Consultation feedback form

Australian Medical Council Limited

Draft model standards and procedures for specialist medical college accreditation of training settings

Thank you for providing feedback on the draft model standards and procedures for specialist medical college accreditation of training settings.

In this consultation, the AMC has included particular questions for colleges and health services as the primary users of the standards and procedures. However, the AMC welcomes feedback from all stakeholders, and stakeholders are invited to answer any of the questions as they see relevant.

To return your feedback, please email this form in MS Word format to accreditation@amc.org.au by close of business on 11 November 2024.

Consultation questions relating to **draft model standards**:
General feedback
Are the model standards easy to read and understand?
RACS thanks the AMC for the opportunity to provide feedback on these draft model standards. In compiling this response, we have consulted with all nine specialties across Australia and Aotearoa New Zealand, our trainee representative group RACSTA and key RACS governance representatives. Unfortunately, the tight timeframe for response has not allowed us to finalise a response from our Indigenous Health Committee and RACS would hope that the AMC is amenable to input in the coming weeks to ensure that the cultural safety element of the model standards is ensured. RACS has provided an Appendix to this response to include feedback received that is not addressed in the questions asked for response. RACS finds the standards to be clear and accessible. Although the model standards appear to be intentionally general to ensure relevance across all medical specialties, RACS seeks clarification on whether specialty-specific outcome measures can be included. This is particularly relevant for procedural specialties, such as surgery, where prioritising and protecting trainee time for procedural activities is essential. Additionally, it is important that Health Services receive clear guidance on the requirements needed to meet these model standards. RACS welcomes the introduction of cultural safety directly into the wording of the standards and criteria and the emphasis of trainee health and wellbeing being the first Domain stated. However, RACS believes that further clarification is needed within the standards on aspects such as supportive learning culture, fatigue and trainee welfare, assessment and feedback, levels of supervision, access to leave, access to teaching and training, and support for supervisors.
Are there any criteria in the model standards that would raise challenges for your organisation? **For colleges:** this would include any challenges in implementing the model standards. **For health services:** this would include any challenges in being assessed against the model standards, for example, in smaller settings, rural and regional settings, general practice and non-government settings.

RACS is committed to working with the AMC to implement the model standards and seeks the opportunity to participate in a staged implementation and evaluation process. This approach would allow RACS to provide AMC with valuable insights to ensure the model standards are fit for purpose.

RACS anticipates that the main challenge in implementation will be identifying the specific outcomes and evidence required to demonstrate that a Health Service has met the model standards. These outcomes are essential for ensuring the necessary support, education, and clinical experience are provided to allow trainees to fulfil their training requirements. Defining these outcomes will require further development, and RACS is ready to assist with this. For example, what will be the outcome measure for trainee health and well-being? How will it be determined that a Health Service's education program effectively addresses training needs? RACS has encountered cases in its accreditation processes where a Health Service has a published calendar of education events, yet trainee feedback indicates the program is not consistently delivered.

Accordingly, RACS recommends that clear outcome measures be developed to provide clarity for colleges, Health Services, trainees, and accreditors to ensure a consistent standard of implementation.

Additionally, where conditions are imposed, jurisdictions (i.e., units/hospitals/networks) should be required to develop a documented action plan with measurable outcomes (e.g., in SMART format) to address the concerns raised. This should be done in collaboration with colleges, with accountabilities clearly defined.

Should there be any additions to, or deletions from, the model standards?

RACS considers that colleges should be able to align their current standards to the Model Standards.

At a recent conjoint workshop of the Health Workforce Taskforce and AMC, Minter Ellison provided a presentation on new legislation regarding psychosocial safety and the key message was that Colleges and Health Services have a joint responsibility for this. The model standards do not currently refer to this joint responsibility and the need to identify/assess the risk, make decisions about ways to eliminate or minimise the risk, implement strategies to control the risk, monitor effectiveness of the strategies implemented and document a plan to demonstrate action on issues identified. Where a jurisdiction is required to investigate a matter relating to culture, the outcome should be shared with the college in a way that maintains confidentiality and, where required, anonymity. That is, confidentiality and anonymity should not be reasons for not sharing the outcome as the action plan is a shared responsibility.

There is currently a culture of trainees not speaking up due to fear of repercussions that will impact their training and future employment. Colleges and Health Services have a joint responsibility to address this. An example is that trainees at one hospital in Aotearoa New Zealand are working 24 on-call hours which involve working a lot overnight. As part of the provision for safer hours the hospital allows them to have the day off the next day and provides them with a taxi chit to get home, however the trainees are then missing out on their scheduled theatre lists and training and educational experiences.

RACS would like to share an example where a training post was disaccredited due to persistent bullying and discrimination issues. Despite the hospital claiming to have policies and visible posters promoting respect throughout the hospital, an accreditation inspection revealed these measures had been ineffective in addressing the issues. The behaviours had continued over a number of years, with what was perceived as no substantive change in the behaviours. This led trainees to feel discouraged from reporting issues, as they perceived the administration as being unresponsive. RACS is keen to engage with Health Services to effect real change and suggest that this joint responsibility for providing and maintaining a safe environment for trainees is reflected in the model standards. The work of the AMC in defining the model standards is a unique opportunity to facilitate greater cooperation between the colleges and the hospitals to facilitate a better training environment.

Feedback regarding college-specific requirements
Criterion 2.1.6 enables recognition of accreditation of training settings/providers by other accreditation bodies e.g. health service quality and safety bodies. **For colleges:** Would it be necessary to include specific requirements to assess this criterion, for example, requiring the training setting/provider to be accredited by an industry body/regulator such as NATA or a radiation safety authority? **For health services:** What should be considered in developing college-specific requirements for this criterion?
RACS considers that recognition of accreditation of training settings by other accreditation bodies is appropriate. For example if the provider/setting is a trauma centre, then they should have trauma verification by the appropriate body.
Criterion 2.2.1 provides for effective clinical supervision of trainees. **For colleges:** Would it be necessary to include specific requirements to assess this criterion, for example, ratios for supervisors to trainees? If yes, please explain why ratios are needed, how ratios would be determined and how such ratios align with outcomes based accreditation? Please explain how would ratios accommodate: • flexibility for training in regional, rural and remote settings • situations where training settings have difficulty in recruiting supervisors despite best efforts • remote supervision? **For health services**: What should be considered in developing college-specific requirements for this criterion?
Ratios To ensure effective clinical supervision, it is essential to establish a pre-determined ratio of supervisors to trainees, which facilitates appropriate levels of oversight. The supervisor-to-trainee ratio should be assessed based on the specific clinical context and may well be different for each specialty college, with consideration for rural settings being made on a case-by-case basis. Maintaining appropriate ratios is crucial to provide trainees with appropriate levels of support and supervision and ensures training providers are aware of the minimum expectations of roster time for supervisors to fulfil their obligations. Trainees require access to a variety of supervising consultants, thereby enhancing the diversity of clinical cases they encounter. Trainees require access to different consultants to allow for a both a variety of casemix to meet curriculum requirements as well as ensuring that assessments are valid and reliable. RACS also considers that more than one consultant is necessary in the situation where a trainee is underperforming. Underperformance is multifactorial and requires evaluation of the causes for the underperformance to ensure an effective remediation plan is developed and implemented. A single consultant involved in training has the potential to result in conflict of interest and/or unconscious bias which may impact on providing the trainee with the necessary assistance to address the underperformance. **Flexibility for training in regional, rural and remote settings** RACS recognizes the challenges faced in regional, rural and remote settings. RACS has established a Rural Health Equity strategy to address these issues and is working with our Specialty Societies to implement this strategy. RACS recognises the need to be flexible in these setting and that urban ratios are not

necessarily either appropriate nor achievable. At a recent FATES 2 workshop in Darwin RACS engaged with consortium partners to consider models for delivering surgical training in the Northern Territory and are encouraged that flexibility can be achieved yet ensure high quality training for our trainees.

Flexibility in trainer ratios needs to be considered in a context specific way and is specialty dependent. Therefore, RACS would welcome the model standards allowing this context specific consideration across all medical specialties.

Situations where training settings have difficulty in recruiting supervisors despite best efforts.

RACS recognizes that certain training settings have difficulty in recruiting supervisors despite best efforts. However, adequate supervision is crucial for training and as such RACS remains committed to ensuring supervision that supports trainees and training posts that do not provide the required supervision for trainee safety cannot be supported.

As training programs transition towards competency-based models with increasingly complex requirements, supervisors are shouldering additional responsibilities. To address this, supervisors must be supported with appropriate trainee-to-supervisor ratios; failure to do so risks reducing participation in supervisory roles.

Remote Supervision

RACS acknowledges the complexities of remote supervision in surgery, given the technical demands and patient safety considerations inherent to the specialty. While remote supervision may be effective for some medical fields, RACS believes it is unlikely to be viable for surgery, and should be carefully monitored and reviewed on a case-by-case basis within surgical training.

For example, in situations where a trainee encounters challenges during an operation, remote guidance may offer next steps, but there remains a risk if the trainee cannot execute those steps effectively. Often a surgical trainer may need to take over more complex aspects of an operation. Additionally, trainees may not always recognise risks as they arise, potentially impacting patient safety. Onsite supervision is also particularly important when managing trainee performance issues.

Criterion 3.1.1 provides for a clinical caseload and casemix to achieve the training program outcomes.

For colleges: Would it be necessary to include specific requirements to assess this criterion, for example, logbook requirements, theatre time?

For health services: What should be considered in developing college-specific requirements for this criterion?

RACS considers it important for Colleges to provide specifics in regards clinical caseload and casemix to achieve the training program outcomes. This information is important for both trainees and Health Services. Casemix requirements are essential to ensure that trainees get the appropriate breadth of training to meet curriculum requirements. RACS specialty training committees review trainee logbooks to ensure that they are gaining the operative experience to ensure safe and competent surgeons for Australia and Aotearoa New Zealand. Some specialties (e.g. Cardiothoracic Surgery) have a longitudinal approach to logbooks over the 6 year training program and each 6 month rotation is reviewed. General Surgery New Zealand have progress reporting in real time, showing trainee progress on all aspects of curriculum. including milestones to be achieved by certain dates.

RACS specialties recognise that not all training requirements can be met by some clinical rotations and as such encourage trainees to move locations to achieve the curriculum requirements. In implementing our Rural Health Equity strategy, RACS is considering the best mix of urban, regional and rural locations to achieve the required operative experience.

Criterion 3.1.2 provides for trainees to engage in structured and unstructured learning activities to achieve the training program outcomes.

For colleges: Would it be necessary to include specific requirements to assess this criterion, for example, a requirement for trainees to complete a research project, or a requirement that trainees have protected teaching/study time? Please explain your reasoning.

For health services: What should be considered in developing college-specific requirements for this criterion?

RACS considers it is essential to include specific requirements with respect to structured and unstructured learning activities to achieve the training program outcomes. There is a natural tension between training and service delivery. Colleges are accredited by the AMC to provide training and hospital training posts are essential for this to occur. Hospitals are required to deliver patients services and college trainees are a critical element of this service delivery. To ensure adequate training for our trainees there needs to be a commitment from both Colleges and Health Services to manage the training/service delivery tension and RACS considers that specific criterion for the model standards would assist.

Research project

Surgical specialties have different research requirements, and this is not a requirement for all specialties. Where a specialty requires research, RACS would welcome the ability to make specific requirements to address this criterion.

Protected teaching/study time

RACS supports the importance of providing trainees with protected teaching and study time as part of their learning program. Best evidence medical education supports self-directed[i] learning as a critical aspect to ensuring lifelong learning. Scheduling conflicts can result in Trainees missing critical educational opportunities and consultant surgeons becoming frustrated at lack of attendance. Specific criterion would ensure that this is addressed.

RACS specialties currently review the hospitals education program against rosters to identify conflicts. It is an expectation that rostering takes the educational program into consideration and the model standard should support this.

Additional specific requirements for structured and unstructured learning activities to achieve the training program outcomes

RACS trainees are hospital employees that are providing surgical services to their patients. However they are also trainees on a training program and as such require both time and space to undertake structured and unstructured learning activities.

RACS considers the need to provide trainees with access to a quiet study space where they can store and access both electronic and paper-based resources as critical for their training success. Study spaces also facilitate the formation and participation in study groups which have been linked to improved training outcomes and exam performance.

The recently released Medical Training Survey results also highlight areas for improvement which directly relate to areas of accreditation criteria which are assessed. The relevant areas of concern include the following:

- Overall satisfaction with orientation and teaching sessions
- Proportion who received formal orientation
- Safe mechanism for trainees to raise concerns
- Trainee input into training and workplace issues and activities
- Competing for training opportunities in workplace

• Accessing protected study time/leave

• Workplace facilities – IT, training resources, working space and teaching space

• Workplace culture – support to manage stress or traumatic events; support to staff-wellbeing; flexible training; work-life balance; workhours and overtime; supervisor expectations; workplace conflict and lack of appreciation

• Discrimination, bullying and harassment

Given that these are ongoing trainee concerns, it is essential that the model standards set a strong baseline with respect to these areas to support the health and wellbeing of trainees.

RACS considers that specific criteria being included within the model standards will ensure that these issues are addressed.

Criterion 4.2.1 provides for clinical or other equipment needed for trainees to achieve the training program outcomes.

For colleges: Would it be necessary to include specific requirements to assess this criterion, such as a list of specialist equipment?

For health services: What should be considered in developing college-specific requirements for this criterion?

RACS considers that specific requirements for equipment to support trainee learning should be assessed on the site specific casemix/operations undertaken. Health Services undertaking specific surgical procedures should have the appropriate equipment to support those surgeries and hence trainee learning however it would not be appropriate to mandate specific equipment requirements if the Health Service is not undertaking those specific services e.g robotics. RACS considers that this needs to be evolutional as Health Services change their casemix and operations provided change.

RACS suggests that the hospital's equipment should be assessed based on its appropriateness for the training experience and the range of procedures trainees will encounter. RACS also suggests that equipment requirements should be linked to patient and trainee safety (e.g. in orthopaedics, where imaging is prevalent and existing standards require specific radiation safety equipment are required to protect trainees and the patient).

Are there any other college-specific requirements that are necessary in relation to other criteria and what should be considered in developing these?

As previously stated, RACS welcomes the opportunity to provide specific surgical specialty requirements to further clarify the expected outcomes of the model standards.

Feedback regarding implementation

For colleges: What is a reasonable timeframe for adoption of the model standards by your college and why?

What would assist your college to adopt the model standards in a more timely manner (for example, shared training, shared resources etc.)?

To maintain the standard of training and, consequently, the quality of healthcare in Australia and New Zealand, we believe it is essential that profession led specialist medical colleges, retain responsibility for accreditation while also supporting collaboration and sustainability. Achieving this will require clear information flow, supported by robust systems and processes, such as MOUs with health services and colleges. As part of the implementation we would also like to see a review of complaints management process to explore opportunities for improvement. However, several aspects of implementation need clarification, including whether the model standards will be implemented across the colleges and information shared with others, how data will be shared to drive efficiencies, and what systems will support this exchange. Consistency in assessment standards is crucial; for example, if RACS accredits a health facility, other colleges need assurance that the standards align with their expectations. Furthermore, responsibility for providing and training accreditors must be defined to ensure standards remain consistent across colleges and data is reliable, especially as RACS currently relies on volunteer fellows who require significant lead time for availability. We look forward to gaining a clearer understanding of the adoption and implementation process and suggest that this clarification should occur before the standards are approved.

RACS is of the understanding that the model standards and adoption/implementation aims to reduce the duplication and burden on health services in particularly, however this will also achieve efficiencies for both Colleges and Health Services and RACS is very supportive of this.

RACS is keen to participate in a staged implementation of the model standards and their evaluation. Accreditation schedules are established in the previous year and as such immediate full-scale implementation is not practical as health services are already in the process of preparing their submissions or submitting against the current specialty standards. However, RACS feels that a staged implementation in 2025 is practical.

A staged implementation which accommodates the quinquennial nature of RACS (and many other colleges) existing training post inspections, would potentially ensure a smoother implementation. RACS also acknowledges that accreditation of training site provides challenges as colleges use a pro bono workforce for inspections who requires significant advance scheduling to participate.

Health Services will require clear explanation of what is necessary to meet the standards and the evidence that they are required to produce.

For health services: What is a reasonable timeframe for your organisation(s) to be ready for assessment against the model standards and why?

RACS has been undertaking work to map our current standards to the model standards and as such is in a strong position to be part of a staged implementation. Given accreditation schedules have already been established for 2025 and Health Services notified RACS believes that implementation for some specialties and some Health Services could be achieved in the second half of 2025.

Other feedback

Do you have any additional comments regarding the model standards that are not covered above?

RACS is concerned that the need to provide accommodation and relocation support to trainees rotating away from their primary place of residence has been removed from the draft model standards. This requirement was previously provided by RACS to the Miller Blue Consulting group. RACS wishes to highlight this especially in the context of rural, regional and remote training rotations and our efforts to address these workforce shortages.

The following standard criteria raise questions for RACS:

- 2.1.2 Trainees can provide input and feedback into how their local training is delivered - RACS thinks it is important to provide input into how their training is delivered.

- 2.2.5 Supervisors are supported in meeting their education and training responsibilities, including in providing culturally safe supervision and contributing to a culturally safe environment. RACS thinks it is important that the Health Services are involved in assessing supervisors to ensure their performance is adequate and that they are ensuring adequate supervision and training.

Consultation questions relating to **draft model procedures**:

General feedback

Are the model procedures easy to read and understand?

RACS considers the Model procedures easy to read and understand. RACS would like clarification on the rationale for introducing the terminology "provisional accreditation". It is unclear what this term means and our specialty societies have concerns as this new terminology is not in alignment with what is currently used (accredited, not accredited, or accredited with conditions to be met within an agreed timeframe). This change in terminology will necessitate a comprehensive overhaul of processes, procedures, IT systems, and documentation for both colleges and hospital staff. The terminology of "provisional accreditation" could lead to significant misunderstandings among hospitals and trainees as to whether or not the hospital has met the model standards or not.

It is acknowledged, however that the Australian Orthopaedic Association has already adopted the term "Provisional accreditation" into their current hospital accreditation standards.

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Are there any requirements in the model procedures that would raise challenges for your organisation?

RACS has concerns around the suggested timelines for Application Requirements under Section 4, page 10 the Model Procedures document as below:

"Settings applying for accreditation for the first time are recommended to start the application process at least six months before they would like training to begin"

This timeframe is not a sufficient period of time as RACS requires applications to be submitted at least 9-12 months in advance of when a hospital would like to commence training. This lead time ensures that sufficient time is allocated for processing the documentation (liaising with the hospital where clarification required) and undertaking the accreditation review and inspection where required.

RACS therefore suggests a minimum timeframe of 9 months for new hospital accreditation applications.

Feedback regarding agreed terminology

For colleges: Are there any obstacles to your college implementing the common terminology for:

- assessment against the standards: met; substantially met; not met
- accreditation outcomes for new settings: provisionally accredited; not accredited – refused
- accreditation outcomes for existing settings: accredited; conditionally accredited; not accredited – revoked.

A significant challenge will be the time needed to educate and retrain all stakeholders on the new terminology, including hospital staff and administration, jurisdictions, accreditation inspectors, hospital supervisors, specialty board and committee members, internal staff, and accreditation panels.

The Australian Orthopaedic Association (AOA) shared their experience where they simultaneously introduced updated standards and processes several years ago, and commented that the workload was substantial. They implemented a transition period to help training sites adapt to the new requirements. They extensively communicated with their members and sites about the new terminology, emphasising that the goal was quality improvement for training delivery. This was a multi-year effort to ensure understanding and compliance.

RACS advocates that a major lesson from the AOA experience is that substantial changes need time to be fully integrated and stakeholders engaged and educated.

For colleges: In what timeframe could your college implement this terminology? What support may assist quick adoption?

RACS considers a staged adoption the best approach along with a clear communication plan with all stakeholders. RACS considers that full adoption/implementation will require at least a 12-18 month timeframe from the time of approval.

Feedback regarding the risk matrix

Is the risk matrix appropriate for accreditation decision making?

RACS considers the risk matrix as an appropriate framework for decision making at an initial level, however it does not fully allow all accreditation decisions to be made using this framework. In some instances providing the hospital with information regarding significant concerns and allowing them to develop a plan to mitigate this prior to a decision being made has avoided dis-accreditation in a number of instances (e.g. Australian Board in General Surgery has approx. 15 examples in recent times).

RACS suggests there is another option available on the risk matrix that identifies an extreme risk is not always an immediate withdrawal.

There needs to be a mutual understanding that many accreditation decisions are handled on a case-by-case basis, many of which do not neatly fall into this matrix.

The risk matrix allows colleges to decide whether or not to impose a condition where the criteria are substantially met or not met but the overall risk assessment is low.

Is this appropriate or should there be a requirement for a condition to be imposed for any criterion assessed as 'substantially met' or 'not met'? Please explain your views.

RACS considers that it is appropriate for a condition(s) to be imposed should minimum standards of the criterion not be met. Full accreditation should only be granted when all standards are satisfied. Conditional accreditation is a good approach; however, it is important to note there is no current distinction between conditions which were imposed for minor concerns, compared to major risk concerns. This could (and has previously) cause concern among hospital posts and trainees, as it may unintentionally make the hospital appear to be sub optimal for training when they only have a minor condition imposed.

RACS requests there is a clear distinction between conditions imposed for minor concerns compared to major risk concerns. If this distinction could be put in place, acceptance of this terminology may be more widely accepted.

The risk matrix indicates that steps to revoke accreditation should be taken when the overall risk assessment is extreme. Is this appropriate?

RACS considers that this is an appropriate approach to risks assessed as extreme, however, there should be a degree of understanding that each case is different, and all risk assessments and approaches to manage these will not be the same.

Other feedback
Do you have any additional comments regarding the model procedures that are not covered above?
The word “college” is spelt incorrectly on page 7, it appears as “Collee”. The model standards propose to share the draft report with site **AFTER** Accreditation Committee deliberation. RACS considers that this approach to the process would almost certainly cause unnecessary double handling and an overall inefficient and an impractical process. RACS suggests that the draft report be sent to the training site prior to the Accreditation Committee deliberation. This allows the hospital to raise any material that might have been missed/miss interpreted which would affect the Accreditation Committees deliberation and could change their recommendation. The accreditation process should follow principles of administrative law, ensuring decisions are made fairly, transparently, and based on sound evidence. Only in exceptional cases will decisions be postponed to allow for escalation or the gathering of additional advice and information be necessary to support the decision-making process. Appendix 1 attached to this response include our responses from RACSTA our trainee representatives and additional Specialty specific comments

Organisational details and contact	
Organisation name/details:	Royal Australasian College of Surgeons
Contact name:	[redacted]
Contact email:	

The AMC may publish submissions on its website in the interests of transparency and to support informed discussion among the community and stakeholders. Published submissions will include the names of the individuals and/or the organisations that made them, unless confidentiality is expressly requested, or you advise us that you do not want your submission published. We would not include the contact details for individuals.

We will not place on our website, or make available to the public, submissions that contain offensive or defamatory comments or which are outside the scope of the subject of the consultation.

Please advise if you **do not** agree to your feedback being published?

☐ **NO – I do not agree to my feedback being published.**

Kaufman DM. Applying educational theory in practice. *BMJ. 2003 Jan 25;326(7382):213-6. doi: 10.1136/bmj.326.7382.213. PMID: 12543841; PMCID: PMC1125068.*

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Appendix 1 – Additional RACS stakeholder feedback

RACSTA feedback

Standard 1.1 – identified, (investigated), managed and recorded – RACSTA feels that this standard is not clear enough and that this wording should be stronger, to ensure appropriate investigation AND action, rather than any issues 'managed and recorded'. This is to ensure issues are not just documented and ignored, especially as Trainees can be in particularly vulnerable positions. We would suggest "management plan actioned" for stronger wording.

Standard 1.1.1 – intent – small settings having informal personalised mechanisms
- RACSTA feels informal mechanisms may not be sufficient for safety and procedural fairness to occur, and that there should always be a formal pathway, rather than ad hoc. This is especially important in smaller departments e.g. Urology in a rural hospital, where even other consultants may not be empowered to speak up/raise issues within their own department.

Standard 1.1.5 with fatigue and work volume - again, to add that issues should be investigated, and solutions actioned, rather than only 'managed' and recorded

Standard 1.1.6 – RACSTA would encourage the need for provisions for leave as mandatory to avoid burnout, not just in accordance with employment conditions as there have been instances of Trainees not being provided leave due to no relief cover which has resulted in burnout over the course of a six month rotation. Especially if there is no leave granted for a whole rotation, and only at a later time during the second rotation.

Standard 2.2.1 – "colleges should allow for flexibility in how supervision is provided" – RACSTA's position is that this is not strong enough. Essentially this suggests a supervisor could be totally off site and not present/not supporting – this would be considered 'flexible' and could be the intention behind the wording of the AMC. Adequate supervision and support is vital to Trainees, and Supervisors of Training should be provided training and support in these roles.

Domain 2 – RACSTA highlights the need for robust feedback mechanisms for Supervisors of Training, and that this should be mandatory, alongside the ability to give feedback on a Hospital and their training experiences via robust and safe reporting systems for Trainees as a whole as they proceed through training. Multiple examples of trainees in rural and regional hospitals in New Zealand were experiencing bullying or in one instance sexual harassment by their Supervisor of Training.

Standard 3.1 Learning opportunities:
RACSTA's position is that Protected teaching time should be structured into education. "The opportunity to" is not strong enough wording; there are many instances of trainees all over both Australia and New Zealand missing out on teaching time despite it being written into contracts for example in New Zealand; if it is within the HTP process this should ensure it is protected. Teaching should be both clinical and non-clinical and include the ability to attend courses for further education and examination preparation.

Standard 4.1 appropriate quiet space – our RACSTA position is that this should be a protected/designated space for Trainees as any space could then be designated appropriate e.g. hot desk, or MDT shared space, which is unacceptable in the setting of 24 hour call. Also we would specify the need for access to adequate technology/ computers.

Welfare specific concerns that also need to be raised/included from a Trainee-safety perspective – access to safe parking if on call back, designated office/room if required to be on site/24hr on call including ability to lock the door There have been multiple instances of staff being assaulted by members of the public at Middlemore Hospital after hours while walking from the hospital to their cars, including one trainee who was attacked while walking to his car (in a parking building across the road from the hospital, over a railway line) after a long day shift. There was an example of a Sexual Assault of a trainee in rural Victoria in an overnight on call room that had a broken lock; this had been flagged for maintenance but not fixed.

RACSTA would also like to see a provision in the guidelines for training teaching protection as part of our role, and not just being service provision for a hospital service. This is something that we have raised to include when considering the outsourcing of operating to the private sector of public patients.
RACSTA raise one final concern with page 27 last bullet point: "Sometimes evidence of best practice is not available, is unclear or contested, particularly in areas such as acceptable volumes of work, working hours, or effective supervision. In these cases, colleges and training providers should have open discussions about the evidence and how it should be applied in the context of the particular training setting to achieve the best outcome." This seems like a baseless claim. The Medical Unions in New Zealand such as the Resident Doctors Association or STONZ; or surgical educators within RACS would be able to provide evidence to the contrary. There is ample literature on the impact of safer working hours on Trainee safety, and by extension patient safety.

Additional Specialty Society Feedback

- How is managing fatigues measured - a hospital could easily say they managed fatigue/volume of work, however how do we measure this requirement against the criteria?
- Safe work hours are not mentioned – how is this assessed? For example, a trainee in WA was required to work every day for four months. A trainee therefore who has been rostered 6 days out of seven and on call the 7th day working four months straight without a day off would still meet the standard.
- Lack of specificity means potential problems in interpretation - For example, trainees might gain experience in multidisciplinary teams, but the experience might not be beneficial or properly contribute to their training. Similarly, while training and professional development opportunities might be labeled as transparent and equitable, if no one receives these opportunities, the standard would still be considered met despite it being detrimental to trainees.
- Lack of mention of supervisor support. Supervision is largely done probono with no support in terms of paid time or resources. The AOA undertook a refresh of their activity-based costing last year and if they were to charge the trainees for the fellow contributions that are all pro bono, it would actually be quadruple the price of training. There is definitely a risk if we start taking reducing this support. There are many challenges faced by training supervisors, particularly when dealing with underperforming trainees, which can demand significant time and effort. As training programs shift towards competency-based models with more requirements, supervisors face increased responsibilities without corresponding remuneration, which is unsustainable. Supervisors must be protected with sufficient ratios as without addressing these issues, there is a risk of declining participation in supervisory roles and emphasizes the need for strong advocacy for proper compensation.