 8	Educational resources including supervision and accreditation of training posts and programs
Standard 9	Continuing professional development (CPD)
Standard 10	Assessment of specialist international medical graduates

The AMC's 2015 review of the standards led to significant changes reflecting changing expectations of specialist medical education and training, and of the colleges, including:

New standards

- engagement with the Indigenous health sector; Indigenous health and cultural competence as curriculum content, and recruitment and support of Indigenous trainees
- processes to address bullying, harassment and discrimination in training
- managing conflicts of interest in training programs
- reporting when patient safety concerns are raised in the assessment of trainees.

Strengthened standards

- college's education purpose linked to meeting community need
- management of training-related complaints

- trainee welfare and wellbeing
- accreditation of training posts and programs
- CPD programs
- specialist international medical graduate assessment.

2.3 ACCREDITATION CONDITIONS AND MONITORING OF ACCREDITED PROGRAMS

Between accreditation assessments, the AMC monitors developments in accredited programs and providers to ensure accreditation standards continue to be met. It seeks regular reports from accredited providers, structured against the accreditation standards. Providers also report to the AMC on progress towards meeting accreditation standards.

2.3.1 AMC MONITORING OF COVID-19 RELATED CHANGES

In response to COVID-19, in March 2020 the AMC circulated advice to colleges on AMC actions to apply flexible accreditation requirements while colleges and health services were dealing with the impacts of COVID-19 on their operations, staff and trainees.

The statement linked to a proforma in which colleges could provide notification of changes to their specialist medical programs in response to COVID-19.

The AMC indicated that its focus was on being assured that trainees are able to progress through training, although training and education structures may be different; that college communication about training requirements supports trainees and supervisors to meet program objectives; and that specialist medical trainees graduating from accredited programs will be prepared to practise as specialists. The AMC identified specific accreditation standards and changes that it intended to monitor and asked colleges to keep internal records of other changes, for reporting to the AMC in 2021. The forms (called the COVID-19 change forms in this document) and instructions are available on the AMC website here.

The AMC's analysis of colleges' responses in 2020 is provided in section 4 of this report.

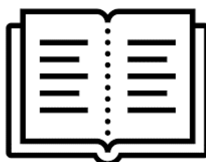
3. METHODOLOGY

This section elaborates on the AMC data sources and the data analysis approach used in this report.

The AMC has used a mixed methods analysis to investigate the barriers and enablers of equitable access to learning opportunities and resources for specialist medical trainees. The primary method employed is thematic analysis of AMC accreditation findings written up in AMC reports – accreditation reports and reports on assessments of College comprehensive reports for extension of accreditation - and of college submissions, as well as AMC COVID-19 change forms and Department of Health COVID college questionnaires. This was informed by the analysis of other documents, including public statements of key stakeholders and jurisdictional submissions to AMC college accreditations. Qualitative findings of the thematic analysis are triangulated quantitatively using the results of the Medical Training Survey (MTS) and, where relevant, AMC accreditation survey results. The findings are written up as thematic narratives under the main headings of 'enablers' and 'barriers'. Under each thematic narrative, links to relevant accreditation standards are made, and detail is provided on developments to the theme during the COVID-19 pandemic.

3.1 DATA SOURCES

AMC accreditation findings & college submissions



At key decision points in the accreditation cycle, colleges provide accreditation submissions to the AMC. These submissions provide evidence of the colleges' performance against the standard, and provide insight into their perceived accomplishments and challenges. AMC uses college submissions, along with an assessment visit (if required) in which trainees and other stakeholders are interviewed, and other external data – including AMC surveys of trainees – to make accreditation determinations against the standards, resulting in a report describing the accreditation findings and outcomes. The accreditation findings and college submissions finalised since the most recent change to specialist medical program accreditation standards in 2015 are a key input for the thematic analysis, since they provide insight into the pre-COVID-19 state of equity and access.

COVID-19 Change forms & Department of Health submissions

In order to balance oversight and reduce accreditation burden during the COVID-19 pandemic, the AMC asked specialist colleges to submit COVID-19 change forms responding to AMC questions about changes in response to COVID-19. The Department of Health similarly requested colleges respond to a different series of questions. These returned forms and submissions, which nearly every specialist college completed, are the other key input for the thematic analysis, since they provide insight into access during the COVID-19 pandemic.

Other internal and external data

Other internal and external data were collected, where there was potential relevance to access to learning and training. These included AMC accreditation survey results, which are surveys distributed to trainees during accreditation assessments; jurisdictional submissions to AMC accreditation assessments of specific programs and colleges; and statements from CPMC on college collaboration and discussion points during COVID-19.

Results of the Medical Training Survey (MTS)

The Medical Training Survey is a national and annual survey of all doctors in training in Australia. It was first conducted in September and October 2019, and again during the same period in 2020. Extensive survey data on trainee well-being, facilities, educational opportunities, and more is available.

3.2 DATA ANALYSIS METHODS

Thematic analysis

Thematic analysis of the key documents – AMC accreditation findings and college submissions, and COVID-19 change forms and Department of Health submissions – was undertaken using a four-step process.

Documents were collected and uploaded to NVivo.

AMC accreditation staff identified key search terms and standards of focus relevant to equity and access issues.

Key search terms were tested and refined in NVivo, then used as Text Searches on all AMC accreditation findings and college submissions for the period 2016 to 2019.

Search terms used (NB: “this phrase” means the phrase must appear in the order its written; “one two”~10 means the two words must appear within 10 words of each other): remote, regional, rural, equality, equity, equitable, access, “online learning”, “online seminar”~10, “online tutorial”~10, webinar, “exam preparation”, “online assessment”, “online OSCE”~10, “online exam”~10, “online vivas”~10, “online MCQ”~10, “unplanned leave”, “part time”, flexibility, flexible, consistent, consistency, “online interview”~10.

Search terms were not applied to COVID-19 change forms and Department of Health submissions, which were usually one to four pages in length.

The search term hits of all AMC accreditation findings and college submissions were read and descriptively coded. COVID-19 change forms and Department of Health submissions were completely read and descriptively coded.

Tentative themes were identified and discussed with AMC staff group. Descriptively coded passages of documents were thematically coded against the tentative themes.

The thematic structure was finalised after further discussion with AMC staff. Documents were coded against the final enabler and barrier themes. The themes and findings are set out in section 4.

Document analysis

Other internal and external documents were analysed for content which spoke to the final enabler and barrier thematic structure. Any relevant content was highlighted for integration into written findings.

Quantitative analysis

Using the MTS 'Create your own report' tool (https://www.medicaltrainingsurvey.gov.au/Results/Create-your-own-report), survey results from all specialist trainees, specialist trainees training in rural and regional areas, and specialist GP trainees were generated. The results were examined to identify any correspondence with the final enabler and barrier thematic structure. The results of the AMC accreditation surveys were also considered.

3.3 USE OF THE TERM 'RURAL'

In this report, the word 'rural' is used to refer to regional, rural, and remote areas. The Australian Government Department of Health uses the remoteness classification system Rural, Remote and Metropolitan Areas Classification (RRMA) to define rural and remote areas, but the AMC and many specialist colleges define 'regional', 'rural', and/or 'remote' more loosely in accreditation related documents, if at all. Generally speaking, when this report refers to rural, it is reflecting on references to 'regional', 'rural', and/or 'remote' in the sources used in analysis. This report uses the term 'rural trainees' when referring to those specialist trainees training and generally living in rural areas as indicated in the sources used in the analysis.

The MTS uses three geographic classifications for trainees: metropolitan, regional, and rural. The regional and rural classification combined contain the results of all trainees outside capital cities; however, only using the rural classification ('more than 15km from the closest town with a population of at least 15,000') would exclude many trainees in RRMA 3 and 4 areas, which are both considered rural by the Department of Health. Therefore, any reference to MTS findings specific to rural trainees include the MTS regional and rural classification, even though this includes RRMA 2 areas, which are defined as urban by the Department of Health.

4. ANALYSIS AND FINDINGS

This section outlines key findings of the thematic analysis of equity of access to medical education relevant to specialist colleges. It focuses on answering four key research questions:

1. *What was the pre-COVID-19 state of access and equity to specialist medical education and training as revealed by AMC accreditation processes?*
2. *What new challenges and opportunities to access and equity to medical education have resulted during the COVID-19 pandemic?*
3. *Are there issues of access and equity that have particular impact on rurally based trainees and rural health services?*
4. *Has the impact of COVID-19 and the move to place educational resources online had an effect on the issues of access and equity for rurally based trainees and rural health services?*

4.1 SUMMARY OF AMC FINDINGS

The commentary below explores the barriers to and enablers of equitable access to learning and training pre-COVID-19 and then during the COVID-19 pandemic, drawing on AMC accreditation findings and supporting material. The pre-COVID-19 period covers 2016 to 2019, since 2016 marked the introduction of the revised *Standards for Assessment and Accreditation of Specialist Medical Programs and Professional Development Programs.* In the period 2016 to 2019, the AMC completed at least one assessment of each specialist medical college program.

The key themes identified in relation to enablers of and barriers to equitable access to learning resources and training in the period 2016 to 2019 (pre-COVID) are as follows:

Enablers

- Investment and funding esp STP, IRTP
- Training material and policies online
- Policy transparency and communication
- Collaboration with health sector organisations
- Consistent assessment and resource access
- Policy robustness and flexibility
- Explicit commitment to rural health and flexible training

Barriers

- Training policy inconsistency and rigidity esp flexible training and RPL
- Uneven resource access including specific requirements e.g. simulation
- Culture of specialist medical training and specialist medical programs
- Lack of stakeholder collaboration
- Facility inaccessibility
- Colleges not addressing issues (e.g Indigenous and rural trainees needs)
- Colleges adapting to service and workforce needs and structures

Through thematic coding discussions with AMC staff, triangulated by the results of key search terms, accreditation standards relevant to enablers and barriers of equitable access were identified. A high-level overview of the key issues for specialist medical training programs, linked to accreditation standards, is available as Figure 3 below.

Figure 3: Key issues for specialist medical training programs related to equity and access before and during COVID-19, linked to accreditation standards

4.1.1 AMC FINDINGS CONCERNING COLLEGES’ TRAINING-RELATED RESPONSES TO COVID-19

The AMC’s approach to monitoring changes to specialist medical programs during COVID-19 is outlined in section 2.

As the accreditation authority, the AMC’s approach focused on maintenance of standards to ensure that program graduates are prepared for specialist practice, and supporting colleges to adapt their training and education pathways, policies and approaches. The effect of changes colleges have made in response to COVID-19 on enablers and barriers, as revealed by this study, are summarised in Figure 4 below.

The AMC’s overall observations of colleges’ responses include:

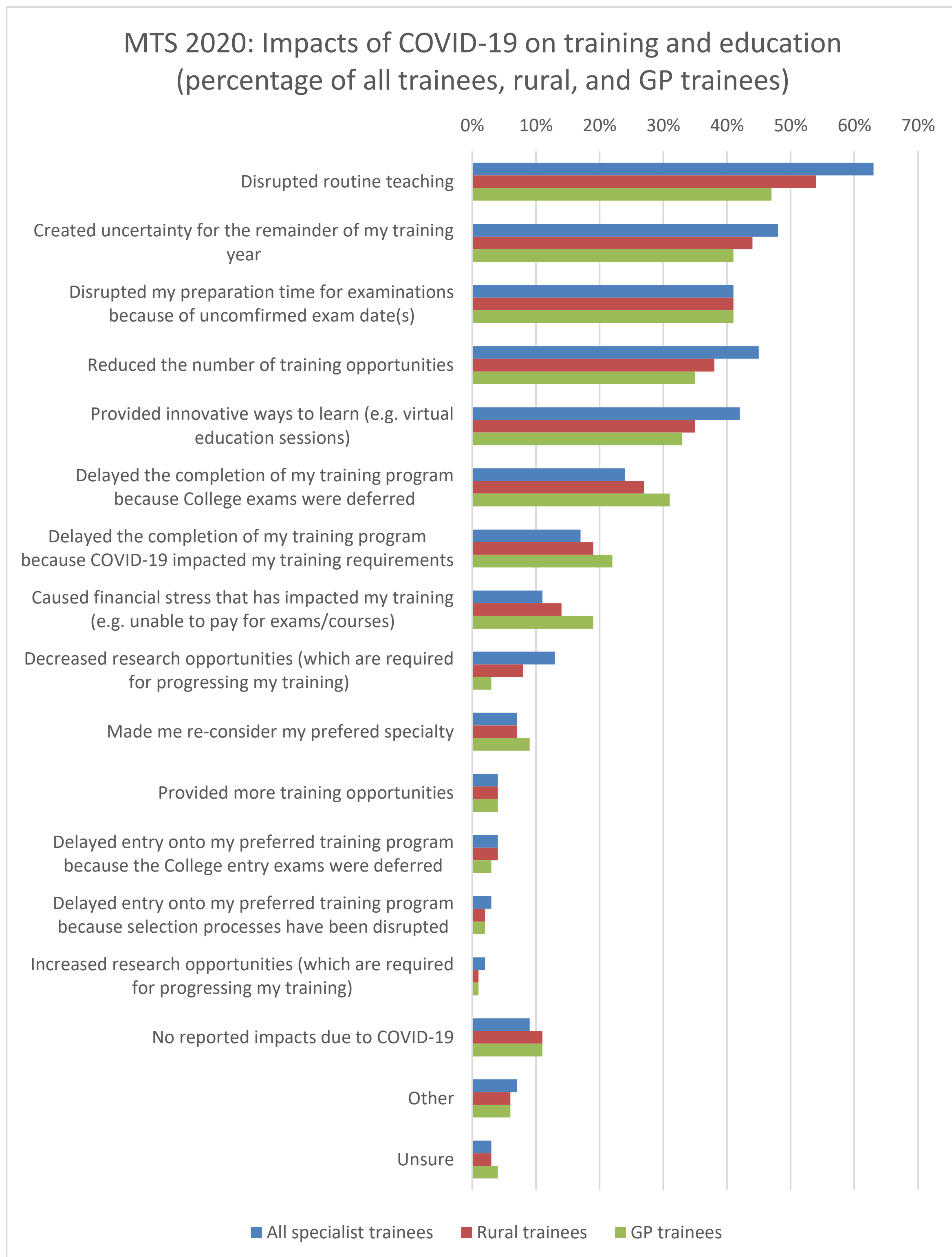
- colleges responded rapidly to expected change but sustaining and continuing to adapt to change is challenging
- colleges recognised trainees’ completion delays
- colleges communicated with trainees, supervisors and health services about changes but trainees frequently wanted additional information about implications of changes
- moving assessment online and changing assessment requirements, location and timing has been complex, and caused trainees significant anxiety
- college accreditations of training posts and programs were generally postponed and some moved to videoconference
- colleges have shared learning and there has been a shift towards greater collaboration.

Figure 4: Direction of changes to identified barriers to, and enablers of, access to training and learning resources in response to COVID-19

Enablers	Barriers
Investment esp STP, IRTP Training material and policies online Policy transparency and communication Collaboration with health sector organisations Consistent assessment and resource access Policy robustness and flexibility Explicit commitment to rural health and flexible training	Uneven resource access but specific resources and training requirements e.g. simulation Training policy inconsistency and rigidity esp flexible training and RPL Culture of specialist medical training and specialist medical programs Lack of stakeholder collaboration Facility inaccessibility Colleges not addressing issues (e.g Indigenous and rural trainees needs) Colleges adapting to service and workforce needs and structures

In 2020, the Medical Training Survey included a question concerning respondents’ perception of the impact of COVID-19 on medical training. The AMC extracted the results of the survey for all specialist medical trainees, all trainees who report as completing rural or regional training, and general practice trainees, as show in Figure 5 below. These results point to significant disruption in regular training and teaching, but also show opportunities to innovate in learning and teaching.

Figure 5: Medical Training Survey 2020 results. Question on the impacts of COVID-19 on training



The AMC is continuing to monitor changes in 2021. The AMC expects to be able to draw further conclusions about the nature and extent of changes from its 2021 monitoring.

4.2 ENABLERS OF EQUITABLE ACCESS TO LEARNING AND TRAINING

Figure 6: Accreditation standards related to identified enablers of access to training and learning resources

Accreditation standards (see Appendix 2)	1.6	2	3	4	5	7	8	10
Themes: enablers								
Investment and funding	X			X			X	
Training policies and materials online				X	X	X		X
Policy robustness and flexibility			X			X	X	X
Policy transparency and communication			X			X	X	X
Collaboration with health sector organisations	X							
Consistent assessment and resource access				X	X			X
Explicit commitment to rural health and flexible training		X						

4.2.1 INVESTMENT AND FUNDING

Relevant standards:

1.6 working with the Department of Health and jurisdictions to identify opportunities and gain access to supported programs, most critically Integrated Rural Training Pipeline and Specialist Training Program

4 investing staff time and resources into online learning platforms

8 investments in creating regional, rural, and remote training posts).

While many colleges spoke of creating more rural posts and Indigenous health training opportunities as a key priority, a key facilitator most colleges pointed to for creating these posts was Department of Health funding. Colleges consistently credit the Integrated Rural Training Pipeline (IRTP) and Specialist Training Program (STP) with having provided the policy framework and resources to create dozens of discrete regional, rural, and remote training opportunities, as well as develop standardised teaching and learning materials to ensure geographically spread trainees have equitable access to resources.

> *"The provision of both STP and IRTP funding has been pivotal in developing rurally-based training positions that encourage trainees to move to the country. This helps deliver [trainees] to rural areas and introduces potential fellows to a potential rural practice."*
>
> *(College submission)*

Jurisdictions indicate in their submissions to the AMC that collaborating with colleges on targeting and securing STP funding creates a helpful opportunity for broader collaborative work on rural posts and educational needs.

The analysis showed at least one college established a regional training network in the last few years and indicated that IRTP funding would be crucial to its future success.

In reports, the AMC encourages colleges to strengthen or continue to engage with the Department of Health on IRTP and STP funding opportunities. For at least one college, the AMC indicated that sole reliance on these funding streams could be a sustainability risk.

In order to standardise and increase access to learning and teaching opportunities – and occasionally, make assessments, college training pathways and progress information more accessible – colleges have invested heavily in creating scaffolded online learning resources, that is with learning support appropriate to the stage of training. Some of this investment has come from IRTP and STP funding, but colleges also charge fees for access to online eLearning modules and assessments, as they would with face-to-face workshops.

Effect of COVID-19 on Investment and funding

Colleges did not speak to any COVID-19 related developments around IRTP or STP funding in their submissions to AMC or the Department of Health.

Seven colleges, particularly those that had not previously invested strongly in online learning and teaching, reported that they were making facilities available, allowing remote supervision, and expediting the development of eLearning tools and materials in response to COVID-19. For instance, one college said that it was:

> *"fast-tracking development of its online learning program to support trainees' learning during the COVID-19 crisis. An 8-week lecture series, supported by readings, key questions and a discussion forum will commence [soon]."*
>
> *(College submission)*

4.2.2 PUTTING KEY MATERIALS ONLINE

Relevant standards:

4 online teaching and learning materials

5 online assessment

7 online trainee selection

10 online specialist international medical graduate assessment.

Colleges have invested in developing online platforms and creating novel learning material, and there has been an increasing trend of placing existing learning and teaching, assessment, selection, policy processes and resources online. One college acknowledges that a key motivation in placing these resources online is that:

> *"Although the majority of [college] trainees are located in… the main metropolitan centres, the College is conscious of the need to make educational material available to all."*
>
> *(College submission)*

- Putting learning and teaching materials online

  Colleges increasingly use Learning Management Systems (LMS) to place educational materials online, including seminars, examination preparation resources, eLearning modules recorded conference proceedings, and the content of relevant journals. LMS are particularly described for

basic training and for material on uncommon presentations. Even colleges that have not developed an LMS increasingly place ad-hoc lecture recordings online.

Three colleges indicated that they have adopted forms of remote supervision, particularly for trainees in rural postings. Colleges acknowledge that access to study groups, specialised equipment, and supervisors with specialised knowledge remains a challenge at regional, rural, and remote sites.

- Putting assessment online

  Pre-COVID-19, there was limited adoption of online assessment, particularly for key exams required to progress through the training program. Some colleges require the satisfactory completion of assessments at the end of eLearning modules, usually in the form of multiple choice questionnaires (MCQs). More common, though still not widely adopted by colleges, is the use of Training Management Systems (TMS)[2] to track assessment progression in real time, particularly workplace based assessments, multi-source feedback, and logbooks.

  There were also limited online Specialist International Medical Graduate assessment interviews.

- Putting training policies online

  Through their website or other dedicated IT tools, most - if not all - colleges now place all pertinent training policies on flexible training, rural training, curriculum and progression requirements, and others online. This has enhanced transparency for all trainees, including those in rural and regional locations and those seeking greater flexibility in training pathways, for example for part-time training. Some colleges have made significant progress towards making individual training pathway progression more readily understandable, and requests for flexible work easier to make, through TMS tools.

- Putting trainee selection online

  Pre-COVID-19, only a handful of colleges indicated that they used videoconferencing and other online tools to facilitate trainee selection.

<u>Effect of COVID-19 on putting key materials online</u>

COVID-19 has accelerated colleges' adoption of online platforms for educational and selection functions.

As previously mentioned, some colleges reported they were accelerating timelines for creating new eLearning material. Many colleges indicated they had substantially increased the amount of available online seminars and learning sessions, with some sessions previously available only face-to-face in a certain region now being centralised or recorded and put online for all trainees. The AMC notes that in the 2020 Medical Training Survey, 42% of the specialist trainees who responded reported that they had been provided innovative ways to learn, such as virtual education sessions. The percentage of trainees with access to online modules rose eight percentage points between 2019 and 2020 to 73%; for rural trainees, this rise was five percentage points, to 77%.

[2] Some colleges use similar e-portfolios to track assessments, while others, particularly those with well developed education and IT resources, have created combined IT systems that host learning, teaching and assessment materials.

For trainees at one college, the change was “very warmly welcomed” since trainees can now access the lectures “nationally”

> *Weekly …. lectures and tutorials can no longer be held face-to-face and have been adapted for online delivery. This change has been very warmly welcomed by the trainees who can now access [these] sessions nationally rather than only those within their region. Both lectures and clinical sessions have been delivered in this way. Sessions have been interactive and included Q&A, polling, clinical images etc and made use of breakout rooms for small group sessions. The majority of sessions have been recorded and uploaded as a resource on our Learning Management System.”*
>
> *(College submission)*

Most of those colleges have moved all regular learning sessions online, with major face-to-face workshops and training weeks being developed into virtual models. Some colleges have used more remote supervision and telemedicine to facilitate trainee interactions with patients.

The analysis found that for six colleges, major exams have been placed online in response to COVID-19. This includes multiple choice exams, essay-style exams, clinical vivas, and objective structured clinical exams. There are multiple challenges in placing exams online, and this has been true for colleges, including at least one high-profile exam failure. The AMC hosted a workshop for colleges in November 2020, to share key challenges and learnings in placing exams online. The challenges identified included exam security, robustness of IT infrastructure, availability and training of examiners, and communication with trainees including about contingency plans.

AMC assessment workshops, run from March to May 2021 with key stakeholder involvement confirmed these issues. These are addressed in report 4.

For waypoint exams that were challenging to place online, for instance because the examination included patient interaction or examination, some colleges have rethought the format to enable the exams to be placed online. As an example one college has divided the examination into separate elements, with the patient interaction component of the examination held separately and virtually.

Six colleges reported that they have ensured selection continuity by changing their selection interview format, and their SIMG comparability assessment interviews to videoconferencing from face-to-face.

4.2.3 POLICY ROBUSTNESS AND FLEXIBILITY

Relevant standards:

3 flexible training policies
7 trainee well-being and selection policies
8 post and program accreditation policies
10 specialist international medical graduate assessment policies.

Colleges vary in how much flexibility is built into their flexible training policies, and in the clarity and comprehensiveness of policies that link to equitable access to learning and training such as policies on accreditation and recognition of posts including rural posts, trainee wellbeing, trainee selection and SIMG interviews.

While college culture, the attention to successful and consistent implementation, and workforce imperatives (see 'Barriers' section 4.3) all affect equitable access to learning and training, strong policies are often the foundation for better access and equity.

- Flexible training policy robustness and flexibility

  Accreditation standards require colleges to have policies on flexible training, and many colleges allow, and under some circumstances encourage, highly accommodative arrangements, including allowances for extensive periods of part-time training and open-ended leave from training.

  Despite this, in AMC surveys of specialist medical trainees over the period 2016 to 2019 a majority of trainees who responded did not consider their college's policy was appropriate for their circumstances (see section 4.3 of this report).

  Several colleges have generous Recognition of Prior Learning policies, some of which give additional recognition for rural experience. However, AMC surveys of specialist medical trainees over the period 2016 to 2019 suggest that the policies may not always be applied generously (see section 4.3 of this report).

- Rural experience policy robustness and flexibility

  Several colleges have policies requiring trainees to spend a minimum amount of time in a regional, rural, or remote post, and others ensure that all trainees who ask to have the opportunity to rotate through a rural post. In the accreditation of rural posts, some colleges allow minimum requirements to be relaxed or different requirements to apply, acknowledging the unique opportunities to see a range of presentations and patient populations, including Indigenous patients:

  > *"Expansion of [rural training] opportunities will likely also give trainees greater exposure to the health needs of Aboriginal and Torres Strait Islander people in Australia and Māori people in New Zealand."*
  >
  > *(College submission)*

- Trainee well-being policy robustness and flexibility

  Several colleges have implemented or updated well-being, bullying, and harassment policies to ensure clear reporting and resolution mechanisms. Well-designed policies and programs can be particularly helpful to vulnerable trainee populations, and for trainees in more isolated regional, rural, or remote posts. For one college, stakeholders considered that the new well-being program, "has made a difference, especially in regional areas" (AMC report).

- Trainee selection policy robustness and flexibility

  Many colleges' selection policies have been revised to make requirements more transparent and straightforward for applicants to understand. Some colleges give selection weight to a rural training interest or being an Aboriginal and/or Torres Strait Islander person, or a Māori person.

<u>Effect of COVID-19 on policy robustness and flexibility</u>

The focus of most, if not all, colleges in response to COVID-19 was to ensure that trainees could progress through their training pathway in a timely manner, and that regular training and assessment activities could take place, if in an altered format.

The analysis showed that four colleges granted blanket extensions of training time for their trainees of six to twelve months, and several more indicated they are considering extensions.

Another significant change due to COVID-19 was the shifting of progression requirements. Most colleges implemented some combination of: extending deadlines for assessments and learning tasks, changing the order of waypoint assessments to allow trainees to progress, allowing certain requirements to be waived, and varying the nature of mandatory projects. For some colleges, these changes were extensive.

On flexible training, some colleges indicated that they introduced some form of COVID-19 leave to ensure trainees would not be disadvantaged if they were required to quarantine or became ill. Several colleges indicating they had developed or were developing policies on recognising trainee time spent on secondment. Some colleges increased the flexibility of their Recognition of Prior Learning pathways.

Colleges did not indicate that their general policies around rural training would change, though some colleges, in close consultation with jurisdictions, extended trainees' time in particular rotations/posts at the beginning of the pandemic and others expected trainees might be seconded to a COVID-response related setting.

Many colleges encouraged their trainees to contact college staff and stakeholders if they had concerns, but there was no indication of substantial changes to general college policies on trainee wellbeing. The 2020 Medical Training Survey responses however indicated that trainees felt better supported. Compared to the 2019 survey results, the percentage of specialist trainees who agreed or strongly agreed that their workplace supports staff wellbeing increased by six percentage points to 82%. For rural trainees, this was a more modest but still a statistically significant rise of three percentage points to 84%.

4.2.4 POLICY TRANSPARENCY AND COMMUNICATIONS

Relevant standards:

3 flexible work and training policies

7 trainee well-being and selection policies

8 post accreditation policies

10 specialist international medical graduate interview policies.

Policies, including on progression requirements and flexible work, must be available and plainly stated to give them the best chance of being used by trainees to facilitate equitable access to training. Colleges acknowledge the importance of maintaining open communication with trainees.

> *"The College is aware of the importance of maintaining open communication with trainees and several developments have occurred since 2011. A specific trainee edition of the regular College 'e-news' has been developed. This includes contact details for each regional representative and a communication of College developments relevant to training; this can be found here on the College website."*
>
> *(College submission)*

Many colleges have made policies readily available by posting them on their website and in their IT portal (see 'Putting key materials online' in 4.2.2).

Some colleges have communicated training policy changes through regular newsletters or e-news updates that provide regular insight, in easily-understandable terms, into the potential consequences of a new or updated policy for trainees. A few colleges also have regular forums for trainees to answer questions and address concerns, particularly on college policy.

The analysis found that six colleges have made major changes to their progression/selection requirements and flexible work, and trainee well-being policies in the period 2016-2019. AMC reports indicated that all of these changes were well-documented. Particularly for curriculum-related changes, the mapping of expected outcomes to learning and assessment blueprints often substantially improved.

Effect of COVID-19 on policy transparency

Most colleges published a high volume of communications on policy changes relating to COVID-19, reflecting that the situation changed quickly. Most colleges that already had infrastructure in place to communicate regularly with trainees increased the frequency of those communications. Some colleges also facilitated ad-hoc or regularly scheduled open forums or webinars to communicate changes and address trainee concerns. Colleges also regularly encouraged trainees to contact their supervisor or college staff if they had other questions or concerns.

4.2.5 COLLABORATION WITH HEALTH SECTOR ORGANISATIONS

Relevant standard:

1.6 interaction with government bodies, jurisdictions, health organisations, communities, and other colleges.

Collaboration with the Australian Government Department of Health and other national, and state/territory, government agencies, as well as health organisations and communities is key to sustaining rural and flexible trainee experience. Because health jurisdictions each have unique structures and policies to manage medical workforce and engagement with colleges, approaches vary across state and territories.

> *The college has established a rural training network, which is overseen by the rural qualifications and education committee, to address maldistribution of … services in Australia… The network is actively engaged with AWRAC, the federal ministry, NSW Health, Fred Hollows, Royal Flying Doctors, NAACHOs, and many other relevant stakeholders in trying to establish the necessary conditions for a viable long-term regional training network."*
>
> *(College submission)*

As outlined in the 'Investment and funding' theme above, colleges acknowledge the strategies and policies of the Australian Government Department of Health, and particularly, IRTP and STP funding, as vital to expanding training opportunities. Colleges that have successfully built relatively large numbers of rural training posts also work with a range of other stakeholders to identify and gain support for seeking out those opportunities.

Colleges put particular emphasis on working closely with jurisdictions. These jurisdictions may help identify and facilitate the creation of rural training posts. The varying workforce and policy requirements between jurisdictions mean that, in order to create cross-jurisdictional training networks – which is often key to trainees gaining a range of exposures and experiences – colleges

must work closely with the jurisdictions. In submissions to the AMC, jurisdictions largely commended colleges for close work on health workforce planning and communications around changes to training requirements.

Some colleges mention having worked with workforce planning bodies on prioritisation and opportunity mapping exercises.

Working with health services, there are a few examples of colleges creating flexible posts, for instance in the form of two part-time posts which fill a full-time training position need at a hospital.

To a lesser extent, colleges work with each other to create rural training opportunities. In Queensland, Royal Australian College of General Practitioners, Australian College of Rural and Remote Medicine, and Queensland Health established the Queensland Rural Generalist Pathways, which has supported the creation of rural training posts and pipelines to rural practice. These types of collaborations are limited, but reportedly effective at reducing administrative burden on rural posts and colleges.

Effect of COVID-19 on collaboration with health sector organisations

The Council of Presidents of Medical Colleges (CPMC) maintained frequent contact both between the colleges and between the colleges, and national and state/territory government departments.

While not reported directly in colleges' COVID change forms, through this project the AMC has been informed of collaboration across colleges. From early February 2020 CPMC established a weekly round of meetings with colleges to manage training and exams, coordinate and communicate among the specialties, enable upskilling in critical care and sharing of resources. Working closely with jurisdictions in the rollout of public health measures, this ensured safety in the delivery of specialist services through activation of surge plans in all jurisdictions, critical care capacity building, establishing respiratory clinics, enhancing access to telemedicine, and support for increased access to mental health services. The rapid and positive response was underpinned by effective communications so that any disruptions to training activities were managed. Throughout 2020, all College Presidents met weekly for the first six months, then fortnightly, inviting jurisdictional representatives and experts to engage in discussion concerning ongoing management of COVID-19, vaccines and training arrangements into the future, mindful of the disruption to surgical specialties and the virtual context of examinations.

Only one college did not submit a response to the Department of Health COVID impact questionnaire.

A handful of colleges have reported increased collaboration with their stakeholders, mainly on workforce issues and projecting the impact of the pandemic, as a result of COVID-19.

Some colleges have indicated that they have increased the level of communication with their regional training network staff. Otherwise, colleges have written relatively little on increased collaboration in their COVID-related submissions to the AMC and the Department of Health.

4.2.6 CONSISTENT ASSESSMENT AND ACCESS TO LEARNING RESOURCES

Relevant standards:

4 *learning and teaching material access*

5 *consistent assessment across sites*

10 *specialist international medical graduate exam preparation and learning material access.*

Along with putting learning and teaching, and assessment materials online (see 'Putting key materials online' in 4.2.2), colleges have put effort into making local teaching approaches, and quality and assessment expectations consistent across different sites and posts, as well as ensuring that vocational/specialist training trainees and SIMGs have access to the same learning and teaching resources.

To ensure equitable opportunities across regions, colleges have considered how to standardise learning and teaching, with different results. The common approach is to put teaching materials and learning resources online. One college encourages Fellows to travel to regional and rural locations to deliver teaching sessions. Another college supplemented education courses delivered in each jurisdiction with standardised learning resources. In addition, many colleges have begun to introduce online examiner training and/or rubrics, or local assessment, such as workplace-based assessments.

Several colleges have also made exam preparation and basic learning materials available to specialist international medical graduates as refresher and practice content, ensuring specialist international medical graduates get the same standardised content and opportunities as basic trainees.

Effect of COVID-19 on standardisation

As discussed in 'Putting key materials online', COVID-19 has accelerated the move to common online learning and teaching resources. Some colleges have been explicit that training and assessment flexibility available to trainees will also be available to specialist international medical graduates.

4.2.7 EXPLICIT COMMITMENT TO RURAL HEALTH AND FLEXIBLE TRAINING

Relevant standard:

2 *purpose includes an explicit commitment to rural health and/or flexible training.*

There is opportunity for colleges to state an explicit commitment to rural health and/or flexible training in the college purpose or when discussing policies around those topics, which several colleges do.

Jurisdictions' submission to AMC accreditation assessments from 2016 to 2019 speak positively of colleges that have actively contributed to identifying and securing additional training posts including rural posts, including instances of proposing flipped training models.

These are also the colleges that draw commendations from the AMC for their success in creating rural health posts and creating opportunities for flexible training. For instance, one College included in its purpose:

"Assist [trainees] in establishing and maintaining an appropriate work/life balance, and effectively meet the challenges of their professional life."

(College submission)

Through their actioning of that purpose, the college received the commendation:

"The college is very supportive of flexible training in a range of circumstances."

(AMC report)

Effect of COVID-19 on explicit commitment to rural health and flexible training

There was no mention of changes to colleges' level of commitment to rural health and flexible training in college COVID-related submissions. There were no specific questions to colleges about this topic.

4.3 BARRIERS TO EQUITABLE ACCESS TO LEARNING AND TRAINING

Figure 7: Accreditation standards related to identified barriers to access to training and learning resources

Accreditation standards (Appendix 2)	1.6	2	3	4	5	7	8	10
Themes: barriers								
Training policy inconsistency and rigidity			X			X	X	X
Uneven resource distribution				X		X		
Culture of specialist medical training and specialist medical programs			X				X	
Lack of stakeholder collaboration	X							
Facility inaccessibility				X			X	
Colleges not addressing issues	X					X	X	
Colleges adapting to service and workforce needs and structures	X						X	

4.3.1 TRAINING POLICY INCONSISTENCY AND RIGIDITY

Relevant standards:

3 *flexible training policies*

7 *trainee wellbeing and selection policies*

8 *training post accreditation policies*

10 *specialist international medical graduate assessment policies.*

Colleges have developed policies around flexible training, trainee wellbeing, rural posts, and specialist international medical graduate assessment policies that have made their training programs easier to access, but some colleges continue to have rigid policies in some areas, and policies may not be consistently applied administratively or at training sites.

The design of some policies related to these areas raises minor concerns, while a handful have major issues. For example, at some colleges, part-time training was not an option at certain key points in the training program, such as the first year. At one college, this left

> *"trainees requiring parental leave in their first year of training without the option of a flexible return to work."*
>
> *(AMC report)*

In AMC surveys of specialist medical trainees over the period 2016 to 2019, for all but three of the colleges assessed, less than 50% of trainees agreed or strongly agreed their college policy on flexible training was appropriate to their circumstances. In addition, for all but three of the AMC surveys of college trainees, a significantly lower percentage of trainees indicated that they had been able to arrange part-time employment if required.

Colleges also varied as to what FTE level was the minimum requirement for part-time training, with some colleges offering 0.2 FTE part-time training and others setting 0.5 FTE as the minimum. The AMC acknowledges that some variations relate to educational requirements, e.g. requirements that trainees consolidate learning and skills at specific stages of training.

A consistent criticism that trainees across many colleges offered in AMC accreditation surveys was that Recognition of Prior Learning policies were limited in scope and inflexible. AMC surveys of specialist medical trainees over the period 2016 to 2019 suggest that the policies may not always be applied generously. In all but three of the colleges assessed, 40% or less of the trainees responding to the survey agreed or strongly agreed with the statement "the college recognises prior learning for relevant experience" and agreed their college policy on flexible training was appropriate to their circumstances. The highest level of agreement or strong agreement with the statement was 55% of trainees, in one college.

In submissions to the AMC, jurisdictions were occasionally critical of trainee support and flexible work opportunities, though it was noted that workforce needs often complicate flexibility in training pathways.

For a handful of colleges, AMC accreditation findings flagged policies on consistent and common teaching and examination preparation resources across posts as a major issue for equity of access. AMC reports also indicated that flexibility for trainees with family obligations vis-à-vis rural post requirements was sometimes lacking; and in some other instances, rural training requirements inadvertently led to increased training burden and cost on trainees.

Inconsistent administrative application of policies was flagged at some colleges. At one college, the AMC was told by college stakeholders that some of the sub-specialty boards did not facilitate requests for part-time training, despite part-time training being available under college policy. At another, due to a lack of college oversight of regional training committees' implementation of selection policy, the AMC report pointed to inconsistent implementation.

<u>Effect of COVID-19 on policy inconsistency and rigidity</u>

The extent of colleges' changes to training requirements and policy varies, with some making fewer changes to flexibility of their assessment, training progression, and selection requirements than others.

For assessment, a handful of colleges continue to commit to holding exams, particularly waypoint exams, in person. There did not appear to be accommodations for trainees in locations which could be subject to restrictions and lockdowns. One college said – without explaining how trainees who might miss the exam might be accommodated:

> *"In cases where candidates are enrolled to sit a certain examination at a specific regional location but are unable to sit due to COVID-19 restrictions, the examination may still proceed at unaffected regional centres under the contingency arrangements."*
>
> *(College submission)*

One college has had extensive issues with changing the format or flexibility of a waypoint exam, exacerbating an existing bottleneck of trainees who need to take the exam. AMC is monitoring the College's communication and actions as part of its COVID-19 monitoring.

Some colleges also indicated that they would cancel mandatory waypoint courses or workshops, without explaining how trainee progression requirements might change or timelines might shift.

While many colleges shifted their selection interviews to videoconference format in response to COVID-19, a handful of colleges and programs continue to pursue face-to-face interviews, with one sub-specialty indicating that it:

> *"Plans on holding selection interviews at a central location (one in Australia and one in New Zealand) with applicants attending in person, and interviewers attending virtually."*
>
> *(College submission)*

4.3.2 UNEVEN DISTRIBUTION

Relevant standards:

4 distribution of learning and teaching resources

7 targeted support for Aboriginal, Torres Strait Islander, and Māori trainees and rural trainees.

As national education and training providers, colleges use a mix of national, state/territory, and local education and training methods and resources. Much day-to-day education and training is delivered by local clinicians and through the trainee's employing health services or facility; while some educational activities require resource commitments and delivering on a larger scale. In a similar vein, it is inevitable that

> *"practice in a capital city tertiary referral hospital is not the same as practice in a major regional hospital, or practice in an outer-urban or provincial hospital."*
>
> *(College submission)*

But this need not result in unequal distribution of educational and training resources.

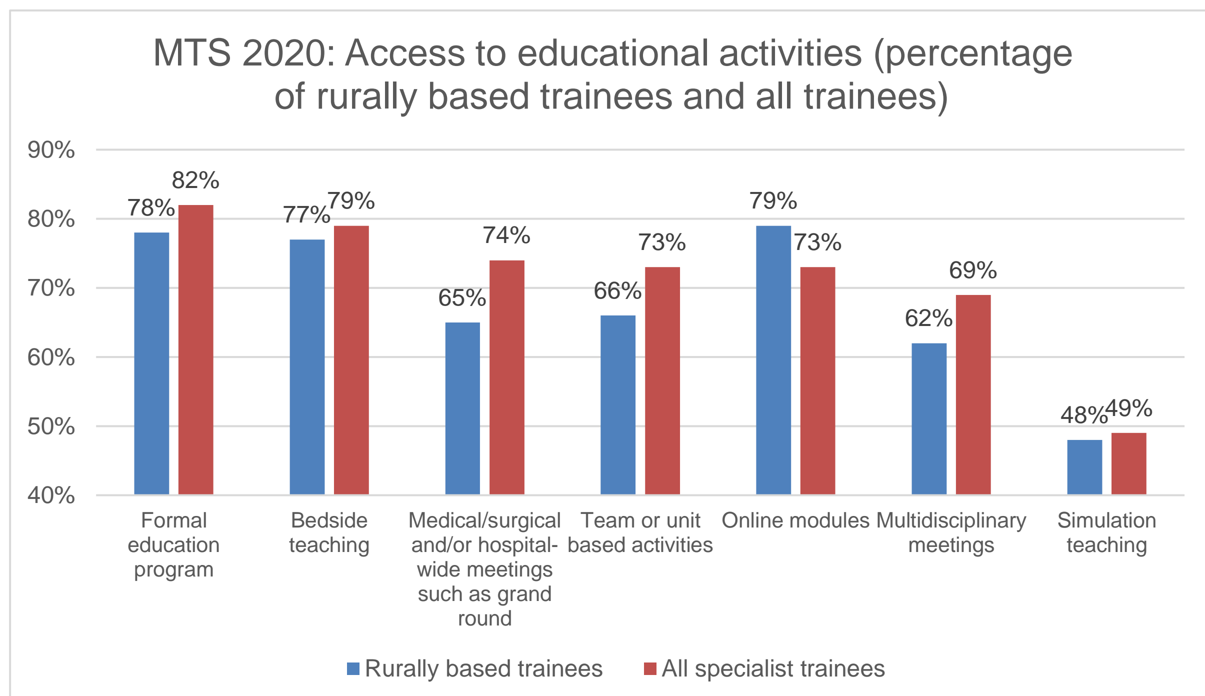
For several colleges, it is the case that regional and rural training posts, and training posts in different regional areas – particularly smaller areas – do not always have equitable access to core educational resources. Regular education sessions are often delivered in regional centres or metropolitan centres, and online streaming of the sessions is irregular. Several colleges also undertake college-wide workshops and training on a regular basis, usually at least annually. This puts a burden on rural and regional trainees as well as trainees in states and territories with small training programs, since they

must travel extensively and navigate leave requests to secure access to those education and training venues. Trainees also regularly report that access to high-quality examination preparation materials, study groups, and other resources and activities to prepare for assessment are variable, with particular shortcomings for rural trainees. This leads trainees to believe that their educational program and opportunities will be lower in quality and quantity in rural posts (see 'college stakeholder and trainee culture').

AMC findings are supported by the MTS findings, as shown below.

The results from the checkbox question "which of the following educational activities are available to you in your current setting?" in the Medical Training Survey 2020 show a smaller percentage of rural trainees report having access to all types of educational activities except online modules, with the difference being significant for some activities.

Figure 8: Medical Training Survey 2020 results. Question on access to educational activities



For some colleges, mandatory courses were offered on a state/territory level rather than centrally. Differences in the standard of teaching, or even whether the course is regularly offered at all, was sometimes observed between the states and territories by the AMC. One college attributed this to differences in funding availability between jurisdictions.

As noted in the enablers of equitable access to resources, some of the investment in education resources is through training fees. These fees can be substantial, with one college reporting that five mandatory 20-40 hour online modules were $1800 each.

The level of targeted support available to Aboriginal, Torres Strait Islander, and Māori trainees and trainees in rural postings was not always addressed by colleges in their submissions. This may, in part, be explained because some colleges have a low number or total absence of Aboriginal, Torres Strait Islander, and Māori trainees or trainees in rural postings. Given that the accreditation standards

oblige the colleges to "consider the needs of groups of trainees that may require additional support to complete training," and actively work to increase recruitment and selection of Aboriginal, Torres Strait Islander, and Māori trainees and rural origin trainees, support policies should be in place, even for colleges with few or none of these trainees.

Effect of COVID-19 on resource distribution

A handful of colleges spoke to activating specific support for trainees in rural posts to check on trainee wellbeing and safety. As indicated in 'Putting key materials online', some colleges moved courses previously available only in a certain state/territory and in-person to available nationally and online.

4.3.3 CULTURE OF SPECIALIST MEDICAL TRAINIGN AND SPECIALIST MEDICAL PROGRAMS

Relevant standards:

3 flexible training arrangements

8 accreditation of posts and programs.

The culture of specialist medical training and specialist medical programs along with inconsistent and variable college communication may undermine college efforts to amend policies and training requirements.

The role of resistance to change among specialist medical training stakeholders in slowing the uptake of flexible training arrangements was clearly stated in some AMC reports. In one college, a lack of female applicants was ascribed to "gender differences in 'medical interests'" rather than a relatively inflexible training pathway. At other colleges, AMC teams reported that trainees worried they would receive low end-of-term assessment marks as a consequence of asking for access to flexible work arrangements. A general culture where part-time training "is not well-regarded" (AMC report) caused hesitation to ask for access among some trainees at several colleges.

Perceptions about rural training among trainees were repeatedly pointed to as a barrier to more trainees taking up these posts including geographic isolation, and less access to specialised equipment and specialist supervisors. However, as one college pointed out, there are many benefits.

> *"Trainees have provided extensive feedback on their experiences during training rotations … and through evaluation surveys. There was a widely-held historical view among trainees that rotations to remoteness area 2 or above would be of a lower standard than metropolitan rotations. However, trainee feedback indicates that several regional rotations are of a high standard. The positive feedback relates to greater access to various modalities (particularly magnetic resonance imaging) and procedural work, less on-call work allowing for more study time and differing case mix and presentation of cases. Much of the negative feedback relates to personal and financial aspects, including time away from family and professional isolation. While most regional rotations include accommodation and travel support, trainees raised concerns about rotations between metropolitan sites within a training network."*
>
> *(College submission)*

Many trainees still feel that the training and educational experience offered at rural sites is not the same quality and offers less opportunity for networking and career advancement than metropolitan training does.

Colleges need support of Fellows, jurisdictions, and health services when making policy change in areas affected by training culture. As AMC reports make clear, the track record of some colleges in effectively communicating and collaborating with these stakeholders is mixed (see also 'Collaboration with health sector organisations' and 'Lack of collaboration').

The analysis showed that for five colleges, AMC reports indicated that major changes in trainee progression requirements or policies related to flexible training were not well-communicated, often owing to inadequate consultation and change management work. At one college:

> *"There were generally low levels of awareness of the [curriculum change project] and consultations that had taken place… beyond the trainees directly involved in the relevant committees."*
>
> *(AMC report)*

Effect of COVID-19 on College stakeholder and trainee culture

College submissions and AMC reports do not explicitly address the impact of COVID-19 on the culture of specialist medical training.

Colleges have made large changes to their training and progression policies in general, including some policies that impact on flexible work and training (see 'Policy robustness and flexibility'). Many colleges have committed to clear and regular communication on these changes (see 'Policy transparency'), and trainees appear to be more satisfied with college communications. Despite the unprecedented nature of the changes, the Medical Training Survey results show that the percentage of trainees who agree or strongly agree that their college clearly communicates with them about changes to their training program and how they will affect them improved by five percentage points between 2019 and 2020, to 71%. This improvement in communication could be carried through cultural change.

4.3.4 LACK OF STAKEHOLDER COLLABORATION

Relevant standard:

1.6 interaction with government bodies, jurisdictions, health organisations, communities, and other colleges.

Since specialist medical colleges run national education programs and set requirements for work-based training in conjunction with health services and training sites, to deliver training they must engage multiple stakeholders, at all levels of government, and in health services and community organisations. Collaboration with jurisdictions creates particular challenges, especially when trying to create training networks that cross jurisdictional lines, since colleges have to contend with a variety of requirements and approaches. In jurisdictional submissions to the AMC, two colleges were broadly criticised for the low level of collaboration and information sharing on workforce issues including changes to programs.

AMC reports occasionally point to potential room for strengthening engagement.

One area where a lack of collaboration sometimes caused issues was trainee access to training opportunities and flexible work. AMC reports made recommendations for improvement and

sometimes applied accreditation conditions for colleges to engage more closely with training providers and key individuals to advocate on behalf of their trainees.

Another area where AMC reports identified room for improvement was collaboration with other medical colleges and jurisdictions to bolster networks of rural posts. Some colleges had great success working with partners to plan workforce issues and pool accreditation and learning resources, but these positive examples have yet to be taken up by many other colleges.

Effect of COVID-19 on lack of collaboration

It is not clear from college submissions or AMC reports that COVID-19 has exacerbated the absence of collaboration between colleges and/or their stakeholders; for greater collaboration under COVID-19, see 'Increased collaboration'.

4.3.5 FACILITY INACCESSIBILITY

Relevant standards:

4 learning resource accessibility

8 provision of services and support at rural and extended posts.

The absence of some amenities in rural and regional posts, and the geographic distribution of resources like labs, simulators, and specific patient populations, can create equity issues if not addressed through well-designed and -implemented policies.

IT services in rural and regional locations, though improving, are still cited as a barrier for trainees in AMC reports. Poor internet might prevent trainees from participating fully in interactive online learning and teaching, and from engagement in governance arrangements. The Medical Training Survey indicates that rural trainees rate the quality of the internet access at their training site slightly higher than specialist trainees overall, with 78% of rural trainees reporting their internet access as excellent or good. However, rural trainees rely more on internet to access educational resources – for instance, in the 2020 MTS 84% of rural trainees agreed or strongly agreed that online modules were useful to their development as a doctor, as opposed to 80% for specialist trainees overall. This was a decrease from an eight percentage point gap in 2019 (81% agreed/strongly agreed for rural trainees and 73% for specialist trainees overall). The decrease may be explained by the increasing importance of online modules in delivering educational content for all specialist colleges and trainees during COVID-19. One college mitigated these issues by providing IT kits with access to networked data to trainees.

Distribution of resources to support learning and training across health services, while not always in the hands of colleges, is also frequently cited as an issue. At one college, which mandates skills training in a simulated environment, the geographic distribution of simulators meant some trainees were potentially disadvantaged by distance. Colleges and the AMC point to rotating through posts and carefully planning resource locations as potentially mitigating these issues.

Effect of COVID-19 on facility inaccessibility

Under COVID-19, the ability to move between facilities was restricted at times, potentially further impacting on inaccessibility issues for trainees in rural postings. However, it is not clear from college submissions or AMC reports that COVID-19 has had a broader effect on inaccessibility.

4.3.6 COLLEGES NOT ADDRESSING ISSUES

Relevant standards:

1.6 gaps in reporting on collaboration

7 gaps in reporting on specific support

8 gaps in reporting on availability of rural training.

In accreditation submissions, colleges sometimes do not address specifically issues of rural and regional training, recruitment and support for Aboriginal, Torres Strait Islander, and Māori trainees, and flexible training where the standards give them room to. This includes reporting on collaboration related to medical workforce or development of additional training posts under standard 1.6, specific support available for Aboriginal, Torres Strait Islander, and Māori trainees and trainees in rural and regional posts under standard 7, or the availability of rural and regional posts under standard 8. Gaps in reporting point to colleges potentially not prioritising these issues.

More rarely, a lack of attention on these issues is clear. For one college, specific support for trainees at rural posts was only briefly mentioned. In the AMC report, the college was required to "Develop and implement pathways and resources to address trainee concerns safely" (AMC report).

<u>Effect of COVID-19 on colleges not addressing issues</u>

The COVID-19 forms the AMC and Department of Health asked colleges to complete contained specific questions, and most colleges answered them with a good level of detail, though there was a lack of specifics in some. For example, the AMC form asked for details on internal approval process for changes, which some colleges did not answer or appeared to confuse with communications about those processes. Many colleges did not speak extensively about the issues of collaboration, support, and availability of rural posts in their forms, likely because they were not asked to in the forms.

A few colleges did not return an AMC and/or Department of Health COVID form.

4.3.7 COLLEGES ADAPTING TO SERVICE AND WORKFORCE NEEDS AND STRUCTURES

Relevant standards:

1.6 coordination with jurisdictions and workforce stakeholders

8 infrastructure availability at rural training sites.

Competing service demands of jurisdictions and other workforce stakeholders can lead to barriers to access flexible training and rural posts. Differing jurisdictional arrangements increase the difficulty of creating robust, cross-jurisdictional training programs which facilitate rural and regional accredited training and posts.

Some jurisdictions' submissions to AMC accreditation assessments note that colleges need to adapt to jurisdictional changes to service networks, and some trainees report that college-networked training can be geographically hard to navigate or can be out of step with health service changes.

Occasionally, work rosters means that infrastructure required to carry out training tasks is not available in certain locations. In addition, the needs of health services can preclude part-time training, although this can be mitigated through creative collaboration with the providers.

Effect of COVID-19 on workforce needs

In their initial AMC COVID form submissions, several colleges indicated that they expected trainees to be seconded to emergency COVID-19 response roles, and that regular training opportunities, particularly in private practice, would be disrupted. In later submissions, many colleges commented that the number and length of secondments and disruption to regular training was "far less than anticipated".

> *"The training impacts of reduced clinical and surgical activity and the suspension of rotations due to COVID19 were far less than anticipated. Ophthalmology trainees were not redeployed to work in other medical areas, elective surgery and acute clinics were cancelled for a short time only and trainees continued to engage in didactic and clinic based training activities in workplaces."*
>
> *College submission*

It is not clear from college submissions and AMC reports if COVID-19 has had an impact on workforce-related issues of access to flexible training and rural posts.

4.4 RELEVANT ACCREDITATION CONDITIONS, RECOMMENDATIONS AND COMMENDATIONS

As outlined in Section 2 and Appendix 1, in the decision on an accreditation assessment, the AMC may apply conditions, and identify recommendations for improvement and commendations. The AMC applies a condition when a program and/or the college do not meet a standard. The condition identifies the action required to meet the standard and the timeframe available to address the condition. The AMC provides recommendations in areas where it identifies opportunities for quality improvement, and commendations highlight areas of strength.

Conditions, recommendations, and commendations alone do not capture the extent of barriers and enablers of equitable access, but as they are central to the AMC's accreditation findings, they provide a useful summary of the issues highlighted by the AMC in its accreditation findings and reports.

The themes from commendations, recommendations and conditions, and are summarised in Figures 9, 10 and 11 below; and a bar graph showing the number of conditions, recommendations, and commendations relevant to equitable access applied in each year is at Figure 12. These figures show that there is a particularly wide gap between colleges with respect to trainee issues (standard 7) and interaction with the health sector (standard 1.6) as it relates to equitable access, with some colleges having robust policies and leadership in these areas and others receiving a range of accreditation conditions. The themes also reveal the AMC consistently identifies issues with flexible training arrangements and policies across colleges (standard 3), with a high number of conditions and recommendations, and few commendations in this area.

Figure 9: Themes from AMC accreditation commendations of specialist medical programs related to access to training and learning resources

Standard	Themes
1.6 (Interaction with health sector)	• Collaboration with stakeholders on workforce issues
2 (Purpose and outcomes)	• *No themes emerged*
3 (Curriculum)	• Transparency of training documents
4 (Learning and teaching)	• Transparency of learning and teaching opportunities • Availability and quality of online learning modules
5 (Assessment)	• Fairness and transparency of examination schedule • Support for examination preparation
7 (Trainees)	• Developing and implementing bullying, harassment, and discrimination policies • Selection and targets for Aboriginal, Torres Strait Islander, and/or Māori students
8 (Program implementation)	• Work with training networks/Colleges to expand settings
10 (Specialist international medical graduates)	• Transparent/fair assessment policies • High level of support and resources for specialist international medical graduates
Other	• Online education resources/website (Standard 1.5) • Monitoring and evaluation programs in relevant areas (Standard 6)

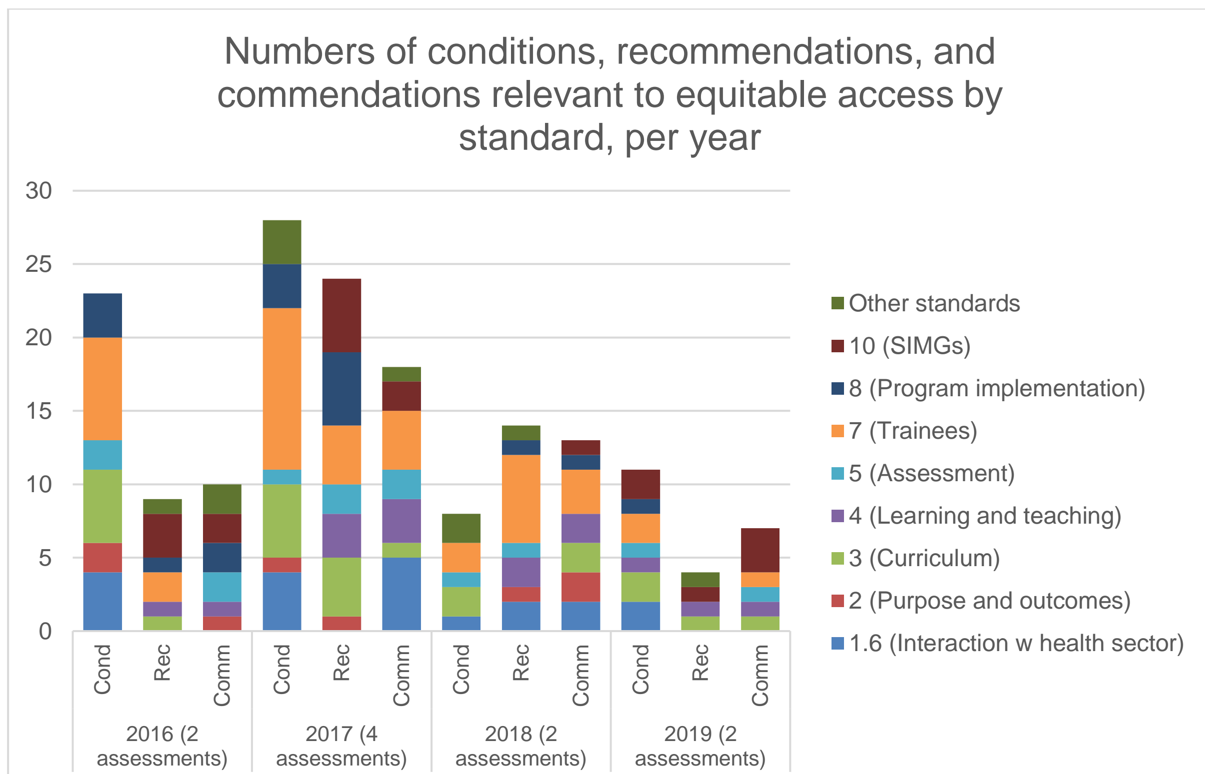
Figure 10: Themes from AMC accreditation recommendations for improvement for specialist medical programs related to access to training and learning resources

Standard	Themes
1.6 (Interaction with health sector)	• Collaboration with stakeholders on workforce issues
2 (Purpose and outcomes)	• *No themes emerged*
3 (Curriculum)	• Improve recognition of prior learning policies • Clarify/promote interrupted training opportunities
4 (Learning and teaching)	• Develop more online learning and teaching resources (esp for benefit of rural trainees) • Improve access to resources generally, incl those of other training networks/colleges
5 (Assessment)	• Standardise assessments through rubrics/forms/review by governance bodies
7 (Trainees)	• Develop/make transparent policies related to trainee wellbeing, training site selection, progression requirements, and/or fees
8 (Program implementation)	• Develop rural training opportunities
10 (Specialist international medical graduates)	• Provide more information to candidates on assessment processes to allow them to better gauge their chances of success
Other	• *No themes emerged*

Figure 11: Themes from AMC accreditation conditions on specialist medical programs related to access to training and learning resources

Standard	Themes
1.6 (Interaction with health sector)	• Develop/implement strategies to improve collaboration with jurisdictions/employers • Develop/implement partnerships with Indigenous health sectors and communities
2 (Purpose and outcomes)	• Strengthen leadership in workforce planning issues
3 (Curriculum)	• Work with employers to help trainees access flexible training • Remove cultural barriers to flexible training
4 (Learning and teaching)	• *No themes emerged*
5 (Assessment)	• Monitor/provide timely information for workplace based assessments
7 (Trainees)	• Develop/implement policies around recruitment of Indigenous trainees • Develop/implement discrimination, bullying, and harassment policy for wellbeing • Ensure selection policies are applied/defined consistently • Ensure better communication on selection policies and flexible work arrangements
8 (Program implementation)	• Identify and develop opportunities for greater exposure to rural and Indigenous communities
10 (Specialist international medical graduates)	• *No themes emerged*
Other	• *No themes emerged*

Figure 12: Bar graph of accreditation conditions, recommendations, and commendations



5. LINK TO NATIONAL MEDICAL WORKFORCE STRATEGY

This section explores AMC actions and functions relevant to this project that are levers for development in medical education and practice standards, and medical programs. It also outlines links between AMC strategic priorities and actions, and themes of the National Medical Workforce Strategy.

As well as drawing on the Department of Health's National Medical Workforce Strategy (NMWS) as at December 2020, this section also draws on discussion at the Australian Medical Council meeting in May 2021, building on a presentation by Associate Professor Susan Wearne, Senior Medical Adviser, Health Workforce Division.

5.1 AMC ACTIONS AND FUNCTIONS THAT SUPPORT REFORMS TO AUSTRALIA'S SPECIALIST MEDICAL TRAINING AND ACCREDITATION SYSTEM POST COVID-19

The AMC has identified the following actions and functions that relate to this project.

Accreditation. As the accreditation authority for the medical profession, the AMC develops the standards for assessment and accreditation of specialist medical programs, continuing professional development programs and specialist international medical graduate assessment processes. Through its accreditation functions across the medical education continuum, the AMC is well placed to identify common challenges and risks across the sector, and barriers and challenges at transition points in the continuum. A number of studies have found that accreditation standards are an important motivator for review and change in medical programs. In addition, the education providers' self-reflection and evidence in preparation for accreditation assessments can support the providers' own change.

The AMC's processes for developing and consulting on accreditation standards ensures broad stakeholder input and engagement in determining the standards, and also act to improve standards.

Assessment expertise. The AMC provides the examination for international medical graduates seeking to practise in Australia. It assesses on average 4,000 international medical graduates per year via a computer adaptive multiple-choice examination and a clinical examination delivered through the AMC National Test Centre and now online. The AMC also sets the standards for the alternate workplace based assessment pathway for international medical graduates and provides a process for accreditation of workplace based assessment programs offered in Australian health services. It has expertise in the development of assessment material, standards setting, delivery of examinations, examiner training and calibration, and the development of assessment resources. It partners with a broad group of assessment experts nationally and internationally.

Cross continuum, interprofessional and intra-agency collaboration. The AMC works with partners and stakeholders to support achievement of its purpose. As the accreditation body for medical programs, it has oversight of standards and programs across all phases of the continuum. In addition to partners within the medical education and regulation sectors in Australia, it has strong links to the accreditation authorities for the other regulated health professions in Australia. It was a founder of the Health Professions Accreditation Collaborative Forum, and provides the secretariat for the Forum. The AMC's established partnerships allow it to bring together expert groups and interested stakeholders to take forward strategic projects.

Measurement of impact. In its accreditation role, the AMC gathers information about all the specialist medical training programs. Its accreditation assessments and monitoring of programs provide expert review of the programs against defined standards. AMC accreditation also gathers stakeholder feedback on specialist medical programs, including trainee, supervisor, health consumer, health service and jurisdictional feedback. As this project demonstrates, the AMC can use this information for analysis of themes across programs and providers, as well as for monitoring and assessing specific programs. The AMC is able to measure the impact of standards and responses to standards through these processes and to contribute to measuring the impact of curriculum change. The AMC has research and process improvement collaborations with a number of accreditation bodies.

Good practice curated collections and support. The AMC assessment website, being developed with Health Workforce Division Support, is an example of a curated collection of good practice using videos, case studies and other resources that will be available to all colleges. Making these resources available to all provides transparent information about expectations in AMC accreditation assessments, and supports those with less access to medical education resources.

Embedding change. AMC accreditation experience indicates that design and implementation of change in specialist medical programs and specialist medical colleges is complex, and this complexity is enhanced by implementation across multiple health services and jurisdictions. As found by the CPMC in their report 1 for this project[3], there is a lack of risk planning to account for the possibility of future pandemics, natural disasters or other national/global disruptions. There are opportunities to use the AMC's accreditation and standards setting role, to identify and consider common barriers to change, managing and identifying training process-related risk and the levers to address them.

5.2 THE NATIONAL MEDICAL WORKFORCE STRATEGY AND AMC'S STRATEGIC DIRECTION

The key themes and priorities in the National Medical Workforce Strategy are shown in Figure 13.

Figure 13: The National Medical Workforce Strategy themes and priorities[4]

[3] Report 1 Training Impacts, responses and opportunities CPMC May 2021
[4] Presentation to AMC Council by Associate Professor Susan Wearne 7 May 2021

The AMC Strategic Plan 2018 to 2028, available at https://www.amc.org.au/wp-content/uploads/2019/01/Strategic-Plan-2018-2028.pdf identifies the AMC's areas of strategic interest.

AMC strategic priority 3, Promoting Aboriginal and Torres Strait Islander health links to the Cross Cutting Theme 1.

Themes within the NMWS that link to the AMC's current and future areas of work and strategic priorities are set out below.

National Medical Workforce Strategy Area 1 Collaborate on planning and design

The AMC sees opportunities to enhance its input to medical workforce planning in partnership with the Health Workforce Division. AMC presentations to the Medical Workforce Reform Advisory Committee, particularly on the review of prevocational years 1 and 2, have expanded sector knowledge of AMC work but also provided additional AMC insight to concerns and interests of medical workforce stakeholders.

National Medical Workforce Strategy Area 2 Rebalancing supply and distribution and Area 3 Reforming training pathways and Cross Cutting Theme2 and Cross Cutting Theme 3

Link to AMC strategic priority 2, Medical education and training responsive to community health needs, and AMC strategic priority 4, Professional practice in a changing world.

The AMC sees considerable alignment between the NMWS and AMC interest and capacity to support change and innovation that results in efficient, effective and clear training pathways for trainees.

- As this report shows, the structure, location and sequencing of training and assessment can be barriers to the participation of trainees in geographically dispersed location. Through accreditation standards, guidance notes and best practise guides, the AMC can set expectations that these barriers be addressed. Through accreditation findings and conditions the AMC can monitor college actions. Accreditation reports, and AMC workshops and fora also provide opportunities to commend and showcase college innovations.
- Online assessment and resources. The move by colleges to place learning and assessment preparation resources online is a key enabler of equitable access to training. AMC accreditation assessments, analysis of responses to the Medical Training Survey and ongoing monitoring of accredited programs can ensure continued availability, accessibility and development of resources is kept under review.
- The AMC has begun analysis of college accreditation practices, and the themes that arise in AMC accreditation assessments concerning these policies and practices. The aim of this work has been to determine whether or not the AMC is gathering appropriate evidence to assess colleges against the current accreditation standards. There are opportunities to extend this work, to look in more detail at the response to the element of these standards that relates to "supporting training and education opportunities in diverse settings aligned to the curriculum requirements including rural and regional locations, and settings which provide experience of the provisions of health care to Aboriginal and Torres Strait Islander peoples in Australia and/or Māori in New Zealand"[5].

[5] See standard 8.2.2, Appendix 2

National Medical Workforce Strategy Area 4 Build the generalist capability of the workforce and Area 5 Build a flexible and responsive medical workforce

Link to AMC strategic priority 2, Medical education and training responsive to community health needs, and AMC strategic priority 4, Professional practice in a changing world.

The accreditation standards (standard 2) presently require colleges to address community health needs in defining their educational purpose and outcomes. The standards also note that “Given the population distribution, health care needs and health service configuration in Australia and New Zealand, specialists need to be trained initially in the broad scope of their specialty.” There are opportunities for the AMC to analyse colleges’ current responses to these requirements and, with stakeholders, consider what additional actions or resources might strengthen these requirements and colleges’ capacity to respond to them.

AMC accreditation assessments provide opportunities for stakeholder feedback on college policies and practices. The AMC has begun discussions with jurisdictions about the questions that it should ask to elicit useful stakeholder feedback on college strategies, policies and approaches that support or act as barriers to jurisdiction strategies and approaches.

There are potentially opportunities for the AMC to provide clear and accessible guidance for health services to support them in their discussions with colleges about training and accreditation requirements.

The AMC is completing a comprehensive review of the National Framework for Medical Internship and developing, on behalf of Health Ministers, a two-year framework for prevocational (PGY1 and PGY2) medical training. This review has presented significant opportunities for engagement with stakeholders about the medical training continuum, the generalist nature of the early prevocational period, and the major transition points in the continuum and to redesign the prevocational period. The AMC sees continuing opportunities flowing from these discussions and collaborations to inform review and reform of medical education and training in other phases of the continuum.

6. NEXT STEPS FOR THE AMC

In this section we set out the next steps in the AMC's process of considering the findings from this project through its accreditation governance structures.

In May 2021 the AMC shared the findings from the draft of this report on barriers to and enablers of equitable access to learning and training in specialist medical programs in Australia with its Progress Reports Sub Committee and Specialist Education Accreditation Committee. Revisions to the report reflect feedback from committee members.

The AMC levers for change are set out in section 5 of this report.

The AMC's planned next steps in relation to this report include:

- consider the linkages between AMC priorities and actions and the National Medical Workforce Strategy as part of the AMC's current review of its Strategic Plan. Continue discussion with the Health Workforce Division on opportunities for further engagement and partnership
- continue monitoring of COVID-19 changes to specialist medical programs in 2021 through the Progress Reports Sub Committee
- working with the Progress Reports Sub Committee, use accreditation monitoring to identify other elements of specialist medical education and training for thematic review
- identify potential changes to accreditation practices, policies and evidence gathering to improve ongoing monitoring of barriers and enablers of access to learning resources and training for discussion by Progress Reports Sub Committee
- use the outcomes of this project as part of the preparation for the next review of the accreditation standards for specialist medical programs.

GLOSSARY

Australian Health Practitioner Regulation Agency (Ahpra)	The agency that provides assistance and support to the National Boards for the regulated health professions, and to the Boards' committees, in exercising their regulatory functions. In conjunction with the National Boards, Ahpra keeps up-to-date and publicly accessible national registers of registered health practitioners for each health profession.
Australian Medical Council (AMC)	The accreditation authority for medical programs under the *Health Practitioner Regulation National Law Act 2009*. The AMC develops accreditation standards and accredits medical programs in all phases of medical education and training.
Council of Presidents of Medical Colleges (CPMC)	The CPMC functions as the unifying organisation of, and support structure for, the Specialist Medical Colleges of Australia. All fifteen specialist medical colleges are members.
Education provider	The National Health Practitioner Regulation Law Act 2009 uses the term *education provider* to cover organisations that may be accredited to provide education and training for a health profession. The term encompasses universities; tertiary education institutions, or other institutions or organisations that provide vocational training; or specialist medical colleges or other health profession colleges. For consistency, the AMC uses the terminology of the National Law in accreditation standards and reports.
Employer	Specialist medical trainees complete work-based training and formal education while employed to practise as a medical practitioner. In the context of specialist medical training standards, employer means the person or persons who have a formal line management responsibility for the trainee's work role and performance.
IRTP	An initiative of the Commonwealth. The Integrated Rural Training Program for Medicine, established 2015-16 has three components: • the establishment of regional training hubs to better coordinate training opportunities for medical students and trainees and build local training capacity; • the establishment of a rural junior doctor training innovation fund to deliver general practice rotations for junior doctors undertaking their internship in a rural area; and • support for an additional 100 places on the Specialist Training Program, targeted specifically to rural areas.
Jurisdiction	An Australian state or territory health department or ministry, the Australian Government Department of Health or the New Zealand Ministry of Health, as well as government in general.

Medical Board of Australia (the Board)	The national board for the medical profession, established under the Health Practitioner Regulational National Law Act, with functions relating to registration of practitioners, development of standards codes and gudielines for the profession, and approval of accredited programs of study.
MTS	The Medical Training Survey is a national profession-wide survey of all doctors in training in Australia, run since 2019. It is run by the Australian Health Practioner Regulation Agency and the Medical Board of Australia.
Specialist Education Accreditation Committee	The AMC committee responsible for developing standards for specialist medical programs and their providers and assessing, accrediting and monitoring programs and their providers against those standards.
Specialist medical program	Is the curriculum, the content/syllabus, and assessment and training that leads to certification in a recognised medical specialty or field of specialty practice.
STP	The Specialist Training Program (STP) seeks to extend vocational training for specialist registrars into settings outside traditional metropolitan teaching hospitals, including regional, rural and remote and private facilities. The program aims to improve the quality of the future specialist workforce by providing registrars with exposure to a broader range of healthcare settings. STP also aims to have a positive influence on future workforce distribution.
Trainee	A doctor in training completing a specialist medical program.
Training posts	Specialist medical trainees complete training in the health services and facilities in which they work. Colleges set requirements for this training, and accredit posts and positions that meet these requirements. Some colleges accredit facilities or programs in facilities rather than individual posts.
Training sites	The organisation in which the trainee works and undertakes supervised workplace-based training and education. Training sites are generally health services and facilities such as public and private hospitals, general practices, community-based health facilities, and private practices, but may also be other sites such as laboratories.
SIMG	A specialist international medical graduate (SIMG) is a specialist doctor who has completed specialist medical training outside Australia.

Supervision	Doctors in training completing a specialist medical program experience various types of supervision: clinical or practice-based supervision, educational supervision and supervision for employment purposes by a line manager. These may overlap.

APPENDIX 1: SPECIALIST MEDICAL PROGRAM ACCREDITATION

The AMC has accredited specialist medical programs since 2002. Initially, the accreditation process was a voluntary quality improvement process that all the specialist medical colleges agreed to undergo. In July 2010, the National Registration and Accreditation Scheme for health professions began in Australia. The AMC was appointed as the accreditation authority for medicine under the National Law. From that date, the accreditation of specialist medical programs was mandated since the National Law makes the accreditation of specialist medical programs an essential element of the process for approval of programs for the purposes of specialist registration.

As the accreditation authority for the medical profession under the National Law, the AMC:

- develops accreditation standards for medical programs and their education providers
- assesses programs against the standards and accredits those that meet the standards
- monitors programs to ensure that they continue to meet standards
- makes recommendations and gives advice on accreditation related matters.

The National Law [S3(2)] defines the objectives of the National Registration and Accreditation Scheme and, in its accreditation work, the AMC must take account of these objectives:

a. to provide for the protection of the public by ensuring that only health practitioners who are suitably trained and qualified to practise in a competent and ethical manner are registered
b. to facilitate workforce mobility across Australia by reducing the administrative burden for health practitioners wishing to move between participating jurisdictions or to practise in more than one participating jurisdiction
c. to facilitate the provision of high quality education and training of health practitioners
d. to facilitate the rigorous and responsive assessment of overseas-trained health practitioners
e. to facilitate access to services provided by health practitioners in accordance with the public interest, and
f. to enable the continuous development of a flexible, responsive and sustainable Australian health workforce and to enable innovation in the education of, and service delivery by, health practitioners.

The AMC addresses these objectives through the accreditation standards it develops, the information and evidence it seeks from specialist medical programs and providers, accreditation methods and tools, and stakeholder consultation and engagement.

ACCREDITATION STANDARDS

The AMC assesses specialist medical programs and their providers against accreditation standards, *Standards for Assessment and Accreditation of Specialist Medical Programs and Professional Development Programs,* and grants accreditation to the programs that meet the standards. The AMC also applies the accreditation standards in monitoring accredited programs and providers to determine if they continue to meet the standards.

By agreement with the Medical Council of New Zealand, AMC-developed accreditation standards also apply to the assessment of medical programs in New Zealand.

The National Law [S5] defines accreditation standards as ' … a standard used to assess whether a program of study, and the education provider that provides the program of study, provide persons

who complete the program with the knowledge, skills and professional attributes necessary to practise the profession in Australia.'

The AMC has developed a common structure for the accreditation standards across the phases of medical education, with separate standards for each phase. Each set of standards is grouped into areas relating to the key elements in a curriculum development process.

The *Standards for Assessment and Accreditation of Specialist Medical Programs and Professional Development Programs* are Appendix 1. The standards are structured as:

Standard 1	The context of education and training
Standard 2	Purpose and outcomes
Standard 3	Specialist medical training and education framework (the curriculum)
Standard 4	Teaching and learning
Standard 5	Assessment of learning
Standard 6	Monitoring and evaluation
Standard 7	Trainees
Standard 8	Educational resources including supervision and accreditation of training posts and programs
Standard 9	Continuing professional development (CPD)
Standard 10	Assessment of specialist international medical graduates

The standards focus significantly on external context and relationships, and health jurisdictions engaged significantly in the 2006, 2008 and 2015 reviews of standards.

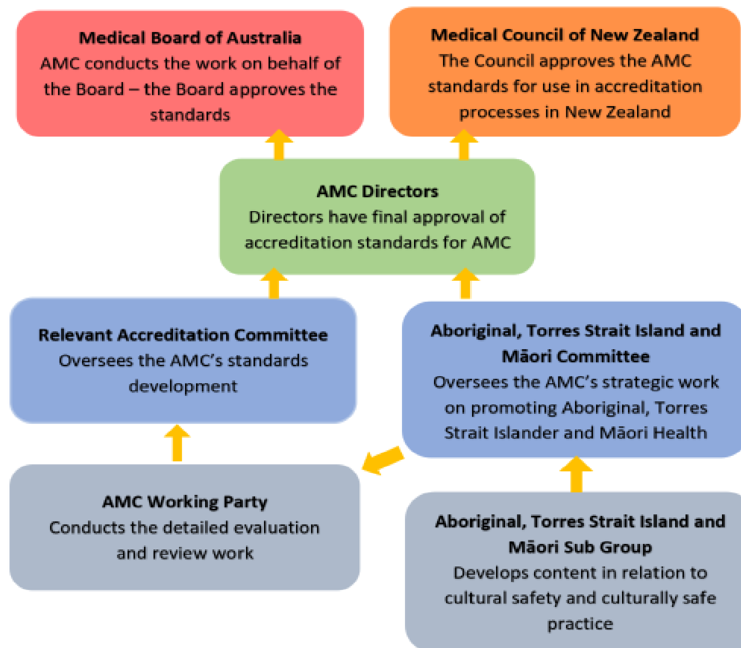
The AMC includes notes with the standards to provide further explanation of the standards and/or guidance on contemporary good practice relevant to the standard. The notes provide guidance that assists programs achieve and maintain compliance with the standards.

REVIEW OF ACCREDITATION STANDARDS

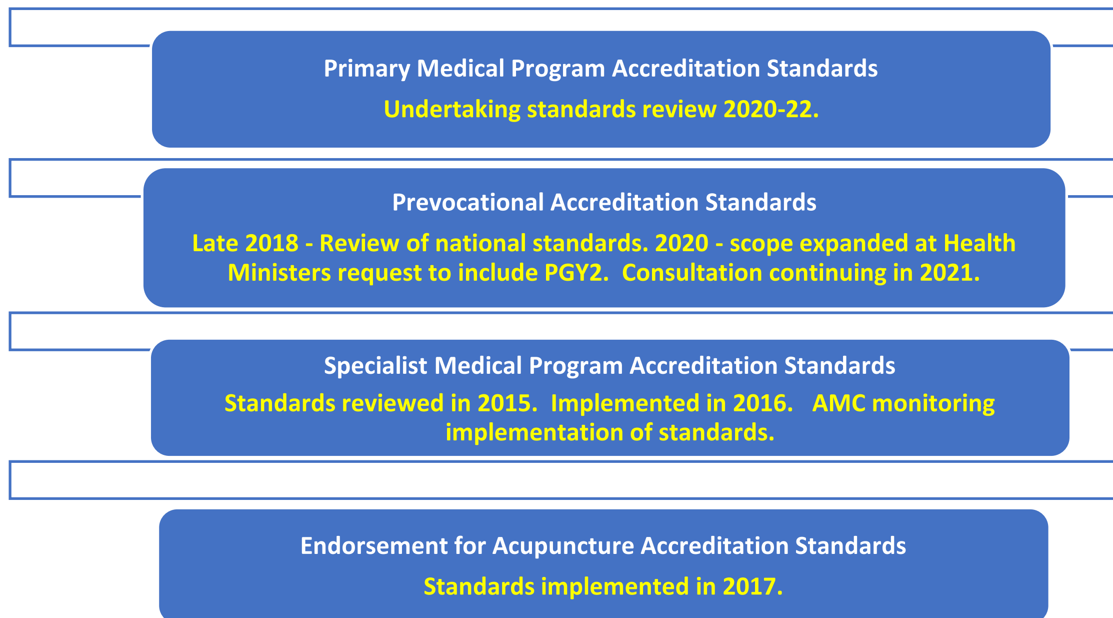
The AMC reviews the accreditation standards at regular intervals, generally every five years. These reviews provide opportunities for stakeholder contributions, and builds on the experience of AMC accreditation committees. The review of the standards for one phase of the medical education continuum also informs the subsequent reviews of standards for other phases of medical education.

The AMC consults widely with medical education stakeholders including education providers, learners, health services, the medical profession, jurisdictions, health consumers and the community, and other health professions. The consultation approach is iterative and responsive to the feedback received. The process is illustrated below:

The typical governance arrangements for a review is as follows:



The cycle of the AMC's reviews of accreditation standards is shown below:



ACCREDITATION PROCESSES

The standards state what is assessed when the AMC accredits programs, but the AMC's request for evidence of meeting the standards, and the way the program and institution are assessed are also key influences.

The AMC follows set procedures in the assessment and accreditation of all programs and their providers and in monitoring them once they are accredited.

AMC accreditation entails a cycle of review of the education provider's programs. The cycle starts with an accreditation assessment, which sets the accreditation period and conditions. The AMC then completes a paper-based assessment to determine if the program and provider are continuing to meet standards at six years, and an AMC team completes a reaccreditation assessment every ten years. Within the ten-year cycle, the AMC may complete additional accreditation assessments if the program and/or its provider do not meet one or more of the accreditation standards and if an assessment is necessary to determine progress against accreditation conditions.

The important elements of the accreditation cycle are as follows:

- The accreditation commences with the education provider undertaking a self-assessment, and developing an accreditation submission.
- The AMC accreditation committee appoints a team to complete the assessment. Teams include a combination of clinicians from private and public health services, and hospital and community sectors, educators, trainees, health consumers and community members, other health practitioners, and health service managers.
- The team meets after the provider lodges its accreditation submission. It discusses the submission, decides on any additional information, plans meetings and any site visits, and decides on preliminary feedback to the provider.
- The AMC invites submissions from stakeholders on the program being accredited. The AMC also surveys trainees, supervisors of training and specialist international medical graduates being assessed by the provider.
- The team completes its program of meetings, interviews and any site visits. The AMC looks for opportunities for teams to observe the provider's educational activities and assessments, for example clinical exams.
- The team prepares a report on its findings, against the accreditation standards. The accreditation committee considers the team's report and any comments by the provider. The committee decides on final wording and the accreditation recommendations.
- The AMC Directors make the accreditation decision.
- The AMC submits the report and the accreditation decision to the Medical Board of Australia. The Board makes its decision to approve, or to refuse to approve, the accredited program of study as providing a qualification for the purposes of registration.
- The AMC publishes its accreditation report including the decision on its website: https://www.amc.org.au/accreditation-and-recognition/accreditation-reports/.

ACCREDITATION OUTCOMES

The AMC accreditation decision states whether the AMC has found the program and provider to meet or substantially meet the accreditation standards; the options available to the AMC in deciding on the period of accreditation; and the period of accreditation the AMC has decided to grant the program. The decision also includes any necessary accreditation conditions.

The decision lists, by accreditation standard, conditions imposed by the AMC so the program and provider will meet accreditation standards. The AMC sets timelines for the program and provider to meet the conditions in consultation with the provider. The report also includes commendations of areas of strength identified in the assessment and recommendations for improvement provided as part of the AMC's collegial peer review process.

ACCREDITATON CONDITIONS AND MONITORING

After the AMC has completed its accreditation assessment, made the accreditation decision and set conditions (if necessary) it monitors the accredited program and its provider to ensure they continue to meet the accreditation standards, and make progress towards satisfying accreditation conditions.

Principal mechanisms are structured progress reports, comprehensive reports for extension of accreditation generally six years' into the accreditation cycle, and full reaccreditation assessments every ten years.

The AMC appoints an independent AMC reviewer to consider each progress report and prepare findings against the standards and accreditation conditions. The reviewer is usually the chair or a member of the last AMC team to assess the provider.

The reviewer's comments and the report are considered by the Progress Reports Sub Committee of the Specialist Education Accreditation Committee. The Sub Committee reports to the Specialist Education Accreditation Committee on its findings in relation to each college. Any matters that may affect the accreditation status of a college are reported in full to the Committee for a decision.

The AMC needs to decide if, on the information available, it is substantially satisfied that the program(s) and the provider continue to meet the accreditation standards. It takes account of both the report overall and the provider's response to any conditions on the accreditation.

The AMC makes one of the following decisions:

1. the report indicates that the program and provider continue to meet (or substantially meet) the accreditation standards, or
2. further information is necessary to make a decision, or
3. the provider and program may be at risk of not satisfying the accreditation standards.

After the AMC has made its decision, AMC staff send the AMC's findings and feedback on the report to the provider including:

- whether standards are met/substantially met or not met
- conditions which are satisfied and do not need to be addressed again
- any questions concerning the report or supplementary information required.

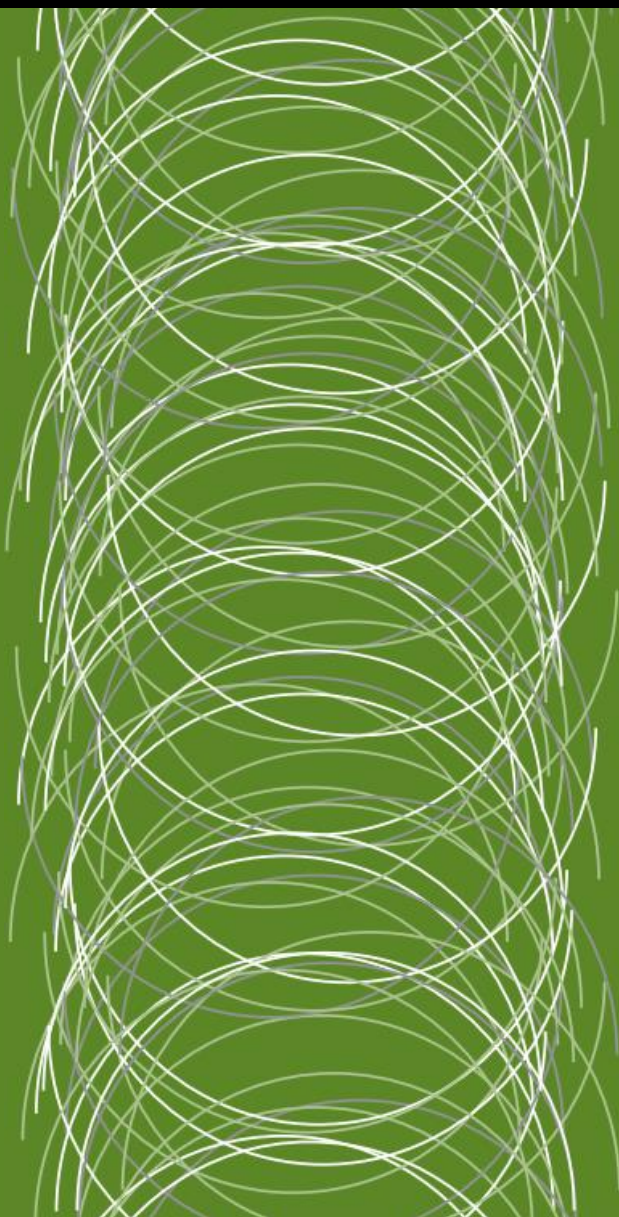
If the Committee considers that the provider may be at risk of not satisfying the approved accreditation standards, then the issue is referred to the AMC Directors, as per the *AMC Unsatisfactory Progress Procedures*. Providers are also advised if any major changes require assessment via correspondence and/or site visit.

APPENDIX 2: ACCREDITATION STANDARDS

Australian Medical Council Limited

Standards for Assessment and Accreditation of Specialist Medical Education Programs and Professional Development Programs by the Australian Medical Council 2015

AMC



Specialist Education Accreditation Committee

Glossary

Assessment	The systematic process for measuring and providing feedback on the candidate's progress, level of achievement or competence, against defined criteria.
Collaboration	Implies a cooperative arrangement in which two or more parties work jointly towards a common goal.
Continuing professional development	Continuing professional development (CPD) is the range of learning activities through which medical practitioners maintain, develop, update and enhance the knowledge, skills and performance required for safe and appropriate practice in the relevant specialty. A CPD program is the range of resources and activities to support CPD; a mechanism for participants to plan, document and self-evaluate activity; processes for assessing and crediting activities, and procedures for monitoring program participation and, where applicable, activity, quality and auditing compliance.
Cultural competence and cultural safety	The AMC draws on the Medical Council of New Zealand's definition of cultural competence.[6] Cultural competence requires an awareness of cultural diversity and the ability to function effectively, and respectfully, when working with and treating people of different cultural backgrounds. Being culturally competent means a medical practitioner has the professional qualities, skills and knowledge needed to achieve this. A culturally competent medical practitioner will acknowledge that: • Australia and New Zealand both have culturally diverse populations • a medical practitioner's culture and belief systems influence his or her interactions with patients, and accepts this may impact on the doctor-patient relationship • a positive patient outcome is achieved when a medical practitioner and patient have mutual respect and understanding. The AMC draws on the Royal Australian College of General Practitioners' explanation of cultural safety: Cultural safety is 'an outcome of health practice and education that enables safe service to be defined by those who receive the service'. Strategies aim to create an environment that is 'safe for people: where there is no assault, challenge or denial of their identity, of who they are and what they need', where there is 'shared respect, shared meaning, shared knowledge and experience, of learning, living and working together with dignity and truly listening'.[7]

[6] Medical Council of New Zealand, *Statement on cultural competence,* August 2006, https://www.mcnz.org.nz/assets/News-and-Publications/Statements/Statement-on-cultural-competence.pdf

[7] Royal Australian College of General Practitioners, *Cultural awareness education and cultural safety training*, April 2011, http://www.racgp.org.au/yourracgp/faculties/aboriginal/education/resources-for-gps-and-practice-staff/cultural-awareness/

Curriculum	A statement of the intended aims and objectives, content, assessment, experiences, outcomes and processes of a program, including a description of the structure and expected methods of learning, teaching, feedback and supervision. The curriculum should set out the knowledge, skills and professional qualities the trainee is to achieve. This is distinguished from a syllabus which is a statement of content to be taught and learnt.
Education provider	The National Health Practitioner Regulation Law Act 2009 uses the term *education provider* to cover organisations that may be accredited to provide education and training for a health profession. The term encompasses universities; tertiary education institutions, or other institutions or organisations that provide vocational training; or specialist medical colleges or other health profession colleges. For consistency, the AMC uses the terminology of the National Law in its accreditation standards and guidelines.
Employer	Specialist medical trainees complete work-based training and formal education while employed to practise as a medical practitioner. Where the standards use the term employer it means the person or persons who have a formal line management responsibility for the trainee's work role and performance.
Evaluation	The set of policies and processes by which an education provider determines the extent to which its training and education functions are achieving their outcomes.
Fellow/specialist in the discipline	Traditionally, in Australia and New Zealand specialist medical programs have been provided by specialist medical colleges. Their fellows are the members who *hold the award which signifies they are specialist medical practitioners in the discipline or disciplines covered by the specialist medical college and contribute to the college for example as supervisors, assessors and committee members. In this document the AMC has used "specialists in the discipline/specialty" rather than fellows.*
Field of specialty practice	This term is used in the Medical Board of Australia's *List of specialties, fields of specialty practice and related specialist titles*. Fields of specialty practice are part of a specialty. These standards also use the term subspecialty.
Generalism and generalist	The AMC accepts the definitions of the Royal College of Physicians and Surgeons of Canada: 'Generalism is a philosophy of care that is distinguished by a commitment to the breadth of practice within each discipline and collaboration with the larger health care team in order to respond to patient and community needs.' 'Generalists are a specific set of medical practitioners with core abilities characterised by a broad based practice. Generalists diagnose and manage clinical problems that are diverse, undifferentiated, and often complex. Generalists also have an essential role in coordinating patient care and advocating for patients.'[8]

[8] Royal College of Physicians and Surgeons Canada: Education Strategy, Innovations and Development Unit, *Report of the Generalism and Generalist Task Force*, July 2013, http://www.royalcollege.ca/portal/page/portal/rc/resources/publications/dialogue/vol13_9/generalism

Health consumer	The AMC has adopted the definition of the Australian Commission on Safety and Quality in Health Care which is 'Consumers and/or carers are members of the public who use, or are potential users, of health care services.'[9] When referring to consumers, the AMC is referring to patients, consumers, families, carers, and other support people. In Australia and New Zealand, health consumers include Aboriginal and Torres Strait Islander peoples of Australia and Māori of New Zealand and consumers from culturally and linguistically diverse backgrounds.
Jurisdiction	An Australian state or territory health department or ministry, the Australian government department of health or the New Zealand Ministry of Health, as well as government in general.
Indigenous health	The term Indigenous health is used to refer to the health of Aboriginal and Torres Strait Islander peoples of Australia and Māori of New Zealand.
Interdisciplinary learning	Interdisciplinary learning occurs when medical practitioners from two or more medical disciplines learn about, from and with each other to enable effective collaboration and improve health outcomes.
Interprofessional learning	The AMC uses the World Health Organization definition of interprofessional education: '**Interprofessional education** occurs when two or more professions learn about, from and with each other to enable effective collaboration and improve health outcomes. • Professional is an all-encompassing term that includes individuals with the knowledge and/or skills to contribute to the physical, mental and social well-being of a community. **Collaborative practice** in health-care occurs when multiple health workers from different professional backgrounds provide comprehensive services by working with patients, their families, carers and communities to deliver the highest quality of care across settings. • Practice includes both clinical and non-clinical health-related work, such as diagnosis, treatment, surveillance, health communications, management and sanitation engineering.'[10]
Outcomes	**Graduate outcomes** are the minimum learning outcomes in terms of discipline-specific knowledge, discipline-specific skills including generic skills as applied in the specialty discipline, and discipline-specific capabilities that the graduate of any given specialist medical program must achieve.

[9] Australian Commission on Safety and Quality in Health Care, *Safety and Quality Improvement Guide Standard 2: Partnering with Consumers,* October 2012, Sydney. ACSQHC, 2012.
[10] World Health Organisation: Health Professions Networks Nursing and Midwifery Human Resources for Health, *Framework for Action on Interprofessional Education and Collaborative Practice,* 2010, http://www.who.int/hrh/nursing_midwifery/en/

	Program outcomes describe what gives a discipline its coherence and identity, and define threshold and typical expectations of a graduate in terms of the abilities and skills needed to develop understanding or competence in the discipline. Education providers are expected to define the broad roles of practitioners in their specialty as the outcomes of the specialist medical program. Program outcomes are specific to the discipline but should reflect the overall goal of specialist medical training and education, as well as the role of clinical or medical expert in the specialty.
Specialist medical program	Is the curriculum, the content/syllabus, and assessment and training that leads to independent practice in a recognised medical specialty or field of specialty practice, or in New Zealand a vocational scope of practice. It leads to a formal award certifying completion of the program.
Stakeholders	The term encompasses: • stakeholders internal to the education provider such as trainees and those contributing to the design and delivery of training and education functions including but not limited to program directors, supervisors, members and fellows and committees • external stakeholders that contribute directly to training and education such as training sites, and specialty societies in some specialties • other external stakeholders with an interest in the process and outcomes of specialist medical training and education such as health workforce bodies, health jurisdictions, regulatory authorities, professional associations, other health professions, health consumers, Aboriginal and Torres Strait Islander peoples of Australia and Māori of New Zealand.
Supervision	Doctors in training completing a specialist medical program experience various types of supervision: clinical or practice-based supervision, educational supervision and supervision for employment purposes by a line manager. These may overlap.
Supervisor	In these standards, supervisor refers to an appropriately qualified and trained medical practitioner, senior to the trainee, who guides the trainee's education and/or on the job training on behalf of the education provider. The supervisor's training and education role will be defined by the education provider, and may encompass educational, support and organisational functions. Education providers frequently define a number of supervisory roles (see standard 8.1.)
Trainee	A doctor in training completing a specialist medical program.
Training and education functions	Specialist medical education providers provide a variety of education and training services and functions, including a specialist medical program, and specific courses for trainees, other health professionals and/or specialists in the specialty. In these standards, the term 'training and education functions' includes the activities covered by these standards, namely providing a specialist medical program leading to a specialist qualification, education and training of qualified specialists and assessment of specialist international medical graduates – as well as additional variable training and education services.

Training sites	The organisation in which the trainee works and undertakes supervised workplace-based training and education. Training sites are generally health services and facilities such as public and private hospitals, general practices, community-based health facilities, and private practices, but may also be other sites such as laboratories.

Standard 1. The context of training and education

1.1 Governance

Accreditation standards

1.1.1 The education provider's corporate governance structures are appropriate for the delivery of specialist medical programs, assessment of specialist international medical graduates and continuing professional development programs.

1.1.2 The education provider has structures and procedures for oversight of training and education functions which are understood by those delivering these functions. The governance structures should encompass the provider's relationships with internal units and external training providers where relevant.

1.1.3 The education provider's governance structures set out the composition, terms of reference, delegations and reporting relationships of each entity that contributes to governance, and allow all relevant groups to be represented in decision-making.

1.1.4 The education provider's governance structures give appropriate priority to its educational role relative to other activities, and this role is defined in relation to its corporate governance.

1.1.5 The education provider collaborates with relevant groups on key issues relating to its purpose, training and education functions, and educational governance.

1.1.6 The education provider has developed and follows procedures for identifying, managing and recording conflicts of interest in its training and education functions, governance and decision-making.

Notes

Education providers have governance structures that relate to organisational or corporate governance, as well as operational governance structures for training and education functions. The corporate governance structures should be such that the education provider has adequate resources and autonomy to manage and deliver training and education functions.

Governance structures typically include decision-making committees, advisory groups and staff. The AMC recognises that the governance structures and the range of functions vary from education provider to education provider. The AMC does not consider any particular structure is preferable, and supports diversity where the structure can be demonstrated to function effectively over time. The internal units encompassed in the governance structures might include branches or regions, as well as chapters, faculties and societies. External training providers might include higher education providers and/or specialty societies.

The governance structures should be such that the education provider's governing body is informed of, and accepts ultimate responsibility for, new specialist medical programs or significant program changes.

The education provider should represent itself, its educational activities and fees accurately.

Relevant groups include internal stakeholders, and external stakeholders who contribute to the design and delivery of training and education. Depending on the role of the decision-making group, relevant external stakeholders might include health consumers, jurisdictions, Aboriginal and Torres Strait Islander peoples of Australia and/or Māori of New Zealand.

1.2 Program management

Accreditation standards

1.2.1 The education provider has structures with the responsibility, authority and capacity to direct the following key functions:

- planning, implementing and evaluating the specialist medical program(s) and curriculum, and setting relevant policy and procedures
- setting and implementing policy on continuing professional development and evaluating the effectiveness of continuing professional development activities
- setting, implementing and evaluating policy and procedures relating to the assessment of specialist international medical graduates
- certifying successful completion of the training and education programs.

Notes

The structures responsible for designing the specialist medical program and curriculum, and overseeing delivery should include those with knowledge and expertise in medical education.

The structures responsible for program and curriculum design should be informed by knowledge of local and national needs in health care and service delivery, national health priorities, and regulatory requirements.

1.3 Reconsideration, review and appeals processes

Accreditation standards

1.3.1 The education provider has reconsideration, review and appeals processes that provide for impartial review of decisions related to training and education functions. It makes information about these processes publicly available.

1.3.2 The education provider has a process for evaluating de-identified appeals and complaints to determine if there is a systems problem.

Notes

An appeals process that provides a fair and reasonable opportunity to challenge the decision is likely to result in decisions that are ultimately correct. Elements of a strong process include an appeals committee with some members who are external to the education provider, as well as impartial internal members. The process should also provide grounds for appeal against decisions that are similar to the grounds for appealing administrative decisions in Australia and/or New Zealand.

In relation to decision-making conduct, the grounds for appeal would include matters such as:

- an error in law or in due process in the formulation of the original decision
- relevant and significant information, whether available at the time of the original decision or which became available subsequently, was not considered or not properly considered in the making of the original decision
- irrelevant information was considered in the making of the original decision
- procedures that were required by the organisation's policies to be observed in connection with the making of the decision were not observed
- the original decision was made for a purpose other than a purpose for which the power was conferred
- the original decision was made in accordance with a rule or policy without regard to the merits of the particular case; and
- the original decision was clearly inconsistent with the evidence and arguments put before the body making the original decision.

Procedural fairness, timeliness, transparency and credibility, including requiring written reasons for decisions to be issued, are also elements of a strong and effective appeals process.

1.4 Educational expertise and exchange

Accreditation standards

1.4.1 The education provider uses educational expertise in the development, management and continuous improvement of its training and education functions.

1.4.2 The education provider collaborates with other educational institutions and compares its curriculum, specialist medical program and assessment with that of other relevant programs.

Notes

Educational expertise includes clinicians with experience in medical education and educationalists.

1.5 Educational resources

Accreditation standards

1.5.1 The education provider has the resources and management capacity to sustain and, where appropriate, deliver its training and education functions.

1.5.2 The education provider's training and education functions are supported by sufficient administrative and technical staff.

Notes

The resources required in the delivery of training and education functions comprise financial resources, human resources, learning resources, information and records systems, and physical facilities. Information systems should be maintained securely and confidentially.

Since training sites provide many of the resources required to deliver specialist medical programs and, in some cases, that training is delivered by external providers, education providers may not have direct control over these resources. This reinforces the importance of the development and maintenance of effective external relationships in the delivery of specialist medical training and education.

1.6 Interaction with the health sector

Accreditation standards

1.6.1 The education provider seeks to maintain effective relationships with health-related sectors of society and government, and relevant organisations and communities to promote the training, education and continuing professional development of medical specialists.

1.6.2 The education provider works with training sites to enable clinicians to contribute to high-quality teaching and supervision, and to foster professional development.

1.6.3 The education provider works with training sites and jurisdictions on matters of mutual interest.

1.6.4 The education provider has effective partnerships with relevant local communities, organisations and individuals in the Indigenous health sector to support specialist training and education.

Notes

While the education provider sets the educational requirements for completion of the specialist medical program, trainees are also part of the training and service delivery system of the health service that employs them. Effective management of specialist medical programs requires education providers to understand the intersection of their policies and the requirements of the employer and the implications for specialist medical training and education, for example in supervision and trainee welfare including discrimination, bullying and sexual harassment.

The duties, working hours and supervision of trainees should be consistent with the delivery of high-quality, safe, culturally safe, patient care. Ensuring trainees can meet their educational goals and service delivery requirements within safe hours of work is the responsibility of all parties.

The education provider’s relationships with local communities, organisations and individuals in the Indigenous health sector should recognise and address the unique challenges faced by this sector. An example of such a relationship is the Collaboration Agreement between the Australian Indigenous Doctors’ Association and the Committee of Presidents of Medical Colleges.[11]

Matters of mutual interest to specialist medical education providers, training sites and jurisdictions include: teaching, research, patient safety, clinical service and trainee welfare. In relation to specialist medical programs, capacity to train, and the implications of substantial proposed changes to specialist medical programs and trainee requirements need to be covered in discussions between education providers, training sites and jurisdictions, as well as changes in community need, and medical and health practice.

Specialist medical training and education depends on strong and supportive publicly funded and private health care institutions and services.

Many benefits accrue to health care services through involvement in medical training and education. Teaching and training, appraising and assessing medical practitioners and students are important functions for the care of patients now and the development of a highly skilled workforce to care for patients in the future.

The AMC considers it essential that the institutions and health services involved in medical training and education are appropriately resourced to support training, educational experience and supervision. It recognises this is not a matter over which individual education providers have control.

Equally, many education providers do not have control over trainee intake, but in working with jurisdictions and training sites should contribute to explaining relationships and drawing attention to problems such as imbalances between intake and education capacity.

Effective consultation should include a formal mechanism for establishing high-level agreements concerning the expectations of the respective parties, and should extend to regular communication with the jurisdictions.

1.7 Continuous renewal

Accreditation standard

1.7.1 The education provider regularly reviews its structures and functions for and resource allocation to training and education functions to meet changing needs and evolving best practice.

Notes

The AMC expects each education provider to engage in a process of educational strategic planning, with appropriate input, so that its training and education programs, curriculum, assessment of specialist international medical graduates and continuing professional development programs reflect changing models of care, developments in health care delivery, medical education, medical and scientific progress, cultural safety and changing community needs.

It is appropriate that review of the overall program leading to major restructuring occurs from time to time, but there also needs to be mechanisms to evaluate, review and make more gradual changes to the curriculum and its components.

When an education provider plans new training requirements or a new program, trainees in transition should be included in the strategic planning.

[11] Australian Indigenous Doctors’ Association and the Committee of Presidents of Medical Colleges, Collaboration Agreement 2013 – 2015, July 2013, http://www.aida.org.au/our-work/partnerships/.

Standard 2. The outcomes of specialist training and education

2.1 Educational purpose

Accreditation standards

2.1.1 The education provider has defined its educational purpose which includes setting and promoting high standards of training, education, assessment, professional and medical practice, and continuing professional development, within the context of its community responsibilities.

2.1.2 The education provider's purpose addresses Aboriginal and Torres Strait Islander peoples of Australia and/or Māori of New Zealand and their health.

2.1.3 In defining its educational purpose, the education provider has consulted internal and external stakeholders.

Notes

Education providers will have both an organisational purpose and an educational or program purpose. While these may be similar, this standard addresses the educational purpose of the education provider.

The community responsibilities embedded in the purpose of the education provider should address the health care needs of the communities it serves and reducing health disparities in the community, most particularly improving health outcomes for Aboriginal and Torres Strait Islander peoples of Australia and Māori of New Zealand, through improving the education of practitioners in Indigenous health.

Education providers are encouraged to engage health consumers when developing specialist medical programs to ensure the programs meet societal needs.

Similarly, education providers should engage the diverse range of employers of medical specialist trainees in developing programs that have due regard to workplace requirements.

The AMC has an expectation that medical specialists will demonstrate cultural competence in their practice of medicine. Both the Medical Board of Australia, in its document, Good Medical Practice[12], and the Medical Council of New Zealand, in its Statement on cultural competence[13], have described their expectation of medical practitioners regarding cultural awareness, safety and competence.

2.2 Program outcomes

Accreditation standards

2.2.1 The education provider develops and maintains a set of program outcomes for each of its specialist medical programs, including any subspecialty programs that take account of community needs, and medical and health practice. The provider relates its training and education functions to the health care needs of the communities it serves.

2.2.2 The program outcomes are based on the role of the specialty and/or field of specialty practice and the role of the specialist in the delivery of health care.

Notes

There are a number of documents that describe the general and common attributes and roles of medical specialists.[14]

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[12] Medical Board of Australia, *Good Medical Practice: A Code of Conduct for Doctors in Australia*, March 2014, http://www.medicalboard.gov.au/Codes-Guidelines-Policies/Code-of-conduct.aspx

[13] Medical Council of New Zealand, *Statement on cultural competence*. August 2006, https://www.mcnz.org.nz/assets/News-and-Publications/Statements/Statement-on-cultural-competence.pdf

[14] Frank, JR., Snell, LS., Sherbino, J., editors. *Draft CanMEDS 2015, Physician Competency Framework – Series III,* Ottawa: The Royal College of Physicians and Surgeons of Canada, 2014 September.

Program outcomes describe what gives a discipline its coherence and identity, and define threshold and typical expectations of a graduate in terms of the abilities and skills needed to develop understanding or competence in the discipline. Education providers are expected to define the broad roles of practitioners in their specialty as the outcomes of the specialist medical program.

Program outcomes are specific to the discipline but should reflect the overall goal of specialist medical training and education which is to produce medical specialists capable of independent practice, able to fill the general roles and multifaceted competencies that are inherent in medical practice, as well as the role of clinical or medical expert in the specialty.

The specialist medical program should provide trainees with the training and education to achieve these outcomes, and the continuing professional development programs should facilitate the maintenance and enhancement of these outcomes throughout the practice lifetime of the specialist. In this way, consideration should be given to ensuring the relationship/connection between specialist medical programs and continuing professional development programs i.e. the continuum of training for skill development and retention.

In considering program outcomes, education providers should consider whether graduates are 'fit for purpose', both in order to attain the award and from the perspective of the patient, stakeholders and the community. This should include reflecting on whether the program is equipping graduates with the necessary and changing knowledge, skills and professional qualities that are not only expected as a practitioner within the specialty but also by consumers and the community.

Consumers and the community expect that changing models of care do not lead to unnecessary fragmentation and/or costs of care. In this respect, education providers' reflection on whether their graduates are fit for purpose should include consideration of the balance between generalism and specialisation in the discipline and its fields of specialty practice in the program outcomes.

2.3 Graduate outcomes

Accreditation standards

2.3.1 The education provider has defined graduate outcomes for each of its specialist medical programs including any subspecialty programs. These outcomes are based on the field of specialty practice and the specialists' role in the delivery of health care and describe the attributes and competencies required by the specialist in this role. The education provider makes information on graduate outcomes publicly available.

Notes

Graduate outcomes are the minimum learning outcomes in terms of discipline-specific knowledge, discipline-specific skills including generic skills as applied in the specialty discipline, and discipline-specific capabilities that the graduate of any given specialist medical program must achieve.

The outcomes should include commitment to professional responsibilities, caring for personal health and wellbeing and the health and wellbeing of colleagues, and adherence to the principles of medical ethics.

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[14] Accreditation Council for Graduate Medical Education (ACGME), *Outcome Project*, ACGME 2003. Note: ACGME revised this information in 2007 when it revised its Common Program Requirements. Refer to the Outcome Project or "The Next Accreditation System (NAS)" http://www.acgme.org/

[14] Medical Council of New Zealand, *Good Medical Practice A Guide for Doctors*, April 2013, https://www.mcnz.org.nz/assets/News-and-Publications/good-medical-practice.pdf

Standard 3. The specialist medical training and education framework

3.1 Curriculum framework

Accreditation standards

3.1.1 For each of its specialist medical programs, the education provider has a framework for the curriculum organised according to the defined program and graduate outcomes. The framework is publicly available.

Notes

Given the population distribution, health care needs and health service configuration in Australia and New Zealand, specialists need to be trained initially in the broad scope of their specialty. It is recognised that their scope of practice will change depending on the context and location in which they practise, as well as their interests and career stage.

The term 'subspecialisation' is frequently used to describe narrow specialisation within a broad specialty. Many specialist medical programs allow trainees to focus their training in a subspecialist area or field of specialty practice. The AMC believes that such training should take account of the broader educational outcomes for the discipline/specialty as a whole. The Australian and New Zealand communities and health systems are better served by avoiding unnecessary fragmentation of medical knowledge, skills and medical care.

3.2 The content of the curriculum

Accreditation standards

3.2.1 The curriculum content aligns with all of the specialist medical program and graduate outcomes.

3.2.2 The curriculum includes the scientific foundations of the specialty to develop skills in evidence-based practice and the scholarly development and maintenance of specialist knowledge.

3.2.3 The curriculum builds on communication, clinical, diagnostic, management and procedural skills to enable safe patient care.

3.2.4 The curriculum prepares specialists to protect and advance the health and wellbeing of individuals through patient-centred and goal-orientated care. This practice advances the wellbeing of communities and populations, and demonstrates recognition of the shared role of the patient/carer in clinical decision-making.

3.2.5 The curriculum prepares specialists for their ongoing roles as professionals and leaders.

3.2.6 The curriculum prepares specialists to contribute to the effectiveness and efficiency of the health care system, through knowledge and understanding of the issues associated with the delivery of safe, high-quality and cost-effective health care across a range of health settings within the Australian and/or New Zealand health systems.

3.2.7 The curriculum prepares specialists for the role of teacher and supervisor of students, junior medical staff, trainees, and other health professionals.

3.2.8 The curriculum includes formal learning about research methodology, critical appraisal of literature, scientific data and evidence-based practice, so that all trainees are research literate. The program encourages trainees to participate in research. Appropriate candidates can enter research training during specialist medical training and receive appropriate credit towards completion of specialist training.

3.2.9 The curriculum develops a substantive understanding of Aboriginal and Torres Strait Islander health, history and cultures in Australia and Māori health, history and cultures in New Zealand as relevant to the specialty(s).

3.2.10 The curriculum develops an understanding of the relationship between culture and health. Specialists are expected to be aware of their own cultural values and beliefs, and to be able to interact with people in a manner appropriate to that person's culture.

Notes

The curriculum must advance trainees' knowledge of the basic principles of research, including how research is conducted, evaluated, explained to patients, and applied to patient care. Trainees should participate in an induction to research that includes codes of conduct, ethics, occupational health and safety, intellectual property and any additional matters that are necessary for the type of research to be undertaken.

The academic development and leadership of individual disciplines depends on some trainees following an academic pathway. Academic advancement in Australia and New Zealand requires demonstration of merit in research as well as clinical activity and teaching. The specialist medical program can facilitate an early start to research, through intercalated research degrees, with appropriate credit towards completion of the program. Trainee presentation of research projects at discipline scientific meetings is highly desirable.

Acquiring knowledge and understanding of the issues associated with the delivery of safe care includes participating in quality and safety systems within health care organisations.

3.3 Continuum of training, education and practice

Accreditation standards

3.3.1 There is evidence of purposeful curriculum design which demonstrates horizontal and vertical integration, and articulation with prior and subsequent phases of training and practice, including continuing professional development.

3.3.2 The specialist medical program allows for recognition of prior learning and appropriate credit towards completion of the program.

Notes

Specialist training is one step in the education of medical practitioners. Other phases, under separate jurisdictions in Australia and New Zealand, include primary medical education, prevocational training, research training, and continuing professional development.

Specialist training and education builds on the knowledge, skills and professional qualities developed in other phases and cannot be considered in isolation from those earlier phases, particularly the education, experience and training obtained during the intern year and other prevocational training. A complementary relationship is essential.

The AMC supports activities to develop the linkage between primary medical education, prevocational training and vocational training. It also considers that collaboration between the various bodies concerned with medical education is essential to achieve appropriate quality assurance and efficiency across the continuum of medical education.

Recognition of prior learning policies should support trainees to transition between specialist medical programs with appropriate credit.

3.4 Structure of the curriculum

Accreditation standards

3.4.1 The curriculum articulates what is expected of trainees at each stage of the specialist medical program.

3.4.2 The duration of the specialist medical program relates to the optimal time required to achieve the program and graduate outcomes. The duration is able to be altered in a flexible manner according to the trainee's ability to achieve those outcomes.

3.4.3 The specialist medical program allows for part-time, interrupted and other flexible forms of training.

3.4.4 The specialist medical program provides flexibility for trainees to pursue studies of choice that promote breadth and diversity of experience, consistent with the defined outcomes.

Notes

In determining the duration of the program, education providers should consider:

- the outcomes of the primary and prevocational medical education stages related to the specialty discipline
- the program and graduate outcomes for the specialist medical program, and the role of the specialist in the health sector
- possible alternatives to time-based educational requirements such as outcomes-defined program elements, measurements of competencies, logbooks of clinical skills and workplace experiences. Such alternatives depend highly on agreed valid and reliable methods for measuring individual achievements.

Policies about flexible training options should be readily available to supervisors and trainees. Education providers should provide guidance and support to supervisors and trainees on the implementation and review of flexible training arrangements.

Education providers are encouraged to monitor the take up of flexible training options, and to measure their success by incorporating appropriate questions in surveys and by analysing the pattern of applications by trainees. They are also encouraged to work with the training sites and employers to create appropriate opportunities for flexible training.

Standard 4. Teaching and learning

4.1 Teaching and learning approach

Accreditation standards

4.1.1 The specialist medical program employs a range of teaching and learning approaches, mapped to the curriculum content to meet the program and graduate outcomes.

4.2 Teaching and learning methods

Accreditation standards

4.2.1 The training is practice-based, involving the trainees' personal participation in appropriate aspects of health service, including supervised direct patient care, where relevant.

4.2.2 The specialist medical program includes appropriate adjuncts to learning in a clinical setting.

4.2.3 The specialist medical program encourages trainee learning through a range of teaching and learning methods including, but not limited to: self-directed learning; peer-to-peer learning; role modelling; and working with interdisciplinary and interprofessional teams.

4.2.4 The training and education process facilitates trainees' development of an increasing degree of independent responsibility as skills, knowledge and experience grow.

Notes

It is expected that, predominantly, training and education will be a balance of work-based experiential learning, independent self-directed learning and appropriate supplementary learning experiences. While much of the learning will be self-directed learning related to program and graduate outcomes, the trainee's supervisors will play key roles in the trainee's education.

Learning resources that are specified or recommended for the specialist medical program should relate directly to the graduate outcomes, be up to date and be accessible to trainees.

Adjuncts to learning in a clinical setting include clinical skills laboratories, wet labs and simulated patient environments.

In some specialties, trainees must complete education courses offered by other education providers, for example university programs, to meet the requirements of the specialist medical program. In these situations, the AMC expects the education provider for the specialist medical program to review and monitor the quality of the externally provided courses and the courses' continued relevance to the requirements of the specialist medical program.

Standard 5. Assessment of learning

5.1 Assessment approach

Accreditation standards

5.1.1 The education provider has a program of assessment aligned to the outcomes and curriculum of the specialist medical program which enables progressive judgements to be made about trainees' preparedness for specialist practice.

5.1.2 The education provider clearly documents its assessment and completion requirements. All documents explaining these requirements are accessible to all staff, supervisors and trainees.

5.1.3 The education provider has policies relating to special consideration in assessment.

Notes

Assessment includes both summative assessment, for judgements about progression, and formative assessment, for feedback and guidance. Formative assessment has an integral role in the education of trainees as it enables the trainee to identify perceived deficiencies, and the supervisor to assist in timely and effective remediation. It also provides positive feedback to trainees regarding their attainment of knowledge, skills and professional qualities.

The education provider's documents defining the assessment methods should address and outline the balance between formative and summative elements, the number and purpose of examinations (including a balance between written and practical examinations) and other assessment requirements. It should make explicit the criteria and methods used to make assessment judgments.

Policies on special consideration should be easily accessible. They should outline reasonable adjustments for trainees with short- or long-term conditions and circumstances which may affect assessment performance.

5.2 Assessment methods

Accreditation standards

5.2.1 The assessment program contains a range of methods that are fit for purpose and include assessment of trainee performance in the workplace.

5.2.2 The education provider has a blueprint to guide assessment through each stage of the specialist medical program.

5.2.3 The education provider uses valid methods of standard setting for determining passing scores.

Notes

Methods of assessment should be chosen on the basis of validity, reliability, feasibility, cost effectiveness, opportunities for feedback, and impact on learning.[15] The assessment methodology should be publicly available.

Contemporary approaches to assessment in medical education emphasise a programmatic approach where multiple measures of trainees' knowledge, skills and professional qualities over time are aggregated and synthesised to inform judgements about progress. Assessment programs are constructed through blueprints which match assessment items or instruments with outcomes. The strength of an assessment program is judged at the overall program level rather than on the psychometric properties of individual instruments. In such an approach, highly reliable methods associated with high stakes examinations such as multiple choice questions (MCQ), modified essay questions (MEQ) or objective structured clinical examinations (OSCE) are used alongside instruments which are currently less reliable but assess independent learning,

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[15] van der Vleuten, CPM., 'The assessment of professional competence: developments, research and practical implications'. *Advances in Health Science Education,* vol. 1, 1996, pp. 41-67.

communication with patients, families and colleagues, working in interprofessional teams, professional qualities, problem solving and clinical reasoning.

The AMC encourages the development of assessment programs for their educational impact. A balance of valid, reliable and feasible methods should drive learning to achieve the program and graduate outcomes.

In clinical specialties, direct observation of trainees with real or simulated patients should form a significant component of the assessment.

5.3 Performance feedback

Accreditation standards

5.3.1 The education provider facilitates regular and timely feedback to trainees on performance to guide learning.

5.3.2 The education provider informs its supervisors of the assessment performance of the trainees for whom they are responsible.

5.3.3 The education provider has processes for early identification of trainees who are not meeting the outcomes of the specialist medical program and implements appropriate measures in response.

5.3.4 The education provider has procedures to inform employers and, where appropriate, the regulators, where patient safety concerns arise in assessment.

Notes

Trainees encounter difficulties for many reasons including problems with systems, teaching, supervision, learning, assessment performance and personal difficulties. Not all are within the power of the trainee to rectify. It is essential that education providers have systems to monitor their trainees' progress, to identify at an early stage trainees experiencing difficulty and where possible to assist them to complete the specialist medical program successfully using methods such as remedial work and re-assessment, supervision and counselling.

There may be times where it is not appropriate to offer remediation or the remediation and assistance offered is not successful. For these circumstances, education providers must have clear policies on matters such as periods of unsatisfactory training and limits on duration of training time. As specialist medical training is workplace-based, education providers need to have processes for deciding when to inform employers of a trainee's failure to progress.

Trainees should be told the content of any information about them that is given to someone else.

While the employer will often identify patient safety concerns first, it is important that the provider has clear procedures concerning informing employers and, where appropriate, the regulators. The requirement under standard 5.3.4 to inform employers and, where appropriate, the regulator about patient safety concerns will require action beyond remediation.

In Australia, education providers must also be aware of the Health Practitioner Regulation National Law. This requires registered health practitioners and employers to make notifications about registered medical practitioners who have engaged in 'notifiable conduct' as defined in the National Law. Notifiable conduct by trainees must be reported to the Medical Board of Australia immediately. In New Zealand, the Health Practitioners Competence Assurance Act 2003 provides for a medical practitioner who believes another medical practitioner may pose a risk of harm to the public by practising below the required standard of competence to refer the matter to the Medical Council of New Zealand.

5.4 Assessment quality

Accreditation standards

5.4.1 The education provider regularly reviews the quality, consistency and fairness of assessment methods, their educational impact and their feasibility. The provider introduces new methods where required.

5.4.2 The education provider maintains comparability in the scope and application of the assessment practices and standards across its training sites.

Notes

Assessment should actively promote learning that will assist in achieving the educational outcomes, provide a fair assessment of the trainee's achievement, and ensure patient safety by allowing only competent trainees to progress to become medical specialists.

When the program and graduate outcomes of the specialist medical program or a component of the program change, the assessment process and methods should reflect these changes; assessment should address and be developed in conjunction with the new outcomes. Similarly, new or revised assessments should be introduced where evaluation of specific curriculum components and associated assessment reveals a need.

Reviews of assessment methods should also regularly consider the overall burden of assessment, and result in removal of ineffective assessment methods and individual assessment items that duplicate rather than add to previous assessments.

Specialist medical trainees undertake their work-based training in a wide variety of training sites. It is essential that education providers have systems to minimise variation in the quality of in-training assessment across training sites in all settings.

Standard 6. Monitoring and evaluation

6.1 Monitoring

Accreditation standards

6.1.1 The education provider regularly reviews its training and education programs. Its review processes address curriculum content, teaching and learning, supervision, assessment and trainee progress.

6.1.2 Supervisors contribute to monitoring and to program development. The education provider systematically seeks, analyses and uses supervisor feedback in the monitoring process.

6.1.3 Trainees contribute to monitoring and to program development. The education provider systematically seeks, analyses and uses their confidential feedback on the quality of supervision, training and clinical experience in the monitoring process. Trainee feedback is specifically sought on proposed changes to the specialist medical program to ensure that existing trainees are not unfairly disadvantaged by such changes.

Notes

Education providers should develop mechanisms for monitoring the delivery of their program(s) and for using the results to assess achievement of educational outcomes. This requires the collection of data from a broad range of people involved in training and education and from trainees, and the use of appropriate monitoring methods.

The value of monitoring data is enhanced by a plan that articulates the purpose and procedures for conducting the monitoring, such as why the data are being collected, the sources, methods and frequency of data analysis.

Some examples of changes that may unfairly disadvantage existing trainees include those that lengthen the period of training, introduce more assessment, or change the range or kinds of training placements required to satisfy program requirements.

6.2 Evaluation

Accreditation standards

6.2.1 The education provider develops standards against which its program and graduate outcomes are evaluated. These program and graduate outcomes incorporate the needs of both graduates and stakeholders and reflect community needs, and medical and health practice.

6.2.2 The education provider collects, maintains and analyses both qualitative and quantitative data on its program and graduate outcomes.

6.2.3 Stakeholders contribute to evaluation of program and graduate outcomes.

Notes

When formulating and evaluating its program and graduate outcomes, the education provider considers the needs and expectations of both graduates and stakeholders. This occurs from the level of individual graduate attributes through to the level of overall workforce demand. Education providers should consider methods of evaluation that ensure that recently graduated specialists are of a standard commensurate with community expectation, such as specialist self-assessment of preparedness for practice, review of graduate destinations and community requirements, and other multi-source feedback mechanisms. Stakeholders in evaluation processes include supervisors, trainees, health care administrators, health professionals and consumers.

6.3 Feedback, reporting and action

Accreditation standards

6.3.1 The education provider reports the results of monitoring and evaluation through its governance and administrative structures.

6.3.2 The education provider makes evaluation results available to stakeholders with an interest in program and graduate outcomes, and considers their views in continuous renewal of its program(s).

6.3.3 The education provider manages concerns about, or risks to, the quality of any aspect of its training and education programs effectively and in a timely manner.

Notes

It is important that education providers report their program and graduate outcomes transparently and accountably, which includes how stakeholder feedback is analysed and incorporated into future changes, and how the changes are communicated to stakeholders. Education providers are therefore expected to develop and maintain effective internal reporting mechanisms, and to indicate how and when actions occur in relation to particular findings. In addition, education providers are expected to disseminate its program and graduate outcomes and engage in a dialogue with stakeholders. There should be evidence that stakeholder views are considered in continuous renewal of the education program(s).

Standard 7. Trainees

7.1 Admission policy and selection

Accreditation standards

7.1.1 The education provider has clear, documented selection policies and principles that can be implemented and sustained in practice. The policies and principles support merit-based selection, can be consistently applied and prevent discrimination and bias.

7.1.2 The processes for selection into the specialist medical program:

- use the published criteria and weightings (if relevant) based on the education provider's selection principles
- are evaluated with respect to validity, reliability and feasibility
- are transparent, rigorous and fair
- are capable of standing up to external scrutiny
- include a process for formal review of decisions in relation to selection which is outlined to candidates prior to the selection process.

7.1.3 The education provider supports increased recruitment and selection of Aboriginal and Torres Strait Islander and/or Māori trainees.

7.1.4 The education provider publishes the mandatory requirements of the specialist medical program, such as periods of rural training, and/or for rotation through a range of training sites so that trainees are aware of these requirements prior to selection. The criteria and process for seeking exemption from such requirements are made clear.

7.1.5 The education provider monitors the consistent application of selection policies across training sites and/or regions.

Notes

The AMC does not endorse any one selection process; it recognises that there is no one agreed method of selecting the most appropriate trainees and supports diverse approaches that include both academic and vocational considerations.

In 1998, the Medical Training Review Panel commissioned the report, *Trainee Selection in Australian Medical Colleges*. This report describes good practice in the selection of trainees into specialist medical programs. These standards draw on that report.[16]

The education provider, as the professional body for a particular medical specialty or specialties, should take a leadership role in the development of the criteria for selection of entrants into training for the specialty. Trainees are both postgraduate students in specialist medical programs and employees of the health services. This may cause tension between selection into a specialist medical program and employment. The AMC expects collaboration between the education provider and other stakeholders to determine selection criteria and processes. Training selection panel members on selection processes will add to the rigour of this process.

Due to this tension, selection into a specialist medical program can occur through several different mechanisms, often with the interlinking of processes for selection for employment and selection for training. In some situations the education provider performs the primary selection with employment assured for those selected into the specialist medical program. In other situations, the reverse may occur with employment into a training 'position' as the primary selection mechanism.

[16] Brennan P. *Trainee selection in Australian medical colleges*. Canberra: Medical Training Review Panel, Commonwealth Department of Health and Family Services, 1998.

In the latter situation, in which selection is delegated to an employer or training provider, the AMC expects the education provider will work actively to obtain the cooperation of such other stakeholders in implementing its selection principles.

Strategies to increase recruitment and selection of Aboriginal and Torres Strait Islander and/or Māori trainees should be complemented by retention policies.

The education provider should facilitate opportunities to increase recruitment and selection of rural origin trainees and trainees from other under-represented groups.

Despite the wide variety of selection policies and processes, the AMC recognises a number of benefits to regional coordination of selection processes for both trainees and the employing health services, particularly in ensuring the consistent application of selection policies.

7.2 Trainee participation in education provider governance

Accreditation standard

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

Notes

There are many reasons for trainee participation in education provider governance. From the trainees' perspective, it will promote their understanding of, and engagement in, the specialist medical program and will encourage them to be active contributors to ongoing training and education in their specialty. From a program perspective, it will enable governance decisions to be informed by the users' view of the program and will enhance the education provider's understanding of how training and assessment policies work in practice. It also facilitates the early recognition of, and response to, potential program problems, allowing the identification and deployment of successful strategies to address these.

Governance structures vary between education providers. The AMC does not endorse any particular structure for engaging trainees in the governance of their training, but believes that these processes and structures must be formal and give appropriate weight to the views of trainees.

Recognising the constraints inherent in the education provider's structure, there should be a position for a trainee on the governing council and on every body making training-related decisions. Such constraints may include the education provider's constitution or articles of association, conflicts of interest, and the privacy of other trainees.

The trainees involved should be appointed through open, fair processes supported by the education provider. Election by the trainee body is the most open process possible and is encouraged.

A trainee organisation or trainee committee can articulate a general overview of trainees' experience and common concerns, as well as promoting communication between trainees on matters of mutual interest, and facilitating trainee representation on committees. There are advantages in establishing this committee or organisation within the education provider, since this facilitates communication and sharing of information and data, and provides a structure for funding.

Where the trainee organisation sits outside the education provider, particular efforts are required to ensure shared understanding of obligations and expectations.

Trainee representatives, and trainee organisations or committees are able to assist the education provider by gathering and disseminating information. For these roles, they require appropriate support. This could include providing administrative support or infrastructure, providing mechanisms for the trainee organisation and the trainee members of education provider committees to communicate with trainees, such as access to contact details or email lists, and designating a staff member to support the trainees in these activities. Consideration should also be given to training trainee representatives for their roles. Support that enables trainee representatives to be freed from clinical service commitments to attend necessary meetings should also be considered.

Education providers should supplement the perspective obtained through the trainee organisation or trainee committee by seeking feedback from individual trainees. The trainee representative structure should be complemented by regular meetings between the education provider's officers and its trainees to explore concerns and ideas at a local level. Because trainees' needs and concerns differ depending on their stage and location of training, and personal circumstances, education providers should arrange for contribution from the full breadth of the trainee cohort.

Local and regional educational activities also provide opportunities for trainees to share problems and experiences with peers, and for trainee representatives to canvas views on training-related issues.

7.3 Communication with trainees

Accreditation standards

7.3.1 The education provider has mechanisms to inform trainees in a timely manner about the activities of its decision-making structures, in addition to communication from the trainee organisation or trainee representatives.

7.3.2 The education provider provides clear and easily accessible information about the specialist medical program(s), costs and requirements, and any proposed changes.

7.3.3 The education provider provides timely and correct information to trainees about their training status to facilitate their progress through training requirements.

Notes

Education providers are expected to interact with their trainees in a timely, open and transparent way. To this end, they should have mechanisms to inform prospective and enrolled trainees of training policies and processes, including but not limited to:

- selection into the specialist medical program(s)
- the design, requirements and costs of the specialist medical program(s)
- proposed changes to the design, requirements and costs of the specialist medical program(s)
- the available support systems and career guidance
- recognition of prior learning and flexible training options.

Changes in the content and structure of specialist medical programs have significant consequences for trainees. Trainees should participate formally in the evolution and change of the program. Education providers should communicate in advance with trainees about proposed program changes, be guided by the principle of 'no unfair disadvantage to trainees' specified under standard 6.1.3, and propose special arrangements for those already enrolled when changes are implemented, recognising that sometimes program changes are required due to evolving professional practice and community needs.

In general, the AMC supports the generous application of transitional exemption clauses and retrospective recognition of training completed under previous requirements and regulations.

To assist trainees to make informed choices about a specialist medical program and location, information on career pathways, addressing workforce distribution issues and training opportunities in different regions/states, should be available. Education providers are encouraged to collaborate with stakeholders in workforce planning activities for the specialty, including jurisdictions, to support career guidance systems.

Education providers are encouraged to supplement written material about specialist medical program requirements with electronic communication of up-to-date information on training regulations, and on trainees' individual training status. Mechanisms to support communication on issues of concern such as job sharing and part-time work should also be considered. It is recognised that many of the issues relating to job sharing and part-time work rest with the employer.

7.4 Trainee wellbeing

Accreditation standards

7.4.1 The education provider promotes strategies to enable a supportive learning environment.

7.4.2 The education provider collaborates with other stakeholders, especially employers, to identify and support trainees who are experiencing personal and/or professional difficulties that may affect their training. It publishes information on the services available.

Notes

Education providers can provide a supportive learning environment by promoting strategies to maintain health and wellbeing, including mental health and cultural safety, providing professional development activities to enhance understanding of wellness and appropriate behaviours, and ensuring availability of confidential support and complaint services. The education provider should facilitate education about, and identification, management and support for trainees who have experienced discrimination, bullying and sexual harassment.

The education provider should consider the needs of groups of trainees that may require additional support to complete training, such as Aboriginal and Torres Strait Islander and/or Māori trainees.

Areas for collaboration between the education provider and other stakeholders include developing processes for identifying, supporting and managing trainees whose progress or performance, health, or conduct is giving rise to concern and those trainees who experience personal and professional difficulties related to others' behaviour towards the trainee.

7.5 Resolution of training problems and disputes

Accreditation standards

7.5.1 The education provider supports trainees in addressing problems with training supervision and requirements, and other professional issues. The education provider's processes are transparent and timely, and safe and confidential for trainees.

7.5.2 The education provider has clear impartial pathways for timely resolution of professional and/or training-related disputes between trainees and supervisors or trainees and the education provider.

Notes

Supervisors and their trainees have a particularly close relationship, which has special benefits, but which may also lead to unique problems. Trainees need clear advice on what they should do in the event of conflict with their supervisor or any other person intimately involved in their training. Clear statements concerning the supervisory relationship can avert problems for both trainees and supervisors.

Processes that allow trainees to raise difficulties safely would typically be processes that give trainees confidence that the education provider will act fairly and transparently, that trainees will not be disadvantaged by raising legitimate concerns, and that their complaint will be acted upon in a timely manner.

Trainees may experience difficulties that are relevant to both their employment and their position as a trainee, such as training in an unsafe environment, discrimination, bullying, and sexual harassment. While education providers do not have direct control of the working environment, in setting standards for training and for professional practice, including training site accreditation, they have responsibilities to advocate for an appropriate training environment.

Trainees who experience difficulties often feel vulnerable in raising questions about their training, assessment or supervision, even anonymously, and can be concerned about being identified and potentially disadvantaged as a consequence. Often the same individuals hold positions in the education provider and senior supervisory positions in hospitals and health services, which may lead to conflicts of interest, especially if the trainee has a grievance about either their employment or training. Practical solutions are required to remove the disincentives for trainees to raise concerns about their training or employment.

Standard 8. Implementing the program – delivery of education and accreditation of training sites

8.1 Supervisory and educational roles

Accreditation standards

8.1.1 The education provider ensures that there is an effective system of clinical supervision to support trainees to achieve the program and graduate outcomes.

8.1.2 The education provider has defined the responsibilities of hospital and community practitioners who contribute to the delivery of the specialist medical program and the responsibilities of the education provider to these practitioners. It communicates its program and graduate outcomes to these practitioners.

8.1.3 The education provider selects supervisors who have demonstrated appropriate capability for this role. It facilitates the training, support and professional development of supervisors.

8.1.4 The education provider routinely evaluates supervisor effectiveness including feedback from trainees.

8.1.5 The education provider selects assessors in written, oral and performance-based assessments who have demonstrated appropriate capabilities for this role. It provides training, support and professional development opportunities relevant to this educational role.

8.1.6 The education provider routinely evaluates the effectiveness of its assessors including feedback from trainees.

Notes

The AMC recognises that the word 'supervisor' is used in the workplace to describe an administrative or managerial function equivalent to a line manager, but in this document it refers to supervision in the educational context.

Education providers will devise and implement their own structures in response to specific goals and challenges, but the following functions are common in the educational supervision of trainees. These functions may be combined in different ways and in large programs performed by a number of individuals:

- An individual with overall responsibility for the specialist medical program in a health service, training site or training network. This director oversees and ensures the quality of training and education rather than being involved on a day-to-day basis with all trainees in the work environment.
- Medical practitioners senior to the trainees who have day-to-day involvement with the trainee.
- An individual who has particular responsibility for the direct supervision and training of the trainee, whose involvement with that trainee during the working week is regular and appropriate for the trainee's level of training, ability, and experience.

Medical practitioners make significant contributions to medical education as teachers and role models for trainees. The educational roles of supervisor and assessor are critical to the success of the specialist medical program, especially as most specialist training is workplace-based. It is essential that there is adequate training and resources for these roles. Those filling supervisory roles should know the program requirements, and have skills in adult learning, in providing constructive feedback to trainees, and in responding appropriately to concerns. They need clear guidance on their responsibilities to the trainee and to patient safety in the event that the trainee is experiencing difficulty, including in circumstances where the trainee is not maintaining a satisfactory standard of clinical practice and/or is not meeting the expected fitness to practise standards.

All those who teach, supervise, counsel, employ or work with medical practitioners in training are responsible for patient safety. Patient safety will be protected through explicit and accountable supervision. Education providers should have clear and explicit supervision requirements, including processes for removing supervisors where necessary.

Other members of the health care team may also contribute to supervising, assessing and providing feedback to the trainee.

There are advantages for trainees to an ongoing mentoring relationship with a more senior medical colleague. This person has no formal role in the trainee's assessment or employment but can advise and support the trainee on personal or professional matters.

Education providers should encourage mentorship through a variety of their educational activities. They should also develop processes for supporting the professional development of medical practitioners who demonstrate appropriate capability for the role of mentor.

Because of the critical nature of the supervisory roles outlined above, it is essential that there are clear procedures for trainees and supervisors to follow in the event of conflict. Accreditation standards in relation to the resolution of training-related problems and disputes are provided under standard 7.5.

Assessors engaged in formative or summative assessments must understand the education provider's curriculum and training requirements, be proficient in the issues relating to the level of competence and training of the trainee, and skilled in providing feedback. Those assessing trainees should participate in training and education addressing issues such as constructive feedback, dealing with difficult situations and contemporary assessment methods.

8.2 Training sites and posts

Accreditation standards

8.2.1 The education provider has a clear process and criteria to assess, accredit and monitor facilities and posts as training sites. The education provider:

- applies its published accreditation criteria when assessing, accrediting and monitoring training sites
- makes publicly available the accreditation criteria and the accreditation procedures
- is transparent and consistent in applying the accreditation process.

8.2.2 The education provider's criteria for accreditation of training sites link to the outcomes of the specialist medical program and:

- promote the health, welfare and interests of trainees
- ensure trainees receive the supervision and opportunities to develop the appropriate knowledge and skills to deliver high-quality and safe patient care, in a culturally safe manner
- support training and education opportunities in diverse settings aligned to the curriculum requirements including rural and regional locations, and settings which provide experience of the provisions of health care to Aboriginal and Torres Strait Islander peoples in Australia and/or Māori in New Zealand
- ensure trainees have access to educational resources, including information communication technology applications, required to facilitate their learning in the clinical environment.

8.2.3 The education provider works with jurisdictions, as well as the private health system, to effectively use the capacity of the health care system for work-based training, and to give trainees experience of the breadth of the discipline.

8.2.4 The education provider actively engages with other education providers to support common accreditation approaches and sharing of relevant information.

Notes

Since training and education in most specialties takes place in health services, specialist medical training is a shared responsibility between the education providers and these training sites. The quality of the learning experience depends on the support the unit or service provides.

Education providers have formal processes to select and accredit training sites, and the process and requirements for accreditation vary depending on the medical specialty. Many commonalities exist between education providers' processes but so do inconsistencies. The AMC recognises the significant interest of training sites and education providers in ongoing quality improvements in and streamlining of these processes, including where relevant, greater sharing of information or processes between providers. The

AMC endorses work to develop tools to support consistent approaches to accreditation, such as the Accreditation of Specialist Medical Training Sites Project.[17] The accreditation standards under 8.2.2 draw on the domains for accreditation in that report and education providers are encouraged to use these standards.

Education providers define the range of experience to be gained during training. Education providers should make as explicit as possible the expectations of training sites seeking accreditation, including clinical and other experience, education activities and resources, and expectations for flexible training options. Education provider accreditation processes must verify that this experience is available in training sites seeking accreditation and once accredited must evaluate the trainees' experience in those sites.

The accreditation process should result in a report to the training site. Where accreditation criteria are not met, the report should give guidance so that the training site may address any unmet requirements.

Trainees are likely to gain experience in multiple locations each providing a varying range of experiences of the specialist discipline. For this reason, education providers are increasingly accrediting networks of training sites rather than expecting a single training site to provide all the required training experience, and while all training sites should satisfy the education provider's accreditation criteria, the AMC encourages flexible rather than restrictive approaches that enable the capacity of the health care system to be used most effectively for training.

[17] Australian Health Ministers' Advisory Council Health Workforce Principal Committee, *Accreditation of Specialist Medical Training Sites Project Final Report*, 2013

Standard 9. Continuing professional development, further training and remediation

9.1 Continuing professional development

Accreditation standards

9.1.1 The education provider publishes its requirements for the continuing professional development (CPD) of specialists practising in its specialty(s).

9.1.2 The education provider determines its requirements in consultation with stakeholders and designs its requirements to meet Medical Board of Australia and Medical Council of New Zealand requirements.

9.1.3 The education provider's CPD requirements define the required participation in activities that maintain, develop, update and enhance the knowledge, skills and performance required for safe and appropriate contemporary practice in the relevant specialty(s), including for cultural competence, professionalism and ethics.

9.1.4 The education provider requires participants to select CPD activities relevant to their learning needs, based on their current and intended scope of practice within the specialty(s). The education provider requires specialists to complete a cycle of planning and self-evaluation of learning goals and achievements.

9.1.5 The education provider provides a CPD program(s) and a range of educational activities that are available to all specialists in the specialty(s).

9.1.6 The education provider's criteria for assessing and crediting educational and scholarly activities for the purposes of its CPD program(s) are based on educational quality. The criteria for assessing and crediting practice-reflective elements are based on the governance, implementation and evaluation of these activities.

9.1.7 The education provider provides a system for participants to document their CPD activity. It gives guidance to participants on the records to be retained and the retention period.

9.1.8 The education provider monitors participation in its CPD program(s) and regularly audits CPD program participant records. It counsels participants who fail to meet CPD cycle requirements and takes appropriate action.

Notes

In Australia and New Zealand the community expects that registered medical practitioners will maintain, develop, update and enhance their knowledge, skills and performance so that they are equipped to deliver safe and appropriate care throughout their working lives.

The Medical Board of Australia sets registration standards that require medical practitioners to participate in CPD in Australia. In New Zealand, the Medical Council of New Zealand sets requirements for recertification and CPD under the *Health Practitioners Competence Assurance Act 2003*. The same requirements apply to specialists practising full- and part-time. In both countries, medical practitioners are asked whether they are complying with registration requirements for CPD/recertification when applying for re-registration or recertification and practitioner responses are subject to audit.

In addition to these accreditation standards, the Medical Council of New Zealand has criteria for education providers supporting medical practitioners in vocational scopes of practice in New Zealand that include the mandatory activities required for recertification.

Education providers play an important role in assisting CPD by setting the requirements for CPD and providing a CPD program(s) that is available to all specialists in their specialty(s), including those who are not fellows.

The CPD phase of medical education is mainly self-directed and involves practice-based learning activities rather than supervised training. The education provider therefore requires regular participation in a range of educational activities to meet self-assessed learning needs based on the intended scopes of practice of specialists and, where possible, on practice data. These activities include: practice-based reflective elements that may include clinical audit, peer-review, multi-source feedback or performance appraisal; continuing

medical education activities, such as courses, conferences and online learning; other scholarly activities such as teaching, assessment and research; and activities that contribute to cultural competence, and medical practitioner health and wellbeing.

The AMC encourages education providers to include in their CPD program resources a framework to assist specialists to assess and define their learning needs. Where available and appropriate, participation in external or formal evaluation of personal CPD outcomes is encouraged.

Consultation with potential participants and other stakeholders is important in the development of CPD requirements and programs. Self-evaluation by participants, and monitoring and auditing by the education provider assist participants in achieving their CPD objectives.

Many organisations other than accredited education providers offer CPD opportunities for specialists, including health care facilities, universities, the pharmaceutical and medical technological industries, community and health consumer organisations and for-profit CPD providers. Education providers are expected to have a code of ethics that covers the role of, and their relationship with, other groups that provide CPD activities that may be credited towards the education provider's CPD program(s). In reviewing the educational quality of an activity, the education provider should consider whether the activity has used appropriate methods and resources, and the feedback from participants.

The AMC acknowledges that participation in CPD cannot guarantee competence.

9.2 Further training of individual specialists

Accreditation standards

9.2.1 The education provider has processes to respond to requests for further training of individual specialists in its specialty(s).

Notes

Regulatory authorities set requirements for recency of practice in a medical practitioner's current scope of practice, and requirements to support proposed changes to a medical practitioner's scope of practice. Specialists, employers and registration authorities may ask an education provider to provide further training to meet recency of practice requirements, or to support a change in scope of practice. Education providers develop processes specific to their specialty(s) for practice re-entry and training in new scopes of practice for their fellows and other specialists, consistent with requirements of the Medical Board of Australia and, if relevant, the Medical Council of New Zealand.

9.3 Remediation

Accreditation standards

9.3.1 The education provider has processes to respond to requests for remediation of specialists in its specialty(s) who have been identified as underperforming in a particular area.

Notes

Laws, regulations and codes of conduct set expectations for standards of practice of medical practitioners. Requests to an education provider to address under-performance are made by specialists, employers and registration authorities, or may arise within the education provider itself. Education providers develop processes specific to their specialty(s) for remediation of specialists in the discipline, consistent with relevant laws, regulation and codes of conduct.

Standard 10. Assessment of specialist international medical graduates

10.1 Assessment framework

Accreditation standards

10.1.1 The education provider's process for assessment of specialist international medical graduates is designed to satisfy the guidelines of the Medical Board of Australia and the Medical Council of New Zealand.

10.1.2 The education provider bases its assessment of the comparability of specialist international medical graduates to an Australian- or New Zealand- trained specialist in the same field of practice on the specialist medical program outcomes.

10.1.3 The education provider documents and publishes the requirements and procedures for all phases of the assessment process, such as paper-based assessment, interview, supervision, examination and appeals.

Notes

In Australia, the Health Practitioner Regulation National Law, as in force in each state and territory, provides for the registration of specialist international medical graduates who have successfully completed any examination or assessment required by an approved registration standard to assess a specialist international medical graduate's ability to practise competently and safely in the specialty.

The Medical Board of Australia has decided that the examination or assessment will be undertaken by the specialist medical colleges that are accredited by the AMC. It relies on these assessments to make decisions about whether to grant registration to a particular specialist international medical graduate. The Medical Board has prepared guidelines to support specialist medical colleges in their role of assessing specialist international medical graduates for comparability to an Australian-trained specialist in the same field of specialty practice.[18] These accreditation standards draw on that guidance.

The requirements for specialist registration in Australia differ from the requirements for registration in New Zealand. The assessment of specialist international medical graduates in New Zealand needs to meet the requirements of the Medical Council of New Zealand which are based on legislative requirements. The Medical Council of New Zealand requires education providers to have a process for the assessment of specialist international medical graduates' training, qualifications and experience so that the Medical Council can determine eligibility for registration within a vocational scope of practice.

The AMC expects that the medical practitioners whose qualifications, training and experience are being assessed through these processes would be able to access the education provider's review and appeals processes (see standard 1.3).

10.2 Assessment methods

Accreditation standards

10.2.1 The methods of assessment of specialist international medical graduates are fit for purpose.

10.2.2 The education provider has procedures to inform employers, and where appropriate the regulators, where patient safety concerns arise in assessment.

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[18] Medical Board of Australia, *Good practice guidelines for the specialist international medical graduate assessment process*, November 2015, http://www.medicalboard.gov.au/Registration/International-Medical-Graduates/Specialist-Pathway.aspx

Notes

Methods of assessment should be chosen on the basis of validity, reliability, feasibility, cost effectiveness, opportunities for feedback, and impact on learning.[19] The assessment methodology should be publically available.

The assessment of specialist international medical graduates should include assessment of their ability to contribute to the effectiveness and efficiency of the health care system (standard 3.2.6) and of their cultural competence for practice in Australia and/or New Zealand (standards 3.2.9 and 3.2.10).

In Australia, the 'specialist pathway' is for international medical graduates with overseas specialist qualifications who wish to qualify for specialist registration in Australia. The assessment determines whether the applicant is comparable to an Australian-trained specialist in the same field of practice.

The 'area of need pathway' is for specialist international medical graduates who wish to work in Australia in a designated area of need. The education provider assesses the applicant's qualifications and relevant experience against the specified requirements of a position in a confirmed area of need to determine the applicant's ability to practise safely and competently in the position.

The requirement under standard 10.2.2 to inform employers and, where appropriate, the regulator about patient safety concerns will require action beyond remediation.

In New Zealand, the *Health Practitioners Competence Assurance Act 2003* provides for a medical practitioner who believes another medical practitioner may pose a risk of harm to the public by practising below the required standard of competence to refer the matter to the Medical Council of New Zealand. In Australia, education providers must also be aware of the Health Practitioner Regulation National Law. This requires registered health practitioners and employers to make notifications about registered medical practitioners who have engaged in 'notifiable conduct' as defined in the National Law.

10.3 Assessment decision

Accreditation standards

10.3.1 The education provider makes an assessment decision in line with the requirements of the assessment pathway.

10.3.2 The education provider grants exemption or credit to specialist international medical graduates towards completion of requirements based on the specialist medical program outcomes.

10.3.3 The education provider clearly documents any additional requirements such as peer review, supervised practice, assessment or formal examination and timelines for completing them.

10.3.4 The education provider communicates the assessment outcomes to the applicant and the registration authority in a timely manner.

Notes

In Australia, for specialist pathway applicants, the Medical Board of Australia has provided definitions for assessment of comparability to determine whether an applicant is not comparable, partially comparable or substantially comparable to an Australian-trained specialist in the same field of practice. Education providers are expected to use these definitions in making a recommendation to the Medical Board on whether or not to recommend registration.

In New Zealand, the role of the education provider is to provide comprehensive advice and recommendations on the applicant qualifications, training and experience and whether this is at the level of a New Zealand-trained specialist, and to advise the Medical Council of New Zealand on the suitability of the proposed employment position and supervisor for the assessment period. The term 'equivalent to or as

[19] van der Vleuten, CPM., 'The assessment of professional competence: developments, research and practical implications'. *Advances in Health Science Education,* vol. 1, 1996, pp. 41-67.

satisfactory as' is the statutory definition of the assessment of comparability to the relevant New Zealand/Australasian postgraduate qualification.

10.4 Communication with specialist international medical graduate applicants

Accreditation standards

10.4.1 The education provider provides clear and easily accessible information about the assessment requirements and fees, and any proposed changes to them.

10.4.2 The education provider provides timely and correct information to specialist international medical graduates about their progress through the assessment process.

Notes

Education providers are expected to interact with specialist international medical graduates applying through their assessment pathways in a timely, open and transparent way. To this end, they should have mechanisms to inform prospective applicants and those undergoing the process of the relevant policies and processes, of any proposed changes to policies and processes, and outcomes at various stages of the process.

APPENDIX 3: REFERENCES

Australian Medical Council (2015) Standards for Assessment and Accreditation of Specialist Medical Programs and Professional Development

Australian Medical Council (2019) *Preparedness for Internship Survey Results* Canberra, Australia

Australian Medical Council (2019) *National Framework for Medical Internship in 2019 – 2020* Canberra, Australia

Belfield, C., Hywel, T., Bullock, A., Wynon, R., and Wall, D. (2009) Measuring Effectiveness for Best Evidence Medical Education: A Discussion. *Medical Teacher*. Vol. 23, 2001 – Issue 2.

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