

# Consultation feedback form



## 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](mailto:accreditation@amc.org.au) by close of business on **11 November 2024**.

Note, this response is a combined response from the Australian and New Zealand College of Anaesthetists (ANZCA) and the Faculty of Pain Medicine (FPM), which operates under ANZCA.

### Consultation questions relating to draft model standards:

#### General feedback

Are the model standards easy to read and understand?

Yes, the model standards are generally easy to understand (however may be considered lengthy and difficult to read particularly for those who do not have exposure to the accreditation process).

As a suggestion, under standard 1 the order of criterion may be better to start with positive criteria such as 1.1.3 rather than negative criteria.

Some suggestions for terms and definitions include:

- The terms used as definitions, in particular training program, training provider and training setting are in themselves good terms but perhaps the definition could be improved and used more consistently within the document.
- The definition of training program fails to include roles in practice which is a central part of a training program. If a training program is the curriculum, roles in practice and assessment process then the accreditation process is assessing which components of the curriculum and roles in practice a training setting can currently provide and whether they are performing the clinically based assessments to an acceptable standard.
- The term training provider is a good term and it is appropriate that it should include government departments, however under 2.1.6 (The training provider has been accredited by relevant accreditation Bodies) it is unclear who is the accreditation body for a government department?
- A clear definition of what an accreditation process is and, just as importantly, what it is not would be beneficial to qualify. Accreditation processes often use clinical quality as a surrogate for training quality and then use staffing and equipment concerns as a reason to remove accreditation. Poor quality medicine should be a concern for training providers, training settings and the colleges but this should be managed separately to the training quality; this document attempts to only look at training quality but by removing clinical quality the AMC is removing the canary in the coal mine. Poor quality medicine should not be separated from training site accreditation. Quality training requires time, which is currently a premium in public hospitals and more so in the private sector where training (in specialist practice outside general practice) is not

remunerated. We would also suggest that “supervisor” is the training provider’s surrogate for ensuring patient safety and quality of care. Supervisors don’t only answer to the colleges but also to the training providers to ensure trainees are appropriately supervised clinically and patients are not put in harm’s way by trainees who have yet to acquire the relevant experience and competence. It should also be noted that “supervisors” are voluntary roles and something the trainee relies on as part of their own training to receive the supervision, mentoring and guidance required as part of their training program.

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.

ANZCA already does most, if not all of this so there shouldn’t be notable challenges with implementation, noting the below.

### **Domain 1 (Trainee health and welfare)**

This may be problematic that this is based on identifying bad practice, with a lot of examples of what it includes and what to do about it, implying that diversity, equity, inclusion and cultural safety can be achieved if those bad things don’t happen.

#### **1.1.6 (Trainees can access leave arrangements) and 1.1.7 (Trainees can access flexible working arrangements)**

This doesn’t give much guidance to colleges as they don’t have a mechanism to manage employment issues. Is the only option to threaten to withdraw accreditation? Unsure that problems at sites with race, religion, bullying, harassment and sexual orientation etc may be managed by moving the trainee – making the trainee the problem and the training site failing to address often systemic issues.

1.1.7 may be hard to achieve in most places especially for those with only one trainee.

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

#### **1.1.1 (Effective processes are implemented for trainees to raise concerns, grievances and complaints) and 1.1.2 (Risks to trainees regarding bullying, harassment, discrimination, racism)**

For colleges, there needs to be a clearly identified body to specifically address issues such as trainee bullying or harassment. A formalised approach to 1.1.2 should be developed, with a confidential way trainees can inform the college of issues pertaining to 1.1.1.

#### **1.1.3 (Positive learning environment)**

1.1.3 is very brief. Perhaps requires a more positive balance of what to aspire to as well as what to stamp out. The word equity should be mentioned in 1.1.3, it is different to diversity, inclusivity and cultural competence/safety.

#### **2.1.4 (Trainees provided with effective orientation)**

In terms of ‘effective orientation’ in 2.1.4 - how is this being assessed?

It seems reasonable to include some specifics around what ‘support’ for returning to work after leave looks like. ‘Keep in touch’ days are now available in every state/territory in Australia, and in Aotearoa NZ. It seems reasonable that each service should have a guideline on how to support staff returning after leave, even if a small service including support to attend programs if the service doesn’t offer their own.

#### **Information technology (IT) and identification (ID) requirements to all trainees**

A process to provide IT and ID requirements to all trainees (at a time when they are not otherwise rostered to clinical work) doesn't seem to be in the document. Under Domain 4, there is no mention of paid training time not being requisitioned for clinical work.

### Domains

Domain 1 (Trainee health and welfare), like clinical quality is important and should be part of the accreditation process but is not part of a training program and should be treated separately.

Domains 2/3/4 are adequate, however would add a 5th domain on clinical assessment processes.

### Health service measurable criteria

It is important to develop measurable criteria and have strategies in place to be sure they are implemented in health service. With increase in service demand and workforce shortage, some workplaces forget their role and commitment toward training of doctors in training and many emphasise on their own KPIs.

### 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?

Yes, these accreditation pieces can't be entirely borne by the college, e.g. if the college is unhappy about the radiation standards within a training setting, then they should communicate that to the radiation authority. It is the role of government to determine which organisations/bodies accredit which areas of healthcare provision; the rule should be that there should be no double jeopardy.

Criterion 2.1.6 is relevant but should be in addition to accreditation by the relevant college bodies.

A parallel query is what responsibility can colleges have for bullying, discrimination and sexual harassment (BDSH) occurring by non-medical staff e.g. admin, nursing etc. Would this be a question for overall hospital accreditation? Accreditation for training is a blunt stick and requires a rigorous process. This is ultimately an employment responsibility and should be linked to hospital accreditation as well as training accreditation.

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?

ANZCA already has criteria aligned with this.

Anaesthetists operate in a high risk, complex and dynamic environment that necessitates trainees to demonstrate the appropriate knowledge and skills (especially airway, vascular access and resuscitation skills) through a formalised assessment prior to moving beyond direct 1:1 supervision. Moving to even more distant supervision is predicated on completion of Workplace Based Assessment (WBA) to demonstrate clinical competence to do so.

Outcomes-based education requires it to be student-centric, teacher facilitated and relevant. Trainees need to be reflective to identify and seek out experiences that align with their development in the specialty. In order to best achieve this, they require the support and teaching of vocationally registered, appropriately qualified and credentialed specialists in anaesthesia (i.e. not general practice assistants or ACRRM graduates who may well be experienced but potentially have less training in anaesthesia than the trainee) to assist and guide them to achieve the outcomes of the course. Without adequate senior staff:trainee ratios there will not be the opportunity to develop these sophisticated relationships, or the trust that goes with them. Without setting appropriate ratios, either supervision of trainees or patient care suffers because to supervise trainees requires adequate time (as does patient care). It should be depending on level of trainees (basic/advanced), dual fellowship or first fellowship.

Often regional, rural and remote settings have more junior trainees or additional challenges such as availability of skilled help in a crisis. If we compromise on these ratios, it may be difficult or impossible for a site to provide sufficient supervision for training. To support building a regional workforce, it is vital that 1. Trainees are adequately trained and 2. Trainees have a sufficiently positive experience to consider working in that site again.

It would be detrimental to patient safety to lower these requirements in the context in which we work, and it would not be possible to relax these to allow for flexibility in rural and remote areas or where there is difficulty recruiting supervisors. If supervisors were recognised in some way, either through financial remuneration or accumulation of CPD time, this would make a supervisory role more attractive in hospitals that struggle to recruit a supervisor.

Any exception to the flexibility for rural and regional settings needs to be evaluated by a college and relevant committee before deviating from the required standards.

In addition, trainees should not be surrogate specialists and should not be seen by training providers or jurisdictions as substitutes for adequate specialist cover.

Alternative solutions could be explored e.g. provisional fellowship year (PFY) in rural specialist anaesthesia, with remote supervision of the PFY.

In relation to FPM, they do not require specific ratios of supervisors to trainees. However, do require a bare minimum of staff FTE to facilitate supervision of trainees and to attract a sufficient caseload and patient numbers adequate for training exposure. FPM requires a minimum of one session of clinical support time for the supervisor per fortnight for up to three trainees to enable the supervisor to fulfil their role. If there are more than three trainees in the unit, the supervisor needs to have one session dedicated to clinical support time each week.

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?

It would be necessary for ANZCA to add the specific requirements for interrogation of the Training Portfolio System (TPS), to ensure adequate access to volume of practice (VOP) within the training time the site is accredited for. Best practice for Competency Based Medical Education (CBME) would be to demonstrate that a minimum amount of VOP has and can occur to demonstrate expertise. It would also

preclude sites rostering trainees to theatre but then diverting them to rounds/pre-anaesthesia clinic (PAC) to cover service requirements.

The AMC should stipulate that caseload/casemix should be mapped to the curriculum and roles in practice. The accreditation process is to ensure trainees have access to the caseload/casemix i.e. emergency and elective caseloads and to ensure the ratio of trainee to caseload/casemix is appropriate.

For FPM, they would not set requirements around logbooks or theatre time. Units would need to demonstrate that they provide trainees with training across the breadth of the curriculum. Because FPM has trainees from various backgrounds, one size caseload may not suit every trainee depending on their previous experiences. Training sites should have the flexibility to vary caseload profiles to suit the needs of the trainee. This includes the unit taking on enough new patients each year to provide trainees with exposure to a range of patients. Trainee feedback is necessary to ascertain whether learning goals have been achieved and this is already covered in 2.1.2 (Trainees can provide input and feedback).

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?

Trainees should have protected teaching time, and many regions already have EBAs specifying training time (although unfortunately employment laws affecting junior doctors vary across the various jurisdictions). In order to ensure that trainees are provided with adequate time within their rostered hours to complete their program (rather than doing everything in their personal time), developing recommendations in this area are deemed necessary. This also dissuades education providers using trainees for just service provision.

This could be an alternative method of operationalising those requirements if not in relevant jurisdictional employment laws. It would be necessary for ANZCA to mandate specific requirements for access to teaching and education time, free of clinical responsibilities:

- for teaching exam content and technique to facilitate success
- for teaching and assessing mandatory WBA such as Can't Intubate, Can't Oxygenate (CICO) and advanced life support (ALS)
- for completion of Scholar Role Activities
- protected study time, including time for research literacy, tutorials, case discussion with supervisors or self-study etc.

However, each facility should be allowed the flexibility to develop their own program that works for their trainees. This would prevent situations where smaller or larger facilities are having to fit a model that doesn't suit their context.

A definition of 'unstructured learning' by AMC would also be beneficial. In general, medical training is considered structured or otherwise it is not acceptable towards training and acquisition of the fellowship or anything else.

In terms of a research project - it does not impact the quality of training and not necessarily make you a better clinician, with some challenges in every hospital, sometimes it takes even 6 months to get approval for simple research or even an audit, that will increase unnecessary stress and time-pressure which impact clinical training.

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?

Support expanding criteria to include clinical environment in which the trainee practises to be compliant with standards e.g. adequate staffing, equipment, and institutional facilities and processes to support safe and quality patient care - including pre-assessment, theatre, post anaesthesia care unit (PACU) and Acute Pain Management Service (APMS).

Items/examples for consideration:

- Items such as simulation may penalise smaller teaching facilities that may struggle to afford more expensive equipment. From the perspective of clinical experience, a teaching hospital should have a minimum standard of equipment for the different specialised areas where trainees practice. This equipment would be varied for different specialties, so could not be captured in this document.
- Should all trainees have access to ultrasound guided Intravascular Access or advanced airway equipment?

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

The FPM would have specific requirements to ensure training was taking place within multidisciplinary teams with integrated processes and practice within a sociopsychobiomedical framework. This includes specific requirements relating to:

- FTE of special pain medicine physicians, allied health, other medical specialists and dedicated administrative staff for the unit.
- Access to sessions of related disciplines.
- It would be beneficial to have specific direction in regard to rotation, for example for our college how many hours/sessions per week is required for acute pain.
- Supervisor training time. Trainees require training and whilst this statement might seem to be an anachronism, training requires time. With increasing adoption of competency-based training in medical education, supervisors must have adequate time allocation to provide this (and it should be paid time and not time that specialists must find in amongst all the other competing requirements for time that currently goes unpaid).
- Appropriate case-mix. Trainees need to provide service to their organisations, but that service should have incorporated within it activities that resemble the work that will be performed in an 'authentic' environment as a specialist i.e. they require the appropriate case-mix and opportunities for increasing independence as deemed appropriate by demonstration of competence to their supervisors. They should not be seen cynically as a cheap form of specialist input.
- Training in rural and remote regions requires additional equipment (we already know that these areas are the ones that most commonly have poorer IT connectivity) and appropriate (safe) housing etc provided by the training provider. Good experiences in these areas help to retain trainees following qualification.

### 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.)?

ANZCA does most of this already, however significant changes in policy and process are introduced prior to the commencement of the academic year. Therefore, the earliest the model standards could be introduced is 2026. This will be contingent of availability of resourcing within the college to progress this work and a streamlined approval process, especially recognising the significant burden being placed on colleges with a significant reform, consultation and intellectual property input expected from colleges.

It would be confusing to have to implement new standards in a current training year. After developing measures for the new model, it is advisable to commence implementation of the model standard in the next new training year.

One aspect that may delay the implementation until a later year is if it is determined that an IT system is needed to support the process. An analysis of the increase in demands on units, reviewers and administrative staff will be undertaken to determine this.

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

### Other feedback

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

### Greater emphasis on accreditation of sites to deliver the ANZCA and FPM Training Programs

One overall concern is that the model proposed could weaken down existing and proposed models for ANZCA. Therefore, a greater emphasis on accreditation of sites to deliver the ANZCA and FPM Training Programs and all that these entail is required, from engaging meaningfully with supporting the trainees to attain the graduate outcomes, to fulfilling trainee assessment requirements in the workplace.

### Governance

Governance has not been discussed apart from the fact that jurisdictions need to be notified when a training unit/site has its accreditation questioned. Whose responsibility is it to ensure that local OHS laws regarding rostering, time paid for overtime, bullying, discrimination sexual harassment etc are addressed? Too often in the past the government has washed its hands of the lack of professionalism exhibited by some of those responsible for training (see Tan v Xenos (no 3) Antidiscrimination [2008] VCAT 584) and would suggest that complaints (even informal complaints) is something that the Colleges should want to know about (and should be reportable to jurisdictions if it is not).

## Consultation questions relating to draft model procedures:

### General feedback

Are the model procedures easy to read and understand?

Yes, the procedures are easy to read and understand. Some suggestions are provided below.

Page 13, dot point 5 in section 8 (extract below) – should the relevant jurisdictional department of health also be notified as well?

*Where an urgent response to an Issue is required to protect a trainee's health and safety, the college will communicate the matter appropriately to the accredited training setting to allow for both parties to meet their workplace health and safety obligations. If this includes removal of the trainee from the training setting (for example, providing immediate leave, moving the trainee to another setting), the parties will cooperate and coordinate actions to allow this to occur.*

Page 16, section 9 communication protocol – updated contact points are advised to the college and our records are updated, however there needs to be a process/contact point to advise how AMC will update the website contacts.

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

Some of the items that require consideration include:

- The reconsideration process should attract a fee as it is an intensive process. Our appeals process cost is low in comparison to others (the fee doesn't even cover our associated legal fees).
- What is a 'reasonable period' to implement required conditions? ANZCA is likely to be stricter about this than the AMC, as demonstrated by high-risk new settings being 'provisionally accredited' under this framework, whereas ANZCA I suspect would refuse accreditation in the event all requirements are not either being met and/or have strategies in place to meet the standards.
- Consumer and legal representation on accreditation committee may not be appropriate. Our experience with consumer representatives on accreditation committees in the past has demonstrated little value and feedback from consumers indicate they do not have the knowledge to meaningfully contribute to such processes.
- There is nothing in this document that requires providers or jurisdictions to comply with requirements for accreditation – for trainee safety, the provision of appropriate resources including opportunities for both formal and informal training and time for supervision. Increasingly with a move to competency-based education in the medical specialist sphere, access to time and personnel in the workplace will be a necessary 'evil' creating tensions with service delivery.

#### 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.

Terminology for assessment against the standards are appropriate. ANZCA uses similar terminology already and the terminology around the final exam is moving towards this.

Suggest adding for "accreditation outcomes for existing training settings" (page 15) - accreditation suspended. For smaller Colleges and Faculties where personnel changes (in particular, a resignation or multiple resignations), units may not be able to deliver training or meet the accreditation standards. This results in a period of "suspended accreditation" where trainees must have supervision arranged external to the training unit and training providers may not employ further trainees until the issues are rectified and reviewed, suspension may negate the requirement for the whole process to commence again. This is with the proviso that this is for a nominated period (<12 months). FPM currently have an accreditation outcome that allows a unit to move into a suspended status for up to 12 months to avoid having to remove their accreditation. This suspended status allows for a faster return to being accredited and being able to recruit new trainees. If a suspended outcome is not included in the model procedures, FPM expects that more units will need to have their accreditation withdrawn impacting the training pipeline and waitlists for chronic pain services. It may be an option for smaller training programs such as pain medicine and not the bigger training programs where trainees work in larger teams.

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



<p>The terminology above could potentially be adopted in the second half of 2025 following revision of the accreditation documents.</p>
<p><b>Feedback regarding the risk matrix</b></p>
<p>Is the risk matrix appropriate for accreditation decision making?</p>
<p>Yes. The matrix is helpful as a guide however shouldn't be used as the final template to determine a status or as a replacement for our current system of requirements and recommendations which are brief and to the point usually. For example, if there is a particular sticking point or issue on which a unit fails and consequently does not meet accreditation this needs to be clear, as otherwise the unit will struggle to remedy requirements that have not been met.</p> <p>In addition, there is no way of including a risk to patient safety in the matrix. If patient safety issues highlight deficiencies in staffing, supervision, facilities or equipment impacting on trainees, it should be mandatory to impose a condition (and notify the relevant authority).</p>
<p>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.</p> <p>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.</p>
<p>For criterion that is not met or substantially met, the requirement should be explained so the training setting can be changed/modified to achieve the requirement.</p>
<p>The risk matrix indicates that steps to revoke accreditation should be taken when the overall risk assessment is extreme. Is this appropriate?</p>
<p>Yes, the safety of the public and trainees should be foremost in these decisions. A dysfunctional training setting affects both public safety and trainee opportunities/satisfaction, noting conditional accreditation may be up to 5 years.</p>
<p><b>Other feedback</b></p>
<p>Do you have any additional comments regarding the model procedures that are not covered above?</p>
<p><b>Having sufficient trainees</b></p> <p>Consider adding that maintenance of accreditation requires having trainees. If there are no trainees for a period of time, should the accreditation be considered lapsed (similar to clause in provisional accreditation)?</p> <p><b>Obligation on the training unit/setting to advise the college</b></p> <p>The document doesn't appear to set out the obligation on the training unit/setting to advise the college if they no longer meet the standards and therefore can no longer support training. It isn't solely the responsibility of the college to identify that a training unit no longer achieves the accreditation requirements. The document also needs to set out the obligation for training units/settings to provide information/documentation within timeframes stipulated by the process.</p> <p><b>"Reasonable" timeframe and "extended periods" terms</b></p> <p>In a number of these procedures there are references to "reasonable" timeframes and "extended periods" – these terms are too nebulous and need to be stipulated. Training providers and jurisdictions move at glacial speed. If it is important enough to be identified as an issue for accreditation for the provision of training, there is a requirement for a timeframe to be assigned.</p>

Organisational details and contact	
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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.**