ANZCA
FPM

2022 AMC MCNZ Reaccreditation

12 April 2022

AUSTRALIAN AND NEW ZEALAND
COLLEGE OF ANAESTHETISTS
& FACULTY OF PAIN MEDICINE

ANZCA
FPM

Table of contents

ANZCA
FPM

Tables

Figures

ANZCA
FPM

Appendices

Standard 1: The context of training and education

1.1 ANZCA Immediate past president - Terms of reference

1.2 ANZCA councillor - Resource manual

1.3 ANZCA president - Manual

1.4 ANZCA Council work planner - 2022

1.5 ANZCA Council performance review survey

1.6 ANZCA Governance report – December 2021

1.7 FPM Board annual review - Review questionnaire & FPM Dean 360 survey questions

1.8 College staff organisation chart - February 2022

1.9 Indigenous Health Committee terms of reference

1.10 Draft Reconciliation Action Plan 2022-2024

1.11 Autumn 2021 Bulletin – College Māori name

1.12 Education committees of ANZCA Council – Terms of reference

1.13 Research governance, strategy and committees

1.14 Education committees of FPM Board - Terms of reference

1.15 ANZCA Australian regional committee terms of reference

1.16 New Zealand National Committee terms of reference

1.17 Conflict of Interest Policy

1.18 CPD Committee - Terms of reference

1.19 SIMG Committee -Terms of reference

1.20 ANZCA and FPM projects list

1.21 Reconsideration, review and appeals requests analyses - Interim report February 2022

1.22 Committee diversity matrix – PAEC

1.23 Tri-Nation Alliance MOU – March 2022

1.24 Hong Kong College of Anaesthesiologists (HKCA) & ANZCA MOU – July 2021

1.25 European Society of Anaesthesiology and Intensive Care (ESAIC), Australian Society of Anaesthetists (ASA) & ANZCA MOU – January 2022

1.26 Education unit structure 2016-2021

1.27 College external stakeholders and engagement

1.28 College submissions to enquiries and consultations - 2021

1.29 ANZCA Regional and Rural Workforce Strategy - January 2021

1.30 ANZTADC Medical Director's Annual Report 2021

1.31 ANZCA FPM Strategic Education Framework - Draft 2020

1.32 ANZCA FPM Education Governance Framework - Draft 2020

1.33 ANZCA FPM Education Quality Framework – Draft 2022

1.34 FPM Procedures Endorsement Program Working Groups - Terms of reference

1.35 ANZCA, Australian College of Rural and Remote Medicine and Royal Australian College of General Practitioners MOU – January 2020

1.36 Diving and Hyperbaric Medicine Sub-committee - Terms of reference

1.37 Dual FANZCA-FCICM pathway – Dual Training Pathway Curriculum Working Group draft terms of reference

1.38 Dual FANZCA-FCICM pathway – Draft Implementation plan 2021-2024

Standard 3: The specialist medical training and education framework

3.1 DRGA - Entrustable professional activities

3.2 DRGA – Program of EPAs in 12 months full-time training

3.3 Rural Generalist Anaesthesia Training Program Curriculum - February 2022

3.4 Diploma of Perioperative Medicine – Draft learning outcomes

3.5 Diploma of Perioperative Medicine - Draft curriculum framework 2022

3.6 Competency Based Medical Education - Final report November 2020

3.7 Indigenous Health Learning Outcomes Project Group - Terms of reference

3.8 Communicator Role Project Group recommendation to EEMC - November 2021

Standard 4: Teaching and learning

4.1 ANZCA 2014 library review – Summary of achievements end 2021

4.2 Effective Management of Anaesthetic Crises - Course overview

4.3 Effective Management of Anaesthetic Crises - Learning outcomes 2018

4.4 Regional support 2021- Continuing medical education, courses and exams

4.5 Example e-learning template

4.6 FPM centralised trainee tutorial program evaluation results 2021

4.7 Report from FPM trainee centralised tutorials feedback session 2021

4.8 Diving and Hyperbaric Medicine - Training agreement

4.9 Bunbury and Castanelli (2015) A survey of educator needs to support the implementation of the intrinsic ANZCA roles in practice

Standard 5: Assessment of learning

5.1 Group decision making short report - October 2021

5.2 SAQ primary exam marking rubric

5.3 SAQ final exam marking rubric

5.4 FPM clinical case study marking criteria

5.5 2017 ANZCA Advancing Exams Initiative. Summary Report I to ANZCA: Final Examination

5.6 2017 ANZCA Advancing Exams Initiative. Summary Report I to ANZCA: Faculty of Pain Medicine

5.7 ANZCA primary examination report - 2021.2

5.8 ANZCA final examination report - 2021.2

5.9 ANZCA remediation form and workplan (redacted)

5.10 FPM fellowship examination report – 2020

5.11 FPM feedback interview template - 2021

5.12 FPM long case assessment feedback examples - 2021

5.13 ANZCA early indicator checklists

Standard 6: Monitoring and evaluation

6.1 Educator Skills Project Group - Final report

6.2 2017 Fellowship survey results - Executive summary

6.3 2021 Fellowship survey - Summary report

6.4 ANZCA Trainee Committee survey results - Executive summary 2017-2020

6.5 ANZCA Trainee Survey and the Medical Board of Australia's Medical Training Survey - Key findings and recommendations report

6.6 ANZCA Trainee Survey and the Medical Board of Australia's Medical Training Survey Action plan

6.7 FPM evaluation strategy 2018-2021

6.8 ANZCA Provisional fellowship survey results 2017-2021

6.9 ANZCA Bulletin - Graduate outcomes survey articles 2014 & 2016

6.10 ANZCA Graduate outcomes survey 2016 – Report

6.11 FPM Graduate outcome survey 2016

6.12 FPM Exit survey results comparison 2016-2021

6.13 ANZCA Training dashboard data report 2021

6.14 ANZCA Bulletin - Trainee survey results articles 2017-2020

6.15 Letter to the Medical Board of Australia re: MTS results and action plan – December 2021

6.16 Education and research strategic risk report

6.17 FPM Procedures Endorsement Program evaluation strategy 2021-2024

6.18 DRGA Curriculum consultation proposal

Standard 7: Issues related to trainees

7.1 ANZCA training agreement

7.2 FPM training agreement

7.3 NSW independent trainee data 2019 - 2022

7.4 Independent trainees – EO survey 2022

7.5 ANZCA Trainee Committee - Terms of reference 2021

7.6 ANZCA Training E-Newsletter - September 2021

7.7 FPM Training E-Newsletter - October 2021

7.8 ANZCA Trainee Wellbeing Working Group - Report 2018

7.9 Trainee Wellbeing Project Group – Terms of reference

7.10 Annual Converge International usage statistics 2018-2021

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

8.1 ANZCA supervisor agreements

8.2 Departmental scholar role tutor newsletter - December 2021

8.3 FPM SOT and PDS supervisor agreement

8.4 ANZCA SOT agreement

8.5 Sample SOT workshop programs 2019-2021

8.6 Education Officers Network - Terms of reference

8.7 ANZCA SOT position description

8.8 FPM SOT advisor terms of reference

8.9 WBA leads terms of reference

8.10 ANZCA examiner terms of reference

8.11 ANZCA TAC visitor terms of reference

8.12 FPM TUAC reviewer terms of reference

8.13 TAC - Pre-visit trainee survey questions

8.14 De-identified sample training unit reports

8.15 FPM TUAC - Multidisciplinary Training Unit (MPU) data sheet

8.16 FPM Sample TUAC feedback report

8.17 Pathways for Recognition of the ANZCA Perioperative Medicine Diploma

8.18 ANZCA Educator Competency Framework – Draft 2022

8.19 Academy Working Group – Draft report 2022

Standard 9: Continuing professional development, further training and remediation

9.1 Practice evaluation mandatory activities data 2014-2021

9.2 CPD portfolio support document – 2020

9.3 CPD portfolio support document - 2021

9.4 CPD tracker 2017-2019 EOT 2019 verification

9.5 Example - final from March 31- 2019-2021 EOT and 2021 audit tracker

9.6 2018-2020 CPD End of Triennium completion report April 2021

9.7 COVID-19 impact analysis - status of CPD participants March 2020

9.8 CPD participants completion status dashboards – 2020

9.9 CPD participants completion status dashboards - 2021

9.10 ANZCA Council paper - COVID-19 impact on CPD program

9.11 Letter to AMC re: No CPD verification for 2020

9.12 Rees et al. (2021) A report on virtual 'Can't intubate, can't oxygenate' conference workshops at the 2021 Annual Scientific Meeting of the Australian and New Zealand College of Anaesthetists

9.13 Clinical audit guide – MEBT during compression for HBOT

9.14 Emergency response providers and activity analysis - 2019

Standard 10: Assessment of specialist international medical graduates

10.1 Summary of preliminary review 2022.1

10.2 CPA report form (ANZCA and FPM)

10.3 SIMG PA assessor manual

10.4 Sample SIMG eNewsletter – July 2021

ANZCA
FPM

Acronyms

ACER	Australian Council for Educational Research
ACRRM	Australasian College of Rural and Remote Medicine
AEP	ANZCA Educators Program
AGM	Annual General Meeting
AIDA	Australian Indigenous Doctors' Association
ALEP	Accreditation and learning environment project
ALEPG	Accreditation and Learning Environment Project Group
ALS	Advanced Life Support (course)
AMC	Australian Medical Council
AON	Area of need
ASA	Australian Society of Anaesthetists
ASBD	Acute Severe Behavioural Disturbance (course)
ASM	Annual Scientific Meeting
AT	Advanced training (ANZCA training program)
ATC	ANZCA Trainee Committee
BDSH	Bullying, discrimination and sexual harassment
BPM	Better Pain Management (course)
BT	Basic training (ANZCA training program)
CAT	Clinical anaesthesia time (ANZCA training program)
CBD	Case-based discussion
CBME	Competency-based medical education
CF	Clinical fundamental (ANZCA training program)
CICM	College of Intensive Care Medicine
CICO	Can't Intubate, Can't Oxygenate (course)
CMC	Council of Medical Colleges (New Zealand)
CME	Continuing medical education
CPA	Clinical practice assessment (SIMG assessment)
CPD	Continuing professional development
CPDC	Continuing Professional Development Committee
CPMC	Council of Presidents of Medical Colleges (Australia)
CPR	Clinical placement review (ANZCA training program)
CSO	Committee support officer
CTN	Clinical Trials Network
CTS	Core training stage (FPM training program)
CUR	Core unit review (ANZCA training program)
DHM	Diving and Hyperbaric Medicine

DHMSC	Diving and Hyperbaric Medicine Sub-committee
DipPOM	Diploma of Perioperative Medicine
DOPS	Direct observation of procedural skills (ANZCA training program, FPM Procedures Endorsement Program)
DPA	Director of professional affairs
DRGA	Diploma of Rural Generalist Anaesthesia
EA	Examiner assessor (ANZCA)
EDEC	Education Development and Evaluation Committee (ANZCA)
EEMC	Education Executive Management Committee (ANZCA)
EMAC	Effective Management of Anaesthetic Crises (course)
EMST	Early Management of Severe Trauma (course)
EO	Education officer (ANZCA role)
EPA	Entrustable professional activities
EQF	Education Quality Framework
ETA	Essential topic areas (FPM training program)
FARM	Finance Audit and Risk Management Committee
FESC	Final Examination Sub-committee (ANZCA)
FPM	Faculty of Pain Medicine
GDM	Group decision making
GPA	General practice anaesthesia/anaesthetist
HEY	Hospital employment year
HKCA	Hong Kong College of Anaesthesiologists
HOD	Head of department
IAAC	Initial assessment of anaesthetic competence (ANZCA training program)
IHC	Indigenous Health Committee
IHLO	Indigenous health learning outcomes (working group)
IT	Introductory training (ANZCA training program)
ITA	In-training assessment
JCCA	Joint Consultative Committee on Anaesthesia
LMS	Learning management system
LO	Learning outcome
MANA	Māori Anaesthetists Network Aotearoa
MBA	Medical Board of Australia
MCNZ	Medical Council of New Zealand
MCQ	Multiple choice question
Mini-CEX	Mini clinical evaluation exercise
MOU	Memorandum of understanding
MSF	Multi-source feedback
NZNC	New Zealand National Committee

NZSA	New Zealand Society of Anaesthetists
PAEC	Professional Affairs Executive Committee
PDS	Practice development stage (FPM training program)
PEP	Procedures Endorsement Program
PESC	Primary Examination Sub-committee (ANZCA)
PFT	Provisional fellowship training (ANZCA training program)
POM	Perioperative medicine
RACGP	Royal Australian College of General Practitioners
RACP	Royal Australasian College of Physicians
RACS	Royal Australasian College of Surgeons
RANZCP	Royal Australian and New Zealand College of Psychiatrists
RAP	Reconciliation Action Plan
RCPSC	Royal College of Physicians and Surgeons of Canada
RGA	Rural generalist anaesthesia/ anaesthetist
RI	Remediation interview
RNZGP	Royal New Zealand College of General Practitioners
ROT	Rotational supervisor (ANZCA role)
RPE	Recognition of prior experience
RPL	Recognition of prior learning
RRA	Reconsideration, review and appeals
SAQ	Short answer question
SIG	Special Interest Group
SIMG	Specialist international medical graduate
SOT	Supervisor of training
SPANZA	Society for Paediatric Anaesthesia in New Zealand and Australia
SPMP	Specialist Pain Medicine Physician
SRA	Scholar role activity (ANZCA training program)
SSU	Specialised study unit (ANZCA training program)
STP	Specialist training program
TAC	Training Accreditation Committee (ANZCA)
TAEC	Training and Assessment Executive Committee (FPM)
TC-RGA	Tripartite Committee of Rural Generalist Anaesthesia
TNA	Tri-Nations Alliance
TOR	Terms of reference
TPE	Training program evolution
TPR	Trainee performance review
TPS	Training portfolio system (ANZCA)
TSP	Trainee support process
TUAC	Training Unit Accreditation Committee (FPM)

TWPG	Trainee Wellbeing Project Group
VOP	Volume of practice
WBA	Workplace-based assessment (ANZCA training program)
WBPF	Workplace-based progressive feedback (FPM training program)

ANZCA
FPM

Education provider details

Name of College:	Australian and New Zealand College of Anaesthetists and Faculty of Pain Medicine
Address:	630 St Kilda Road, Melbourne VIC 3004

Chief Executive Officer:	Nigel Fidgeon
Telephone number:	+61 3 8517 5339
Email:	nfidgeon@anzca.edu.au
Officer at College to contact regarding the submission:	Ellen Webber, Learning & Innovation Manager
Telephone number:	0414081172
Email:	ewebber@anzca.edu.au
If the organisation provides training in New Zealand, please provide contact details or a contact person in New Zealand:	
Address in New Zealand	Level 7, Dell EMC House, 5 Willeston Street, Wellington 6140, New Zealand
Executive Officer:	Stephanie Clare, Executive Director – New Zealand
Telephone number:	+64 27 711 7024
Email:	sclare@anzca.edu.au

Training programs offered

Anaesthesia

ANZCA offers one training program in anaesthesia, leading to award of the following fellowship:

FANZCA

Fellowship of the Australian and New Zealand College of Anaesthetists

A re-designed anaesthesia training program was introduced in 2013, replacing the 2004 training program which introduced CanMEDS.

Pain medicine

The Faculty of Pain Medicine of ANZCA offers one training program in pain medicine, leading to award of the following fellowship:

FFPMANZCA

Fellowship of the Faculty of Pain Medicine, Australian and New Zealand College of Anaesthetists

The pain medicine training program was introduced in 1999, with a redesigned program introduced in 2015.

Other training programs

The college also offers a Diploma of Advanced Diving and Hyperbaric Medicine and training for general practice/ rural generalist anaesthetists through the Joint Consultative Committee on Anaesthesia.

Verify submission reviewed

The information presented to the AMC in this submission is complete, and it represents an accurate response to the relevant requirements.

Verified by: Mr Nigel Fidgeon (*Chief Executive Officer/executive officer responsible for the program*)	
Signature:	
Date:	5 April 2022

ANZCA
FPM

Development of submission

The submission was prepared between October 2021 and March 2022, centrally coordinated through the Learning and Innovation team of the Education and Research unit, with extensive input from individuals across the college. The ANZCA DPA education who is a dual FANZCA-FFPMANZCA and an experienced AMC accreditor and leader was centrally involved in the authoring and benchmarking process. A core writing and coordination team used an iterative process to develop the submission, liaising with college staff including directors of professional affairs and relevant committee chairs. A reference review group, ANZCA Council and FPM Board members reviewed the draft submission at various stages and a governance and approval group oversaw the process.

1. **Core writing & coordination team**
    - Dr Lindy Roberts (ANZCA DPA Education)
    - Ms Katy Elliott (Education and Standards Projects Officer)
    - Ms Juliette Whittington (Operations Manager, FPM)
    - Professor Milton Cohen (DPA FPM)
    - Ms Ellen Webber (Learning and Innovation Manager)
    - Ms Shilpa Bakare (Senior Projects Officer)

2. **Authors and contributors**
    - Ms Caroline Beaney (FPM Training, Accreditation and Communications Officer)
    - Dr Suzanne Bertrand (EO Network Chair)
    - Dr Mike Bennett (Diving and Hyperbaric Medicine Sub-committee Chair)
    - Ms Moira Besterwitch (ANZCA Examinations Lead)
    - Ms Adele Broadbent (Communications Manager, New Zealand National Office)
    - Dr Julia Coldrey (ANZCA Primary Examination Sub-committee Chair)
    - Ms Stephenie Cook (Education Development Lead)
    - Dr Kieran Davis (FPM Training and Assessment Committee Chair)
    - Dr Debra Devonshire (ANZCA and FPM CPD Committee Chair, ANZCA Councillor)
    - Dr Kate Drummond (FPM Learning & Development Committee – New Fellow Representative)
    - Dr Harsh Dubey (ANZCA Trainee Committee Co-chair)
    - Mr Maurice Hennessy (Learning and Development Facilitator)
    - Ms Clea Hincks (Executive Director, Policy and Communications)
    - Mr Nigel Fidgeon (CEO)
    - Ms Laura Foley (Operations Manager, Knowledge Resources)
    - Mr Matt Griffin (ANZCA Accreditation Lead)
    - Ms Mairead Jacques (Operations Manager, Fellowship Affairs)

- Dr Fiona Johnson (ANZCA Final Examination Sub-committee Chair)
- Ms Deena Jones (Executive Officer, Council Secretariat)
- Dr Dilip Kaur (Deputy FPM Assessor, SIMG)
- Ms Nadja Kaye (CPD Lead)
- Dr Vaughan Laurenson (DPA Assessor)
- Dr Susie Lord (FPM Board Member and RAP Working Group Chair)
- Mr Colin Lynas (Digital Learning Specialist)
- Dr Scott Ma (SIMG Committee Chair)
- Dr Cameron Maxwell (ANZCA Trainee Committee Co-chair)
- Ms Helen Maxwell-Wright (Community Representative)
- Dr Sharon McGregor (Indigenous Health Committee Member)
- Dr Sean McManus (Perioperative Medicine Steering Committee Chair, ANZCA Councillor)
- Ms Penny McMorran (FPM Professional Affairs Coordinator)
- Ms Renee McNamara (Education Standards and Policy Officer)
- Dr Rodney Mitchell (ANZCA Immediate Past-President and invited observer to the Joint Consultative Committee of Anaesthesia)
- Ms Andreana Newson (Training and Assessment Manager)
- Dr Stephanie Oak (FPM Board Member)
- Associate Professor Robert O'Brien (Executive Director, Education and Research)
- Dr Mary O'Hare (Senior Research Officer)
- Mr Robert Packer (General Manager, Research Foundation)
- Dr Robin Park (FPM Trainee Representative)
- Ms Bernadette Peace (Administrator, Learning and Innovation)
- Dr Nicole Phillips (DPA, Annual Scientific Meeting)
- Ms Nicole Pulitano (Training Lead)
- Dr Pete Roessler (DPA, Professional Documents)
- Ms Jan Sharrock (Executive Director – Fellowship Affairs)
- Dr Cassandra Sparkes, (FPM Projects and Development Lead, Education and Research)
- Dr David Smart (FACEM, DHM Sub-Committee and DHM Examinations Chair)
- Ms Shana Tan (Education Business Analyst)
- Professor Michael Veltman (FPM Training Unit Accreditation Committee Chair)
- Ms Jess Veneziano (SIMG Lead)
- Dr Melissa Viney (FPM Assessor)
- Mr Anthony Wall (General Manager, Policy)

- Dr Leonie Watterson (ANZCA Education Executive Management Committee Chair, ANZCA Councillor)
- Professor Jenny Weller (ANZCA Education Development and Evaluation Committee Chair)
- Associate Professor Deb Wilson (ANZCA Councillor, JCCA Member and Tripartite DRGA Committee Chair)
- Dr Leona Wilson (Executive Director of Professional Affairs)
- Dr Maggie Wong (DPA Assessor)
- Dr Mark Young (ANZCA Training Accreditation Committee Chair)

3. **Governance and approval group**

- Dr Vanessa Beavis (ANZCA President)
- Ms Stephanie Clare (Executive Director NZ National Office)
- Professor Milton Cohen (DPA FPM)
- Dr Chris Cokis (ANZCA Vice-President)
- Dr Kieran Davis (FPM Vice-Dean)
- Ms Leone English (Executive Director FPM)
- Mr Nigel Fidgeon (CEO)
- Associate Professor Robert O'Brien (Executive Director Education & Research)
- Dr Lindy Roberts (ANZCA DPA Education)
- Ms Jan Sharrock (Executive Director Fellowship Affairs)
- Mr Anthony Wall (General Manager Policy)
- Dr Leonie Watterson (Education Executive Management Committee Chair)
- Dr Leona Wilson (Executive DPA)
- Associate Professor Michael Vagg (FPM Dean)

Executive summary

The college presents a point in time self-assessment against the 'Standards for assessment and accreditation of specialist medical education programs and professional development programs and professional development programs by the Australian Medical Council, 2015' and the Medical Council of New Zealand 'Accreditation Standards for New Zealand training providers of vocational medical training and recertification programmes' (effective from 1 July 2022), in accordance with guidance notes and templates provided. The content focuses primarily on the training programs that lead to protected titles under *the National Law* in Australia and to registration in recognised vocational scopes of practice in Aotearoa New Zealand, the ANZCA and FPM CPD standard and program, and the ANZCA and FPM SIMG assessment process.

The submission is self-reflective, with authors encouraged to reflect on specific achievements, opportunities for improvement and future plans from the outset. As such, a specific section on strengths, opportunities for improvement and future plans is included at the end of each standard. Overall, the submission development process has been a valuable exercise in benchmarking college activities against the standards.

In this submission, 'college' refers to organisation-wide, 'ANZCA' refers to anaesthesia-related and 'FPM' refers to faculty-related matters. Reporting covers activities in both Australia and Aotearoa New Zealand, unless specifically qualified. Supporting material is available in links (for information publicly available on the college website) and appendices (for information not publicly available). A list of acronyms is at the front of the document. Each chapter addresses a single standard, including pandemic impacts and reflection on strengths, improvement opportunities and future plans.

Standard 1: The context of training and education

The college (Te Whare Tohu o Te Hau Whakoara) is governed by ANZCA Council with matters relating to pain medicine overseen by the Faculty of Pain Medicine (FPM) Board. All activities are underpinned by our mission *to serve the community by fostering safety and high quality patient care in anaesthesia, perioperative medicine and pain medicine.* Key strategic documents include the 2018-2022 strategic plan, draft Reconciliation Action Plan, doctors' health and wellbeing framework, rural and regional workforce strategy, and the strategic education framework. Diversity and inclusion initiatives include gender equity, Aboriginal and Torres Strait Islander and Māori health, environmental sustainability and global health.

The CEO manages the organisation across both countries with a dedicated New Zealand National Office and Australian regional offices. There is leadership and resourcing to prioritise and support training, CPD and SIMG assessment. The organisation has an internationally-recognised commitment to high quality research to support best practice care. Our commitment to equity of access for all communities is also reflected in our work on rural generalist anaesthesia.

The college has strong relationships in the health sector, including with training sites and jurisdictions. These have come to the fore during the pandemic. As a leader in quality and safety, the college has a strong history of setting professional standards for anaesthesia and pain medicine. Increasingly, it is also playing a more prominent role in perioperative medicine for optimal patient journeys. The FPM has a strong history of advocacy for those suffering with chronic pain, through initiatives such as the Australian National Strategic Action Plan for Pain Management.

Key areas for improvement include the development of a Treaty of Waitangi strategy, a more systematic and proactive approach to external stakeholder consultation, improved educational renewal and prioritisation through an education quality framework, and improved technology infrastructure through the lifelong learning project under the college ICT strategy.

COVID-19 has presented significant challenges. These have been handled with strong governance, agility and reprioritisation. A focus has been the safety and wellbeing of trainees, fellows, SIMGs and staff. Continuity of decision-making and educational development has been assured through the use of technology. Some projects have been slowed or deferred.

Standard 2: The outcomes of specialist training and education

The college recognises the dynamic and changing environment and is responding by ensuring guiding strategies are contemporary and agile to this changing environment. College educational purpose is expressed through the ANZCA Constitution, the ANZCA and FPM Reconciliation Action Plan (RAP) (in development), the ANZCA and FPM Strategic Plan 2018-2022, the planned 2023-2025 strategy (in development), and the ANZCA and FPM Strategic Education Framework (in development). This is underpinned by organisational purpose, expressed in our mission '*To serve the community by fostering safety and high quality patient care in anaesthesia, perioperative medicine and pain medicine'*.

Graduate and program outcomes are overseen by the ANZCA Education Executive Management Committee (EEMC) (for anaesthesia training) and the FPM Training and Assessment Executive Committee (TAEC) (for pain medicine training). **The program outcomes** are defined by community need and relate to the roles of specialist anaesthetists and specialist pain medicine physicians in the delivery of healthcare. All college training programs have adapted the CanMEDS roles, with permission from the Royal College of Physicians and Surgeons of Canada (RCPSC), to the ANZCA roles in practice and the FPM roles in practice. High-level descriptions of these roles are the basis of **graduate outcomes** for each program.

Standard 3: The specialist medical training and education framework

Each training program offered by the college has a curriculum framework which expresses the graduate outcomes and is based on the roles in practice. The framework is publicly available in the relevant curriculum document, supplemented and supported by a training handbook which has a broad overview of training program requirements, supervision and supervisory roles. All programs are regulated by an ANZCA regulation or FPM by-law which is the basis upon which individual training decisions are made.

The content of each curriculum is expressed in terms of learning outcomes for each training stage and how these are assessed. Each program builds on prior stages of medical training, prepares graduates for continuing professional development and has provision for recognition of prior learning. All programs define progression requirements in terms of competence. Whilst minimum timeframes are defined, there is flexibility both for longer training times if required, as well as flexible training options. Both anaesthesia and pain medicine programs have core and optional elements.

Standard 4: Teaching and learning

Key college teaching and learning resources include courses, the college library and museum, continuing medical education and other events, special interest groups, and eLearning resources in Networks, the college learning management system. Both anaesthesia and pain medicine training programs provide clear guidance for learning through defined outcomes matched to stage of training and, in the case of pain medicine, to the FPM roles in practice.

Training involves mandatory training and skills courses, some convened at departmental and regional or national levels, and others centrally (FPM tutorial program) or externally (Effective Management of Anaesthetic Crises). There are no compulsory university courses. The ANZCA Educators Program and WBA education is available to trainees, SIMGs and fellows. Teaching and learning methods promote increasing responsibility as trainee skills, knowledge and experience grows, and promote self-assessment for learning, role modelling and interdisciplinary and interprofessional learning.

Anaesthesia training is supported by a comprehensive and progressively-improved training portfolio system, whereas pain medicine relies on paper-based portfolios and forms. This deficiency will be addressed in the lifelong learning project. There are plans to implement a new exams management system, trainee portal system and learning management system to support all college training programs, as well as upgrade the existing CPD portfolio.

Standard 5: Assessment of learning

All training programs include a portfolio of assessments that sample across the relevant roles in practice to ensure graduate outcomes are achieved. These include workplace-based performance assessment and examinations, along with other requirements such as scholarly activities, all blueprinted to the relevant curriculum. Valid methods of standard setting are used for all examinations, assisted since 2017 by the Australian Council for Education Research (ACER). Assessment quality is regularly reviewed, for example through the extensive peer-reviewed research by fellows on workplace-based assessments (WBAs) in anaesthesia training and pain medicine assessments review for the 2015 curriculum. Quality of pain medicine training is supported by the involvement of a large proportion of FPM fellows in assessment, also facilitating feedback and change management.

Regular and timely feedback on trainee performance is provided via multiple mechanisms including ANZCA WBAs and FPM workplace based progressive feedback (WBPF), in-training meetings with supervisors, exam reports and individual feedback mechanisms and interviews. Supervisors are informed of trainee performance (including when high-stakes results are released) and are supported for early identification, intervention and escalation where trainees are not meeting outcomes. Formal remediation is through the ANZCA and FPM trainee support and trainee performance review processes, which include escalation to employers and regulators where patient or trainee safety is of concern (fortunately rare).

Areas for improvement include:

- Evolving pain medicine training from the current reliance on paper-based processes to efficient and secure online systems (in the lifelong learning project) to support trainees, their supervisors and the faculty for more efficient and effective decision-making, monitoring and evaluation (including accreditation).
- Improving feedback to successful trainees on examination performance (regularly highlighted in college trainee surveys and the Australian Medical Training Survey as a trainee concern).
- Improved governance of anaesthesia assessments to ensure integration of all assessment modalities, review of the risks and educational and wellbeing impacts of current high-stakes, centralised assessments, and evolution towards a more programmatic approach.
- Review of specific anaesthesia assessment components and processes through the training program evolution project. This includes WBA and portfolio review under the lifelong learning project, greater standardisation of assessment in introductory training, and introduction of problem-focused group decision-making.

- For improved consistency and procedural fairness, a planned college-wide approach to special consideration in assessments.

Standard 6: Monitoring and Evaluation

The governance and decision-making of monitoring and evaluation is overseen for anaesthesia training by the Education Executive Management Committee (EEMC), for pain medicine training by the Training and Assessment Executive Committee (TAEC), for CPD by the ANZCA and FPM CPD Committee and for SIMG assessment by the SIMG Committee. Whilst the college undertakes many monitoring and evaluation activities, a college AMC-MCNZ gap analysis in 2020 identified the lack of an overarching monitoring and evaluation framework. A college-wide framework is in development. See standard 5 for monitoring and quality improvement of assessments, and standard 9 for CPD monitoring and evaluation activities.

FPM evaluates graduate outcomes via an exit survey. ANZCA last administered a graduate outcome survey in 2016. Whilst there are well established pathways for trainee and supervisor input to monitoring and evaluation, there are limited mechanisms for input from employers, consumers and Aboriginal and Torres Strait and Māori communities and organisations. These are areas for reflection and future improvement.

The college recognises that monitoring and evaluation are areas for improvement and has dedicated resources to address these important quality processes. Initiatives in development include a college-wide monitoring and evaluation framework, reactivation of the anaesthesia graduate outcomes survey and establishing systematic processes for seeking external stakeholder input on graduate outcomes from all training programs.

Standard 7: Issues related to trainees

Trainee selection is a regional and local training site process undertaken by employers. There are college-wide selection guidelines and their application is evaluated at accreditation visits. Recognising the need to review this approach, a trainee selection project will commence in 2022.

The college has a well-established approach to **ANZCA trainee representation** at ANZCA Council, where they are invited observers, and on other training-related groups. There is a cultural expectation that trainees are represented on all projects that relate to anaesthesia training. FPM has had an FPM trainee represented on the ANZCA Trainee Committee for some years. Occasionally FPM trainees sit on faculty committees such as Learning and Development or regional and national committees. Embedding FPM trainee representation in the pain medicine committee structure is an area FPM will address in 2022.This process has commenced with a formalised trainee representative position being added to the Learning and Development Committee from the beginning of 2022.

Communication with all trainees occurs via multiple traditional and new mechanisms, including the college website, e-newsletters, email and social media. Training program changes are communicated through multiple channels. This usually includes e-newsletters, the website and the *ANZCA Bulletin*. Major changes are usually communicated in writing to each trainee.

Support for trainee wellbeing is a strong part of the college doctors health and wellbeing framework. The ANZCA trainee wellbeing project (2019-2021), which included several FPM trainees and an FPM board member, initiated significant activities in this area, many of which are now part of business as usual. The college has pathways for prevention and **resolution of training problems and disputes**, although recognises that these are not always widely

recognised by trainees. There are challenges in providing safety especially for trainees in smaller departments and units.

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

All training programs have well established and recognised clinical supervision frameworks that guide trainees in the progressive acquisition of skills to achieve program and graduate outcomes. The college has defined supervisor responsibilities and appointment processes. It provides professional support for them to ensure they are appropriately resourced for their roles. This resourcing is evaluated at accreditation. For anaesthesia supervisors, no specific training for their roles is mandated. Pain medicine supervisors are required to attend regular training workshops. Whilst trainees provide feedback on departments through accreditation and trainee surveys, there is no process for individual supervisor performance evaluation and feedback.

The college has procedures for selection of WBA assessors (for anaesthesia) and examiners (for all exams). For pain medicine training, all fellows may undertake WBPF. There are compulsory workshops for examiners and processes for feedback on examiner performance, although this does not include input from trainees. For WBA assessors and supervisors undertaking WBPF, the college offers training in workplace-based performance assessment and giving feedback, although this is not mandated. There is no process for individual WBA and WBPF assessor performance evaluation and feedback.

Accreditation of anaesthesia and pain medicine training locations is based on seven accreditation standards – quality patient care, clinical experience, supervision, supervisory roles and assessment, education and training, facilities and clinical governance. The process is governed by the ANZCA Training Accreditation Committee (TAC) and the FPM Training Unit Accreditation Committee (TUAC), supported by staff in the Training Assessment and FPM units.

ANZCA accredits training sites which are anaesthesia departments and all facilities within the same complex. It also recognises training experience in sites accredited by other colleges, particularly the College of Intensive Care Medicine (CICM) and the Australasian College for Emergency Medicine (ACEM). ANZCA regional and national committees accredit anaesthesia rotations which are groups of hospitals in each Australian region and Aotearoa New Zealand which can provide a complete training experience to achieve graduate outcomes. The FPM accredits multidisciplinary pain management units, both hospital-based and community-based services such as private practices. The FPM program does not have rotations, but rather uses the term ‘suite of training’ for individual trainee experiences which may occur across more than one unit.

ANZCA and FPM accreditation processes are separate. As part of training evolution, the college recently completed an ANZCA and FPM accreditation and learning environment project (ALEP) a collaborative piece involving both disciplines. Used mixed methodology to benchmark the college against international best practice in accreditation, the ALEP final report *An evolutionary direction for accreditation of college training programs* provided 15 recommendations as a roadmap for future accreditation optimisation. This was endorsed by ANZCA Council in mid-2021.

The key ALEP recommendation is cross-program accreditation redesign with generic and specialty-specific standards and processes that are scalable for all future college training programs. Other recommendations include better monitoring of accredited sites, improved volunteer accreditor support, mapping of standards to graduate outcomes, improved data with

an outcomes focus, bidirectional data sharing with units, strengthened trainee input, and more robust accreditation of anaesthesia rotations. An implementation plan will be developed in 2022. The lifelong learning project will deliver an online accreditation management system for all training programs which will facilitate monitoring (standard 4).

Standard 9: Continuing professional development, further training and remediation

The ANZCA and FPM CPD standard and program are governed by the ANZCA and FPM CPD Committee, reporting to the ANZCA Professional Affairs Executive Committee (PAEC) and hence ANZCA Council. Changes affecting pain medicine require FPM Board endorsement. Staffing is via the CPD team within the Education and Research unit. The standard and program address requirements for both specialist anaesthetists and specialist pain medicine physicians in three categories – practice evaluation, knowledge and skills and emergency response. Requirements are on the college website with recording via a bespoke CPD online portfolio including uploading of evidence, a dashboard to show progress, and automatic generation of compliance certificates. A randomly selected seven percent of participants are audited annually, with non-compliant participants supported to meet requirements. Requirements have evolved to meet requirements of the Medical Board of Australia and the Medical Council of New Zealand, with a CPD redesign underway to meet requirements due 2023 and mid-2022, respectively.

Most requests for further training are in the context of return to work for specialists who have been absent from practice. Occasionally, such requests are from regulatory bodies. Professional document PG50(A) Guideline on return to anaesthesia practice for anaesthetists 2017 provides the framework for return to practice programs for anaesthetists. Based on the ANZCA roles in practice, it includes components of the CPD program such as emergency responses, a period of one-to-one supervision followed by oversight and practice evaluation such as multisource feedback. A similar process for specialist pain medicine physicians is in development.

Pathways for addressing requests for remediation of specialists involve the directors of professional affairs, regulation 26, the guideline *Promoting good practice and managing performance in anaesthesia and pain medicine*, and a professionalism guide. The scope of the latter is being updated to encompass pain medicine. Fortunately, such requests are rare.

Standard 10: Assessment of specialist international medical graduates

Since 2013, SIMG assessment is a joint process for anaesthesia and pain medicine. Within an overarching bi-national and bi-specialty process, there are specialty-specific and country-specific modifications to meet the differing requirements of the MBA and MCNZ. Information on the process is available publicly on the college website.

The SIMG Committee oversees this process, reporting to both anaesthesia and pain medicine governing committees and to the New Zealand National Committee. Staff support is through the Melbourne head office, New Zealand national office and the SIMG director of professional affairs. Recent recruitment has focussed on increased involvement of former SIMGs and pain medicine fellows. The committee, interview and performance assessment panels now reflect most of the countries from which SIMG applicants originate.

Assessment conforms to MBA and MCNZ requirements and has improved in response to major external reviews. Progressively, there has been reduced reliance on examination and greater use of workplace-based performance assessment. From 2022, all SIMGs undergo multisource feedback. Areas for improvement include monitoring and pass rates in the SIMG examination.

Standard 1

The context of training and education

Standard 1: The context of training and education

Overview

The college (Te Whare Tohu o Te Hau Whakoara) is governed by ANZCA Council with matters relating to pain medicine overseen by the Faculty of Pain Medicine (FPM) Board. All activities are underpinned by our mission '*to serve the community by fostering safety and high quality patient care in anaesthesia, perioperative medicine and pain medicine'.* Key strategic documents include the 2018-2022 strategic plan, the draft Reconciliation Action Plan, doctors' health and wellbeing framework, rural and regional workforce strategy, and the strategic education framework. Diversity and inclusion initiatives include gender equity, Aboriginal and Torres Strait Islander and Māori health, environmental sustainability and global health.

The CEO manages the organisation across both countries with a dedicated New Zealand national office and Australian regional offices. There is leadership and resourcing to prioritise and support training, CPD and SIMG assessment. The organisation has an internationally-recognised commitment to high quality research to support best practice care. Our commitment to equity of access for all communities is also reflected in our work on rural generalist anaesthesia.

The college has strong relationships in the health sector, including with training sites and jurisdictions. These have come to the fore during the pandemic. As a leader in quality and safety, the college has a strong history of setting professional standards for anaesthesia and pain medicine. Increasingly, it is also playing a more prominent role in perioperative medicine for optimal patient journeys. FPM has a strong history of advocacy for those suffering with chronic pain, through initiatives such as the Australian National Strategic Action Plan for Pain Management and work with the New Zealand Ministry of Health.

COVID-19 has presented significant challenges. These have been handled with strong agility and reprioritisation. A focus has been the safety and wellbeing of trainees, fellows, SIMGs and staff. Continuity of decision-making and educational delivery has been assured through the use of technology. Some projects have been slowed or deferred.

Key areas for improvement include the development of a Treaty of Waitangi strategy, a more systematic and proactive approach to external stakeholder consultation, improved educational renewal and prioritisation through an education quality framework, and improved technology infrastructure through the lifelong learning project (standard 4).

Key resources:

- ANZCA Constitution.
- ANZCA Strategic Plan 2018- 2022.
- Indigenous Health Strategy and draft Reconciliation Action Plan.
- ANZCA regulations: Committees of ANZCA Council (regulation 2), Regional and national committees of the college (3), Trainee committees of the college (16), Reconsideration and review process (30), Appeals process (31), The ANZCA Council protocol (39), Faculties of the college (40).
- FPM by-laws: The Board of Faculty (by-law 1), Committees and functions of the board (2), Regional and national committees of the faculty (15).

- Professional documents and background papers: *PS40(G) Position statement on the relationship between fellows, trainees and the healthcare industry*, *PS59(A) Position statement on roles in anaesthesia and perioperative care*, *PS62(G) Position statement on cultural competence*, *PS64(G) Position statement on environmental sustainability in anaesthesia and pain medicine practice*.
- Others: Statement on the role of the college in advocating for the health and wellbeing of all people, endorsed guidelines and joint statements (developed by other organisations).

See also: Standard 7 (trainee involvement in governance).

1.1 Governance

The AMC accreditation standards are as follows:	
1.1 Governance	
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.

Corporate Governance

History and background

The training of specialist anaesthetists in Australia and Aotearoa New Zealand began in 1952, with the establishment of the Faculty of Anaesthetists within the Royal Australasian College of Surgeons (RACS) with 69 foundation fellows. By the time the Australian and New Zealand College of Anaesthetists (ANZCA) became an independent college in February 1992, there were more than 2100 fellows and 500 trainees. In 2017, ANZCA celebrated its 25th anniversary as an independent college, marked by the publication of the book *25 Years of ANZCA Leadership*.

In 1998, ANZCA Council approved the establishment of the Faculty of Pain Medicine (FPM). Pain medicine was officially recognised as a medical specialty by the Australian Medical Council (AMC) in 2005 and the Medical Council of New Zealand (MCNZ) in 2012.

The college is responsible for the training, assessment, examination, qualification and continuing professional development (CPD) of specialist anaesthetists and specialist pain medicine physicians, the standards of anaesthesia and pain medicine in Australia and Aotearoa New Zealand, and specialist international medicine graduate (SIMG) assessment. In 2013, the college implemented a redesigned anaesthesia training program and in 2015, a redesigned pain medicine training program was introduced. Both are based on competency-based medical education (CBME) principles.

The college also awards a qualification in diving and hyperbaric medicine (DHM) and trains general practice anaesthesia (GPA), the latter with the Australian College of Rural and Remote Medicine (ACRRM) and the Royal Australian College of General Practitioners (RACGP). It is developing qualifications in perioperative medicine (POM) and a redesigned rural generalist anaesthetist (RGA) diploma (see *Other training programs* across all standards).

The college has a significant role in the advancement of anaesthesia and pain medicine in Asia and the Pacific. While fellowship of ANZCA (FANZCA) training in Hong Kong, Malaysia and Singapore ceased in 2018, the college maintains strong ties in the region through its international relationships and pain medicine training in Hong Kong and Singapore.

Organisational purpose

The college's mission is 'to serve the community by fostering safety and high quality patient care in anaesthesia, perioperative medicine and pain medicine'. ANZCA's vision is 'to be a recognised world leader in training, education, research and in setting standards for anesthesia and pain medicine'. FPM's vision is 'to reduce the burden of pain on society through education, advocacy, training and research'.

Membership categories

The ANZCA Constitution defines membership classes. Individuals are admitted to ANZCA or FPM fellowship (and thus college membership) by completion of the relevant vocational training program or via the SIMG assessment process. As a post-fellowship specialty qualification, candidates for FPM fellowship must hold an approved primary specialist qualification. Trainees, SIMGs and non-FANZCA, non-FFPMANZCA holders of other college qualifications are not members of the college. Honorary ANZCA and FPM fellowship is awarded by ANZCA Council or the FPM Board to distinguished members of the medical profession and other eminent persons. FPM retired an election to fellowship pathway in mid-2021.

Table 1.1 Number of college members by membership category

College membership				
Category	**Total**	**Australia**	**Aotearoa New Zealand**	**Other**
ANZCA				
Fellows	6549	5243	840	464
Retired fellows	1229	853	119	246
Honorary fellows	3	1	0	2
FPM				
Fellows	458	365	40	53
Retired fellows	67	47	11	9
Honorary fellows	9	6	0	3

Governance structure

The college is a company limited by guarantee ('ANZCA') under Australian corporations law, with the college head office in Melbourne, Victoria. In Aotearoa New Zealand, the college is registered with the New Zealand Companies Office as an overseas company. The college is governed by the ANZCA Council. ANZCA regulations govern college conduct and management, consistent with constitutional objectives. These regulations are regularly updated. FPM is a faculty of the college under the constitution, administered by a board as per delegations in regulation 40 which includes the development of by-laws for internal operations. The college annual report is tabled each May at the Annual General Meeting (AGM) and is made publicly available on the college website.

ANZCA Council

ANZCA Council sets the overall direction of the college, ensuring its objectives are achieved. The council is governed by the constitution and its protocol (regulation 39). It has 14 voting members (ANZCA directors), listed on the college website:

- 12 fellows elected by all college fellows, excluding honorary fellows, for three-year terms with a maximum period of 12 years, whether served continuously or not. The college maintains regional and national representation of these 12 councillors via co-option if Aotearoa New Zealand or an Australian state is not represented.
- The FPM Dean, elected by the FPM Board from within its members and serving on ANZCA Council for up to two years.
- A new fellow councillor, elected by all fellows within three years of admission to fellowship for a two-year term. This councillor can nominate subsequently for election as a generally-elected councillor, with their time as new fellow councillor counting towards the aggregate 12-year maximum.

The ANZCA Council elects office bearers, the president and vice-president, for one year. The office bearers are eligible for re-election for a further one-year period, with the president-elect elected in November each year to take office at the AGM in May of the following year. There is also a formal role of immediate past president with terms of reference (appendix 1.1). ANZCA President Dr Vanessa Beavis FANZCA (Auckland, Aotearoa New Zealand) was elected in May 2020 and finishes in May 2022. Current president-elect and vice president from May 2020, Dr Chris Cokis FANZCA (Perth, WA) assumes office in May 2022. The constitution was updated in 2021 so that the president and president-elect cannot lose their seats while in the roles, ensuring leadership continuity.

New councillors receive an **orientation** with key college staff and the college legal counsel and are provided with a councillor resource manual (appendix 1.2). The ANZCA president has a separate manual (appendix 1.3). The college funds annual councillor governance training through the Australian Institute of Company Directors or the Institute of Directors, New Zealand. Almost all current councillors are graduates or fellows of the Australian Institute of Company Directors (GAICD or FAICD), or Aotearoa New Zealand equivalent. In 2021, a new ANZCA Council work planner was implemented (appendix 1.4).

Council meetings are held on a bi-monthly basis with a directors-only session, a section of which is in-camera, an internal session and an open session. The chief executive officer (CEO) attends all but the in-camera session and the executive director of professional affairs attends the internal, open sessions and the directors' session by invitation. The co-chairs of the ANZCA Trainee Committee (ATC), the chair of the ANZCA New Zealand National Committee (NZNC) and up to three other ANZCA regional committee chairs (who attend on rotation) are co-opted observers for the internal and open sessions. The council undertakes **whole-of-board performance evaluation** (appendix 1.5) annually, and the president meets with individual directors to discuss their contribution and performance. The 2022 evaluation is underway and will be completed by the April council meeting.

The presidents of the Australian Society of Anaesthetists (ASA), the New Zealand Society of Anaesthetists (NZSA), the Royal Australasian College of Surgeons (RACS) and the College of Intensive Care Medicine (CICM) are co-opted observers to the open session. In 2021, the council co-opted the president of the Hong Kong College of Anaesthesiologists (HKCA) as an observer to the open session.

Council composition

Council is a fellows-based board. To assist it in discharging its duties in finance, audit and risk management, it has a Finance Audit and Risk Management Committee (FARM). As outlined in regulation 2.24.2, FARM members include the president, FPM dean, vice president, honorary treasurer and up to three other members with recognised skills in contemporary public or corporate practice, legal practice, audit and compliance, one of whom is chair. FARM meeting minutes are tabled at ANZCA Council meetings and the honorary treasurer updates council on matters arising. See standard 6.3 for discussion of educational risk management and standard 7.2 for discussion about the representative role of trainees at council.

College performance reporting

The performance of college activities is captured in multiple ways including via a **Governance Report** (appendix 1.6), produced monthly and tabled at ANZCA Executive, ANZCA Council, FARM, and the FPM Board (for FPM performance). The detailed report provides robust reporting on financial and non-financial targets, performance against targets, trend analysis, and fellow and trainee data. **Non-financial KPIs** of college performance are reported quarterly to FARM and council. A comprehensive **staff delegations policy,** last updated in October 2021, details the approved delegations from council across the organisation.

FPM Board

By-law 1 *The Board of the Faculty* includes the processes for appointing members, their terms of office and guidance on meetings. Membership of the FPM board comprises:

- Seven elected fellows.
- Up to three co-opted fellows.
- One elected new fellow, elected from FPM fellows having been admitted to fellowship via completion of the FPM training program within three years of the closing date for nominations.
- The ANZCA president.
- A second ANZCA councillor.

The FPM dean and vice-dean positions are held for a maximum of two years. The FPM Dean, Associate Professor Michael Vagg, FAFRM(RACP), FFPMANZCA, a specialist pain physician and rehabilitation physician based in Victoria, was elected in May 2020 and his term finishes in May 2022. Vice-dean from 2020 to 2022, Dr Kieran Davis FRCA, FFPMANZCA, FANZCA, a pain physician and anaesthetist based in Auckland, Aotearoa New Zealand, was elected as dean-elect in February 2022.

All members of board have voting rights. The coopted positions on the board were introduced ahead of the 2021 FPM AGM to ensure the board included the skills and diversity required to progress its strategic goals. The board usually meets on the day after ANZCA Council and follows the same processes and protocols. New members undertake a condensed orientation program and may be re-elected or co-opted to a maximum period of 12 years. FPM regional and national committee chairs are occasionally invited observers to the open session. The CEO, FPM executive director and FPM director of professional affairs (DPA) attend board meetings as advisors. Board members are encouraged to complete a company directors course, with one board member a year funded to do so.

In 2019, an **annual performance review** (appendix 1.7) of the board and dean's performance was introduced. Results are discussed at a closed board meeting and professional coaching is provided to the dean. This process continues to evolve as members become familiar with it.

In 2020, FPM Board composition was revised to reflect the full range of primary specialist qualifications now recognised as pre-requisites for awarding FPM fellowship. Previously, the board had representation from all primary qualifications of the founding parent colleges (ANZCA, the Royal Australasian College of Surgeons, Royal Australian and New Zealand College of Psychiatrists and Royal Australasian College of Physicians, including the Faculty

of Rehabilitation Medicine). The reviewed board composition ensure availability of skills were required for delivery of FPM strategic priorities.

Strategic plan

2018-2022

The current strategic plan was developed through an extensive consultation process in 2017 that saw the development and adoption of two strategic plans; one for ANZCA and one for FPM. In early 2020, council and FPM Board endorsed a consolidated plan derived from these separate strategic plans. This was to provide a clear college-wide focus, with improved oversight and coordination of activities.

2023-2025

In August 2021, council, recognising the rapidly changing global environment created by the COVID-19 pandemic, endorsed development of a three-year plan. A high-level overview of the development process is in figure 1.1. Plan development is assisted by the consultancy Resilient Futures who have worked with similar organisations (RACS, Australian College of Optometry, Councils of Presidents of Medical Colleges) on strategic planning. Planning involves the ANZCA Council, the FPM Board, the executive leadership team and the senior leadership team and is informed by recent fellowship and trainee surveys. Other stakeholders such as consumer representatives are not involved. While trainee survey results have informed strategic plan development, trainees have had limited opportunity to have direct input to the strategic plan.

Figure 1.1 Development process for the 2023-2025 strategic plan

Following the combined council and board workshop, a draft plan is in development. This will be reviewed by the council and board with final approval expected at their July 2022 meetings. The finalised plan will be publicly available on the college website and communicated to all ANZCA stakeholders, fellows, trainees, SIMGs and staff, and then cascaded into an operational plan across the organisation.

Corporate structure: Organisational chart

The current management structure is at appendix 1.8. In October 2019, current CEO Mr Nigel Fidgeon replaced Mr John Ilott who retired after four years in the role. In January 2020, a re-alignment of senior management occurred, strengthening the executive team by reducing direct reports to the CEO. An executive leadership team replaced the previous senior leadership team. The term senior leadership team was retained in the realignment but with altered membership. There has been steady growth in staff capacity and establishment,

with current overall FTE of 121.42, including 8.29 FTE in FPM and 4.2 FTE in the New Zealand National Office.

Values and codes of conduct

The People and Culture team is reviewing the introduction of college values for staff in 2022. Staff representatives from different teams and levels will actively participate in the process, ensuring relevance and engagement in values development and embedment. This follows an unsuccessful attempt to introduce staff values in 2016/2017 (these were identified at the time as learning, excellence, accountability and transparency, respect and engagement and new ways/innovation).

At each strategic planning process since the 2012 AMC MCNZ reaccreditation, ANZCA Council has discussed the adoption of values. These discussions have not further progressed to values development. Challenges have included the scope of application (staff only; staff and all fellows, trainees, SIMGs; staff and only fellows, trainees and SIMGs with formal college roles) and how to make them meaningful, particularly as most fellows, trainees and SIMGs are subject to values in their workplaces.

In 2015, council retired the ANZCA code of professional conduct (developed in 2008) and formally adopted the MBA and MCNZ codes of conduct for its fellows, trainees and SIMGs resident in Australia and Aotearoa New Zealand, respectively, as college codes (noting these apply to all registered medical practitioners in any case). In 2014, the college developed a professionalism framework *Supporting anaesthetists professionalism and performance: a guide for clinicians* (standard 9.3). This guide is currently being updated to ensure relevance to pain medicine and current professional issues. In 2020, to support diversity and inclusion, the college developed a code of conduct to promote a safe environment for all delegates at college events.

Aboriginal and Torres Strait Islander and Māori health

In 2010, the college established a bi-national Indigenous Health Working Party. In 2011, the working group evolved into the Indigenous Health Committee (IHC) with terms of reference in appendix 1.9. At that time, the committee had seven members, one of whom identified as Māori and one as Pacific Islander. In 2022, there are 11 IHC members. 55 per cent identify as Aboriginal or Torres Strait Islander (three), Māori (three) or Pacific Islander (one). In 2021, ANZCA Council approved an IHC target of 70 per cent Aboriginal and Torres Strait Islander and Māori membership.

Aboriginal and Torres Strait Islander and Māori health initiatives

Over the past decade, the committee has established a broad set of Indigenous health initiatives. A bi-national, five-year Indigenous Health Strategy was launched in 2018 following 12 months' engagement and consultation with Aboriginal and Torres Strait Islander and Māori health stakeholders. Targeting health inequity among Aboriginal and Torres Strait Islander and Māori peoples in both Australia and Aotearoa New Zealand, the strategy is accompanied by a comprehensive background paper and an action plan linking all college resources, support and activities. Key initiatives of this strategy and plan related to AMC standard 1 include:

- A Te Reo Māori name for the college (Te Whare Tohu o Te Hau Whakaora), inaugural biennial Cultural Safety and Leadership Hui in Waitangi in February 2021, and a Māori Anaesthetists Network in Aotearoa New Zealand for fellows and trainees, with activities driven by network members (standard 1.6.4).

- An acknowledgment guide to recognising Aboriginal and Torres Strait Islander Peoples as the Traditional Custodians of the land, waters and seas in Australia and ngā iwi Māori as the Tangata Whenua of Aotearoa. In 2021, it became mandatory to make an acknowledgment at official college meetings and events in both countries.
- Aboriginal and Torres Strait Islander and Māori health awards to recognise college members who have made significant and sustainable contributions to Aboriginal, Torres Strait Islander or Māori health through public health initiatives or research projects.
- The exhibition Djeembana Whakaora: First Nations medicine, health and healing at the Geoffrey Kaye Museum of Anaesthetic History (standard 4).

Reconciliation Action Plan

Building on prior Aboriginal and Torres Strait Islander and Māori health initiatives and with the current Indigenous Health Strategy action plan drawing to a close in 2022, the college is now developing our first Innovate Reconciliation Action Plan (RAP). A working group of fellows, trainees, the CEO, other staff and a community representative have drafted a plan with 19 actions and over 80 deliverables including yet-to-be-completed initiatives from the Indigenous Health Strategy action plan. Six of the 13 members of the working group are of Aboriginal or Torres Strait Islander background. The group engaged with Reconciliation Australia and Indigenous health organisations, particularly Leaders in Indigenous Medical Education (LIME), in developing the plan. Reconciliation Australia has provided feedback on the draft RAP which is currently being reviewed. The draft RAP is at appendix 1.10.

Focus areas are cultural awareness and competency of staff, trainees (standard 3), supervisors of training (standard 8.1), fellows, SIMGs (standard 10) and working to ensure hospitals are culturally safe spaces for both patients and doctors (standard 7.4). 2022-2023 projects incorporate relevant actions in the RAP, including the ANZCA FPM Indigenous health learning outcomes project (standard 3 '*Improvement opportunities and future plans'*), the ANZCA and FPM trainee selection project (standard 7.1) and the accreditation and learning environment project recommendations implementation plan (standard 8.2).

Te Whare Tohu o Te Hau Whakoara

Following council approval to develop a Māori name for the college, in November 2019 the New Zealand National office engaged Stephanie Tibble (E Tā Ltd), a qualified te Reo Māori translator and media professional, via the Māori Language Commission. In July 2020, three options proposed by Ms Tibble were put to the Māori Anaesthetists Network Aotearoa (MANA).

The preferred name – **Te Whare Tohu o Te Hau Whakaora** – was endorsed by ANZCA Council and FPM Board. The name is a combination of two options presented to MANA:

- Te Whare Tohu denotes the status of a college, or literally a "significant house".
- o means 'of'.
- Te Hau Whakaora means "the life-giving breath".
- The words hau and whakaora have multiple meanings including: hau – 'breath, wind, gas, vital essence of life, aura, prestige, eminence' and whakaora – 'revive, revitalise, rescue, restore to health, cure, healing'.

The name speaks to the important roles of anaesthetists and pain medicine specialists in restoring the breath and 'life essence'/Mauri of their patients. It infers the more holistic and sacred work of specialists to preserve the quality of life of their patients. There is a synergy between this name and the Latin motto on the college coat of arms – Corpus curare spiritumque – which means 'To care for the body and its breath of life'. Former New Zealand Executive Director Kiri Rikihana explains how to pronounce the name in a short YouTube video.

In February 2021, the name was launched at the Cultural Safety and Leadership Hui in Waitangi, with an article published in the *ANZCA Bulletin* Autumn 2021 edition (appendix 1.11). The te reo Māori name will eventually appear in addition to the English name on all college collateral produced in or for fellows, trainees, and SIMGs in Aotearoa New Zealand.

University of Otago partnership

The college partnered with the University of Otago to provide a course that was promoted to anaesthetists as part of their CPD. The course was MIHI 501 ANZCA: Application of Hui Process/Meihana Model to the Australian and New Zealand College of Anaesthetists (2021). The format was interactive and face-to-face with a maximum of 50 attendees. Many fellows, both NZNC members and those involved in FANZCA training, participated. It is hoped that it will continue to be offered, although it is not available in 2022.

Treaty of Waitangi strategy

The Indigenous Health Committee is considering a proposal to establish a steering group to oversee the development of a Treaty of Waitangi strategy for the college. The strategy will consider what actions ANZCA can take under each of the principles set out by the Waitangi Tribunal Health Services and Outcomes Inquiry and endorsed by the Ministry of Health in its Whakamaua: Māori health plan 2020-2025.

Diversity and inclusion

The college finds all forms of discrimination unacceptable as it can negatively impact the health and wellbeing of our trainees, fellows, SIMGs, staff, and the wider community. The college describes its commitment to supporting inclusion and diversity here.

Gender equity

The college strongly endorses gender equity because of its ethical, social, and economic benefits for fellows, trainees, SIMGs and the broader community. To drive gender equity initiatives, the college established a Gender Equity Working Group in 2017. In 2019, the working group released a gender equity position statement and supporting task-oriented 5-year action plan. In 2020, a Gender Equity Sub-Committee replaced the working group to oversee ongoing developments. Three action plan initiatives have been completed: a gender equity resource kit, an unconscious bias and interview panels toolkit, and a gender equity library guide.

The event gender equity position statement illustrates college commitment to gender balance at conferences and events and is achieving positive outcomes. The college has made a commitment to regularly report on gender metrics, which are publicly shared under the 'key metrics' section of the gender equity webpage, in publications and at meetings. Other initiatives supporting this commitment include the *ANZCA panel pledge,* where male college members agree not to participate in male-only presentations or sessions at conferences and other events.

In December 2021, council supported ANZCA working collegially in a cross-organisational partnership involving ANZCA, the ASA, SPANZA and the NZSA to provide and support women in leadership and mentoring across both Australia and Aotearoa New Zealand. The name of this initiative is the Women's Empowerment and Leadership Initiative, and its mission is '*to empower highly productive women paediatric anaesthesiologists to achieve equity, promotion, and leadership'*. Discussions are also underway for the college to become a partner and collaborator in Advancing Women in Health Leadership, a national research and impact project aiming to improve career progression for women in healthcare.

Volunteerism and engagement of fellows, trainees and SIMGs

The college recognises the broad scope of activities undertaken by clinician volunteers. This is in the 2018-2022 strategic plan under 'supporting' with strategies on regional and rural workforce, wellbeing, diversity and advocating for multidisciplinary pain services. Key initiatives to engage and support our volunteer workforce include:

- New fellows support.
- Special interest groups, with ASA and NZSA.
- Health and wellbeing.
- Support for contribution.
- Awards Advisory Panel.

Doctors' health and wellbeing

The college, with the ASA and NZSA has a long history of support for anaesthetist wellbeing with the Welfare of Anaesthetists Special Interest Group (now Wellbeing SIG) established in 1999. The SIG promotes awareness of personal and psychological wellbeing for specialist anaesthetists and pain medicine physicians. It is an education and referral body, with no therapeutic role. The SIG actively promotes initiatives including advocacy; regular educational sessions at the annual Combined SIG meeting, ANZCA Annual Scientific Meeting (ASM) and ASA National Scientific Congress, as well as at Australian regional and Aotearoa New Zealand national conferences and workshops; and resources such as the Wellbeing SIG library guide (standard 4).

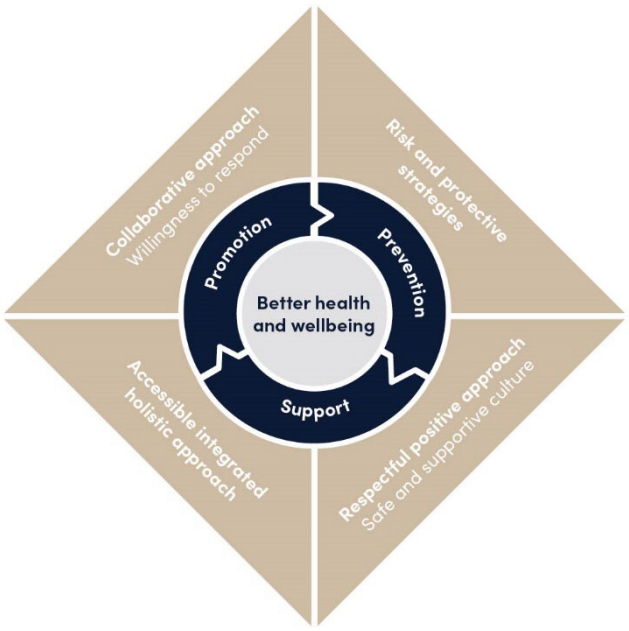
Doctors' health and wellbeing strategy

In 2018, the college placed doctors health and wellbeing prominently in the 2018-2022 strategic plan, as a standalone pillar 'Supporting workforce and wellbeing' (pillar four). This set a direction, ensured resourcing and informed subsequent work in the health and wellbeing space. It has also ensured college focus on improving the health and wellbeing of fellows, trainees, SIMGs and staff.

Doctors' Health and Wellbeing Framework

The first step was the development of the Doctors' Health and Wellbeing Framework which was developed, trialled and implemented in 2019 (figure 1.2). This pilot framework was adapted to college needs from Beyond Blue's "First responders' good practice model for mental health and wellbeing". To ensure relevance, consultation with a broad range of key internal and external stakeholders occurred**.** Subsequently, new business processes and operational tools were established to support college-wide implementation of doctors' health and wellbeing initiatives.

Figure 1.2 Doctors' health and wellbeing framework



Wellbeing advisory panel

In 2021, the ANZCA Professional Affairs Executive Committee (PAEC) approved the formation of this panel to work with the Education and Research, and Fellowship Affairs units to ensure that future wellbeing-related activities remain a collaboration between the various college units and trainees, fellows and SIMGs. For more information on college wellbeing initiatives see standard 7.4. trainee wellbeing.

Governance of education and training and committee composition, terms of reference, delegations and reporting

College committee structure

The college committee structure covers the range of core business and strategic priority areas. Terms of reference (TOR) outline purpose, roles, membership and reporting lines for each committee, sub-committee and working group. ANZCA Council appoints committee chairs, members and other role holders for two-year terms following the AGM in each odd-numbered year. FPM Board appoints committee chairs for two-year terms following the AGM in each odd-numbered year. The membership of committees is then approved by either the FPM Training and Assessment Executive Committee (TAEC) or FPM Professional Affairs Executive Committee, as relevant. Councillors and FPM Board members chair major committees and are represented across the structure. All college committees have members from both Australia and Aotearoa New Zealand, except where their remit is country-specific (for example, the Australian Tripartite Committee of Rural Generalist Anaesthesia and curriculum group).

The following changes to these structures have occurred since the last reaccreditation (2012):

- In 2012, there was an ANZCA educational governance review, council decision to withdraw anaesthesia training in Hong Kong, Malaysia and Singapore, and development of terms of reference for all committees and sub-committees.
- In 2013, a revised ANZCA educational committee structure introduced three overarching educational committees (executive, strategy and management).
- In 2014, the ANZCA PAEC was established to oversee all ANZCA fellowship activities, including CPD via the CPD Committee, which reports to PAEC.
- In 2015, the FPM Learning and Development Committee was established to support the implementation of the revised pain medicine training program.
- In 2016, an FPM governance review established the Training and Assessment Executive Committee with consumer representation, and the FPM Professional Affairs Executive Committee.
- In 2016, increased delegations from council to the Education Executive Management Committee (EEMC) to expand educational policy decision-making, including amendment of regulations under specific circumstances.
- In 2017, a major ANZCA educational governance review led to disbanding of the strategy and management committees with oversight of educational strategy and management consolidated into the roles of EEMC (formerly the Education Training and Assessment Executive Committee). Integration of accreditation and SIMG assessment functions was improved with the Training Accreditation Committee (TAC) and SIMG committees reporting to EEMC (rather than directly to council).
- In 2018, the ANZCA CPD Committee name was changed to ANZCA and FPM CPD Committee to reflect that it serves both specialist anaesthetists and specialist pain medicine physicians.
- In 2019, accreditation integration with anaesthesia training was altered so that TAC now reports directly to the ANZCA Council.
- In 2020, the FPM dean was added to the membership of the ANZCA Executive and FARM Committees to ensure the lens of pain medicine was considered by these college-wide groups. A constitutional amendment is proposed for May 2022.

The following changes are planned for the next three years:

- Strengthening governance of anaesthesia assessment through restructuring the Exams Advisory Group as the Assessment Advisory Group, ensuring anaesthesia primary and final exams, as well as workplace-based assessments (WBAs) are overseen centrally (standard 5).
- Establishing the ANZCA Educators Academy may have an impact on the governance of the ANZCA Educators Program, professional development opportunities for educators and potentially the function of the Education Evaluation and Development Committee (EDEC, standard 8.1).
- Changes to the provisional fellowship committee structure are anticipated.

Committees of ANZCA Council

The committees and subcommittees of ANZCA Council are governed by regulation 2 and TOR (appendix 1.12). The groups that report to council and their purpose are:

- The **FPM Board**, see below.
- The **ANZCA Executive Committee**, responsible for assisting the president and CEO in dealing with matters which arise between council meetings and carrying forward to council matters that need council consideration, action or ratification.
- **New Zealand National Committee (NZNC)** undertakes a leadership role on issues that relate specifically to Aotearoa New Zealand and reports to ANZCA Council on ANZCA affairs in Aotearoa New Zealand.
- **Australian regional committees** assist in implementing college policy in their region, advise ANZCA Council on regional issues, represent, maintain relationships with key stakeholders and have a role in training, CPD and other professional activities in the region.
- **ANZCA Foundation Committee**, acts in an advisory capacity to oversee, monitor, provide advice, take advice and consider recommendations from, and actively promote the ANZCA Foundation to meet its objectives.
- **Education Executive Management Committee (EEMC)** (standard 1.1), oversees and guides education activities across all ANZCA education programs, reports to ANZCA Council.
- **Finance, Audit and Risk Management Committee**, assists the council in discharging its duties in relation to finance, audit and risk management.
- **ICT Governance Committee**, responsible for advice on planning and governance of information management, information and communications technology and project management of major strategic ICT initiatives.
- **Perioperative Medicine Steering Committee**, reports directly to ANZCA Council on the development and implementation of an effective integrated perioperative care model and education offerings for Australia and Aotearoa New Zealand (see *Other training programs* standard 1).
- **Professional Affairs Executive Committee (PAEC)**, advises ANZCA Council on matters pertaining to the college fellows including fellowship, policy, advocacy, engagement, and community development.
- **ANZCA Research Committee**, oversees college research activities including the ANZCA grant program. Research governance, strategy and committees is in appendix 1.13. Standard 1.6 includes external research relationships.
- **Safety and Quality Committee**, assists council by advising on safety and quality in patient care in anaesthesia, perioperative medicine and pain medicine.
- Training Accreditation Committee (standard 8.2).

Committees responsible for training programs, CPD and SIMG assessment are under standard 1.1. These include joint ANZCA and FPM committees for CPD and SIMG assessment.

Committees of the FPM Board

The FPM governance structure is modelled on the ANZCA structure with a board to which report three executive committees and the FPM NZNC Australian regional committees report to the Professional Standards Committee, which reports to the PAEC. Committee terms of reference are at appendix 1.14. Committees responsible for training, CPD and SIMG assessment are in 1.1.

ANZCA and FPM Australian regional committees and offices

Elected regional committees support the ANZCA Council and FPM Board with engagement of fellows and trainees in the Australian Capital Territory, New South Wales, Queensland, South Australia/Northern Territory, Tasmania, Victoria and Western Australia. The ANZCA regional committees are governed by regulation 3 and the FPM regional committees are governed by by-law 15. With few Australian Capital Territory and Tasmanian fellows, FPM does not have FPM specific regional committees in these regions. FPM Tasmanian fellows have a representative on the ANZCA Tasmanian Regional Committee, while an ACT fellow participates in the FPM NSW Regional Committee.

These regional committees act as a conduit between fellows and trainees in the regions, reporting to ANZCA Council and the FPM Professional Standards Committee, respectively. Example TOR are included in appendix 1.15. The regional committees assist with implementing college policy in their region; advising on issues of interest to the college and its fellows and trainees in the region; representing the college and promoting the specialties of anaesthesia and pain medicine in the region; and training, continuing medical education (CME) and other professional activities at a regional level. The activities of the regional committees are supported by dedicated college staff in regional offices in Sydney, Brisbane, Canberra, Perth, Adelaide and Hobart, overseen by the general manager for regional operations. The Victorian Regional Committee is supported by staff in the Melbourne office.

ANZCA and FPM New Zealand national committees and office

The sovereign status of Aotearoa New Zealand is acknowledged, as is the importance of providing locally grounded advice to government in each country. ANZCA regulation 3 details the nature of the ANZCA NZNC as an elected body that acts as a conduit between fellows and trainees in Aotearoa New Zealand and ANZCA Council. The NZNC chair attends ANZCA Council as an observer to support the strong connection between both countries.

The ANZCA and FPM NZNCs are elected bodies that undertake leadership roles on national issues and are conduits between fellows and trainees in Aotearoa New Zealand and the ANZCA Council and FPM Board. Committee TOR are in appendix 1.16. The NZNCs roles include:

- Implementing college policy in Aotearoa New Zealand.
- Advising the ANZCA Council and FPM Board/Professional Standards Committee on issues of interest to the college and its fellows and trainees in Aotearoa New Zealand.
- Representing the college and promoting the specialties of anaesthesia and pain medicine in Aotearoa New Zealand.
- Developing and maintaining relationships with key national stakeholders.
- Implementing training, CME and other activities at a national level.

- Representing the college in dealing with national agencies such as the Ministry of Health and MCNZ, with which there are regular meetings.

The college is a member of the Council of Medical Colleges in New Zealand and a branch advisory body of the MCNZ. The ANZCA NZNC co-opts the president of the NZSA and the chair of the CICM New Zealand National Committee as observers at their meetings, which are held three times per year.

The New Zealand national office in Wellington, Aotearoa New Zealand is responsible for national policy, communications, committee management and events. The staff and roles mirror these high-level responsibilities (see organisation chart in appendix 1.8).

Governance of training and education

Educational function governance

The key bi-national committees for education and training functions are ANZCA EEMC, ANZCA PAEC and FPM TAEC (standard 1.2).

Australian regional and New Zealand national educational governance

Educational governance at an Aotearoa New Zealand national level or Australian regional level is as follows:

For anaesthesia training:

- Education Officers (EOs) in each Australian state and Aotearoa New Zealand are responsible for oversight of the anaesthesia training program, acting as a resource for supervisors of training and reporting centrally to the college. They are members of their respective regional or national committees and connect with one another through the EO network (standard 8.1). The EO network TOR are in appendix 8.6.
- Accreditation officers are members of their regional or national committees and sit on the bi-national TAC committee (standard 8.2).
- Rotational supervisors (ROTS) co-ordinate trainee clinical placements in the various hospitals within their accredited rotations. They have the challenging act of balancing trainee preferences with placement allocations that meet training requirements and appropriate staffing for providing safe and high-quality patient care.

For pain medicine training:

- With a smaller pool of trainees and fellows, FPM has a centralised educational governance structure. The FPM regional and national committees discuss local pain medicine training issues but decision-making and support for trainees is centralised.

For CPD:

- National and regional CME committees deliver activities that contribute towards professional development activities. For anaesthesia, these activities are often organised jointly with the NZSA in Aotearoa New Zealand or the analogous state branches of the ASA in Australia.

For SIMG assessment in Aotearoa New Zealand:

- The NZNC is the branch advisory body to MCNZ for SIMG assessment in Aotearoa New Zealand (standard 10). The chair of the New Zealand Vocational Registration Panel is a member of the NZNC. The New Zealand national office manages SIMG assessment in Aotearoa New Zealand.

For SIMG assessment in Australia:

- There is not a formal regional governance structure for SIMG assessment in Australia. A proposal is in progress to include a SIMG representative on all Australian regional committees. The bi-national ANZCA SIMG Committee oversees SIMG assessment processes in anaesthesia and pain medicine in both countries, and the full process leading to eligibility for specialist registration in Australia. Australian SIMG assessment and the SIMG Committee is managed from the Melbourne office.

Joint programs with other organisations (see *Other training programs*)

Collaborative programs with other organisations currently include:

- GP anaesthesia training through the Joint Consultative Committee on Anaesthesia.

Planned collaborative programs with other organisations include:

- The Diploma of Rural Generalist Anaesthesia (DRGA) with ACRRM and the RACGP.
- The dual FANZCA-FCICM pathway.
- The Diploma of Perioperative Medicine (see *'Other training programs'* at the end of this standard).

Educational prioritisation within the governance structure

The college gives priority to its education and training functions by supporting high-level executive committees that report to ANZCA Council and the FPM Board with broad functions explicitly stated in TOR and clear delegations. These are supported by educational expertise and exchange (standard 1.4) and educational resourcing (standard 1.5). Furthermore, major committees are chaired by ANZCA councillors and FPM board members, providing further evidence of prioritisation and educational leadership.

Policies that reflect educational prioritisation include the strategic education framework and the education governance framework (standard 1.7). Processes that advocate for educational functions among competing priorities include the college risk register, involvement of the executive director of education and research in the executive leadership team and budget allocations.

Stakeholder collaboration

The college understands from the glossary that the AMC defines internal stakeholders as trainees, fellows (including those in supervisory roles) and SIMGs, and external stakeholders as those with an interest in the outcomes of training and education (jurisdictions, health workforce bodies, regulators, professional associations, other health professions, consumers, Aboriginal and Torres Strait Islander and Māori peoples). Internal and external stakeholder collaboration in design and delivery of training and education functions is via ANZCA and FPM collaboration, and representation of internal stakeholders on governance and development committees. External stakeholders are involved through

community representation on committees and strong relationships as outlined in standard 1.6.

ANZCA and FPM collaboration

To foster collaboration across the college the ANZCA president and another councillor are voting members of the FPM Board. The FPM dean is a college director and member of the ANZCA Executive Committee. This allows pain medicine related issues to be understood at council and ensures that the board is likewise cognisant of the strategic priorities being discussed by council.

Internal stakeholder involvement in governance

The primary mechanism for involvement of groups of fellows in college governance is through their representation on the ANZCA Council, FPM Board and educational governance committees. Trainees are involved through attendance of ATC co-chairs at council and committee and project representation (standard 7.2). Heads of department are not represented ex officio on educational committees, although as specialty leaders many council, board and committee leaders have or have had these roles. Supervisory roles are formally represented, particularly on EEMC and the FPM Learning and Development Committee. The SIMG Committee requires specific involvement of those who have been through the SIMG assessment process.

External stakeholders

The college has external representation on the FARM committee, the ICT Governance Committee (two industry experts) and the History and Heritage Expert Reference Panel (curatorial and museum experts).

Consumer representation in governance

The college recognises that the engagement of community representatives is a valuable means of supporting transparency, consistency in decision-making and design and delivery of training and educational functions. As shown in table 1.2, community representatives are members of many college committees and panels. These community representatives are not formally networked with each other. A community representative was involved in early COVID-19 exams contingency planning.

Table 1.2 College groups with current community representation

College groups with current community representation
ANZCA Education Executive Management Committee
ANZCA Perioperative Medicine Steering Committee
ANZCA Research Committee
ANZCA Professional Affairs Executive Committee
ANZCA Safety and Quality Committee
FPM Training and Assessment Executive Committee
FPM Professional Affairs Executive Committee

College groups with current community representation
College Specialist International Medical Graduates Committee and panels in both countries
College appeals committees
Tripartite Committee of Rural Generalist Anaesthesia

In 2010, the college launched a community representation policy. In 2018, this was reviewed to reflect best practice in diversity, recruitment and succession planning, and how councillors, committee chairs, senior staff and committee support officers interact with community representatives.

In early 2020, an initial meeting of the seven college community representatives was convened to explore improvements. Additional meetings were delayed due to COVID-19. However, a workshop involving community representatives, the college president, other councillors and senior staff took place virtually in 2021. Subsequently, the ANZCA community representation policy was revised to simplify language and remove operational details.

An operating procedure to ensure college processes support consistent delivery of the revised policy is also planned. This will cover matters such as position descriptions, recruitment and induction, deputising roles, committee support processes, messaging from committee chairs, interactions with ANZCA Council, tenure limits and succession planning, and a fee review process.

Conflicts of interest

There is a college-wide conflicts of interest policy (appendix 1.17). College volunteers and staff must disclose relevant interests and avoid ethical, legal, financial, or other conflicts of interest involving the college, by removing themselves from positions of decision-making authority with respect to any conflict situation. New college staff, office bearers, councillors, committee chairs, committee members and other college representatives (such as examiners) are required to review and sign the conflict of interest policy as part of their orientation to the college.

Conflicts of interest are managed by committee support officers, with conflicts of interest included as a standing item on all group meeting agendas. Meeting attendees are asked to disclose any professional or personal interests concerning agenda items and are reminded to advise the committee support officer of any general conflicts that arise for inclusion in the interests register. Any disclosures in relation to agenda items are managed in accordance with the policy and recorded in the meeting minutes. ANZCA Council has a central conflict of interest register, with a central register for all ANZCA committees planned. FPM does not have a central register.

Sponsorship and partnership policy

In 2016, the college developed a sponsorship and partnership policy for transparent and consistent sponsorship and partnership across the college and to inform fellows on how this is managed. The college established a working group with fellow and staff involvement to deliver the policy. In 2021, the policy was reviewed with the addition of a sponsorship and partnership procedure.

1.2 Program management

The AMC accreditation standards are as follows:
1.2 Program management
1.2.1 The education provider has structures with the responsibility, authority and capacity to direct the following key functions: o planning, implementing and evaluating the specialist medical program(s) and curriculum, and setting relevant policy and procedures o setting and implementing policy on continuing professional development and evaluating the effectiveness of continuing professional development activities o setting, implementing and evaluating policy and procedures relating to the assessment of specialist international medical graduates o certifying successful completion of the training and education programs.

Educational governance

Major committees of ANZCA Council and the FPM Board provide oversight of educational programs, supported by the education unit (anaesthesia, DHM, POM, and DRGA training; CPD program; SIMG assessment), and FPM unit (all pain medicine programs). Staff, including DPAs, are members of and attend committee meetings. Committees of council and the FPM Board are in standard 1.1, committee membership is available on the college website and terms of reference are in appendix 1.12 and 1.14. For details on staff see 1.5.

The key college educational governance committees are:

- **The ANZCA Education Executive Management Committee (EEMC)**, which is the peak educational governance committee for anaesthesia and related training and SIMG assessment. EEMC reports to ANZCA Council and oversees, guides and reports on ANZCA education activities and the operations of its sub-committees to ensure implementation of the education initiatives of the college strategic plan and annual business plans. The EEMC TOR scope of activities includes education, training, assessment and accreditation in the FANZCA training program and other special programs including the SIMG assessment process, the ANZCA Diploma of Advanced DHM and the DRGA. EEMC is chaired by an ANZCA councillor and its members comprise committee chairs, key college educational staff and a community representative. The Training Accreditation Committee reports directly to ANZCA Council and is represented on EEMC (standard 8.2).
- **The FPM Training and Assessment Executive Committee (TAEC)** which oversees pain medicine training and reports to FPM Board. FPM TAEC is chaired by an FPM board member who also sits on the FPM Executive Committee. Membership of FPM TAEC includes the chairs of FPM education committees, the FPM assessor, key college educational staff and a community representative.
- **The ANZCA Professional Affairs Executive Committee (PAEC)** to which the ANZCA and FPM CPD Committee reports on the ANZCA and FPM standard and program.

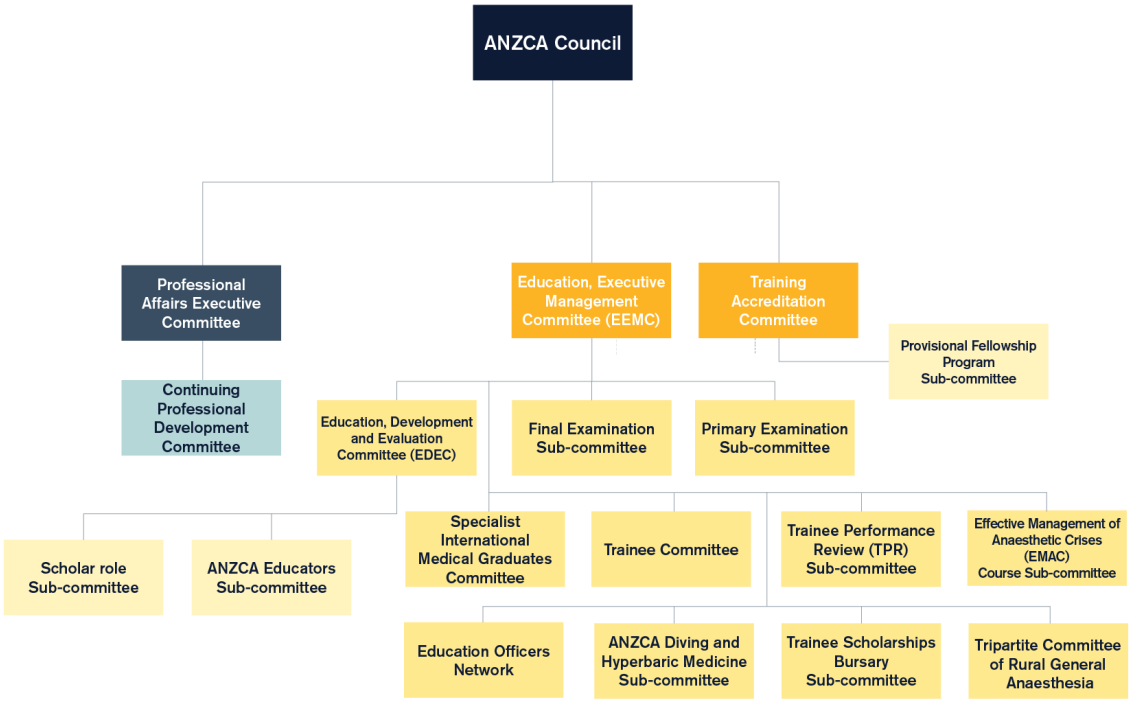
The committees and subcommittees of EEMC, many of which are stewardship of anaesthesia training program components (standard 3), are:

- **Education Development and Evaluation Committee** which supports ongoing quality improvement of ANZCA education activities and provides input to the development of new education and training initiatives, primarily through educational leadership of and representation on project groups. The scope of education activities EDEC inputs to include education, training, assessment and accreditation for the FANZCA training program, SIMG assessment process, Diploma of Advanced DHM, the POM qualification, DRGA and dual FANZCA-FCICM pathway.
- **ANZCA DHM Sub-committee** (*Other training programs* standard 1*)*.
- Education Officers Network (standards 1.1 and 8.1).
- Effective Management of Anaesthetic Crises (EMAC) Course Sub-committee (standard 4).
- ANZCA Educators Sub-committee (standards 4 and 8.1).
- Final Examination Sub-committee (FESC) (standard 5).
- Primary Examination Sub-committee (PESC) (standard 5).
- Provisional Fellowship Program Sub-committee (PFPSC).
- **SIMG Committee** (standard 10).
- Trainee Bursary Evaluation Sub-committee.
- ANZCA Trainee Committee (standard 7.2).
- Trainee Performance Review Sub-committee (standard 5.3).
- Tripartite Committee of Rural Generalist Anaesthesia (*Other training programs* standard 1).

The sub-committees of EDEC are:

- Scholar Role Sub-committee (standard 5).

Figure 1.3 ANZCA education committee structure



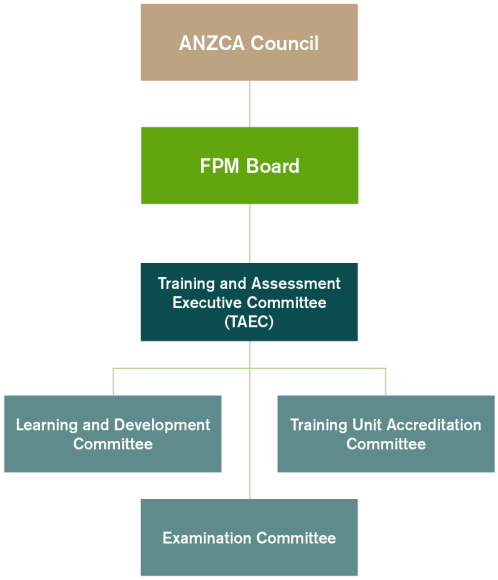
FPM program management

Following introduction of the revised pain medicine training curriculum in 2015, the FPM governance structure was reviewed with the current structure implemented in 2016. FPM uses educational expertise from within the broader college to deliver pain medicine training, by including members of the ANZCA Education and Research unit on key FPM committees. The key educational committees responsible for pain medicine training, reporting to the TAEC, are:

- The **FPM Learning and Development Committee**, responsible for ongoing development, quality improvement and evaluation of the pain medicine training program, including development and delivery of training resources (standards 3, 4 and 6).
- The **FPM Examination Committee** which develops and oversees implementation of coordinated, accountable and auditable processes in the conduct of FPM examinations (standard 5). This committee specifically covers the long case assessments, the fellowship examination and the clinical case study assessments within the FPM training program.
- The **Training Unit Accreditation Committee (TUAC)** which oversees and implements accreditation of multidisciplinary pain management training units for the pain medicine training program (standard 8.2).

FPM does not have separate committees to oversee the SIMG process or CPD program but has two FPM fellows on the SIMG Committee and ANZCA and FPM CPD Committee to ensure pain medicine expertise in college wide decision-making. See the college website for committee membership and appendix 1.14 for FPM committees' TOR.

Figure 1.4 FPM education committee structure



ANZCA and FPM Continuing Professional Development Committee

The CPD Committee reports to ANZCA PAEC and hence to the ANZCA Council on the structure and operations of the ANZCA and FPM CPD program. It provides regular reports to the EEMC. Two FPM fellows sit on the committee, with one providing reports to the FPM Professional Standards Committee. The committee is chaired by an ANZCA councillor. Its duties and responsibilities include overseeing the structure and operations of the CPD program and standard including participation and compliance, continuous quality improvement, including enhancements in relation to international, bi-national and regulatory developments, liaising and collaborating with relevant internal and external stakeholders, and actively promoting the program. The committee TOR are in appendix 1.18.

Specialist International Medical Graduate Committee

The SIMG committee reports to EEMC and hence the ANZCA Council on assessment of SIMGs for practice in Australia and Aotearoa New Zealand and assessments conducted under the Medical Board of Australia “short-term training” (STT) pathway. Two FPM fellows are committee members, providing reports to the FPM TAEC. The SIMG Committee is responsible for making recommendations to EEMC on policy related to SIMG and STT assessment and overseeing the administration of the SIMG and STT assessment processes. The committee TOR are in appendix 1.19. See standard 10.

Project and working groups

Time-limited project and working groups are formed for discrete purposes, also with clear TOR. Generally, these are formed for set time periods to progress education projects and activities and report to substantive committees. A list of current project and working groups of ANZCA, FPM and joint projects is at appendix 1.20.

Certification of completion of training

For admission to ANZCA fellowship and college membership (in accordance with regulation 6), an ANZCA DPA assessor certifies the trainee's successful completion of all relevant education and training components (on application). The ANZCA Executive Committee, on delegation from council, approves admission to fellowship, on a weekly basis to ensure timely progression and workforce continuity.

Admission to FPM fellowship and college membership is undertaken by the FPM Board following compliance checking by the FPM assessor, at present a voluntary role undertaken by an FPM fellow. Other FPM assessor tasks include individual trainee decisions (approval of exemptions under by-law 4, assessment of primary specialist qualifications for equivalence prior to award of fellowship, approval of individual practice development training sites, input to trainee performance reviews). This role will be undertaken by the new DPA (FPM education) (standard 1.5).

As the FPM training program is run predominately without the use of IT systems, many processes have multiple sign-offs in place to ensure compliance. This is particularly the case for sign-off of training program completion. First, the nominated supervisor confirms that the trainee has met training program requirements and is performing at the expected level to progress to fellowship. Two FPM staff members then review the trainee record before it is sent to the FPM assessor for review. Once satisfied that all requirements have been met, the FPM assessor recommends to the FPM Executive Committee that the trainee is admitted to fellowship.

MCNZ college viability framework

Explanations regarding how the college meets each element of the MCNZ college viability framework are included below:

Critical mass: ANZCA more than meets the necessary critical mass required of vocationally registered doctors and trainees to deliver its training, education and recertification functions. With approximately 7000 fellows (anaesthesia and pain medicine) and approximately 1800 trainees (16 per cent in Aotearoa New Zealand).

Sustainable base: ANZCA demonstrates a sound sustainable base that supports the long-term vocational scope of training requirements.

Infrastructure: ANZCA has a highly qualified and experienced workforce to administer all aspects of education and training functions across both countries. In addition, ANZCA's governance structure and organisational committee structure support all aspects of training, education and recertification across both countries.

Funding: For the year ended 31 December 2021, ANZCA is in a strong financial position with total assets of $A78.099m, equity of $A47.449m and a positive working capital of $A8.765m. During 2021, ANZCA recorded an operating surplus of $A5.504m and generated positive cash flow from operations with a cash balance of $A21.34m.

Collegiality: ANZCA is well recognised for the strong collegiality and support networks that are embedded across the organisation. This is evidenced by outcomes from ANZCA trainee surveys and the Medical Board of Australia medical training survey, demonstrating ANZCA benchmarks consistently above other medical colleges across a range of indicators.

Viability: The ANZCA training program is recognised as delivering on the long-term vocational scope of medicine to meet community needs in Aoteroa New Zealand and has continued to respond to changing demand that also addresses cultural and health equity needs of community.

Risk management

The college's risk management processes are managed by the risk and governance manager and are operationalised under the ANZCA risk management framework, based on the principles from AS/NZS ISO 31000 Risk Management. Project risk is managed under the following processes:

- Step 1: Identify project risks.
- Step 2: Analyse project risks (including evaluating control and risk assessment).
- Step 3: Plan risk responses (including treatment plans, risk owners).
- Step 4: Monitor and control risk (including risk escalation procedures).

College procedures require projects to be approved by its Project Control Board, including the risk management plan. With the project linked to the grant activity approved, most decisions are made by the project manager in consultation with risk owners. The project manager then escalates risks per the risk rating within treatment plan appetite table in the framework. Escalation is required for significant impacts to the project's scope, budget, schedule, change management, technical performance, or business performance objectives. Additionally, the project manager must escalate those risks determined to need cross-organisation involvement, are controversial, or require executive leadership team involvement and/or decisions. The context and size of the project, and risk rating will be considered in determining the escalation of the risk to the CEO, committee, or ANZCA Council. Finally, any risk event that impacts the terms and conditions of the grant agreement will lead to the Department of Health being immediately contacted.

The risk management plan is updated and presented to the committee with governance oversight of the project as part of project status updates. Including the communication of risk management status and risk response follow-through. The risk management plans are stored within a project management tool to ensure there is transparency and visibility across staff with different responsibilities and to enable efficient and effective reporting for project governance.

1.3 Reconsideration, review and appeals processes

The AMC accreditation standards are as follows:	
1.3 Reconsideration, review and appeals processes	
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.

Reconsideration, review and appeals processes and transparency

The college reconsideration and review processes are described in regulation 30 and appeals process in regulation 31, both publicly available on the college website. These reconsideration, review and appeals (RRA) processes are including in other regulations on training and SIMG assessment (37.35 and 23.21), FPM by-law 3, by-law 4 and by-law 19, and in all training handbooks (the ANZCA handbook for training section 3.7, FPM Training Handbook item 16, and Handbook for Advanced DHM Training item 11). These processes are included in all communications about college decisions to individual trainees, fellows and SIMGs.

These are college-wide processes that are available to all fellows, trainees and SIMGs who are dissatisfied by a college decision type listed in the regulations and that they consider disadvantages them. At each stage of the process the reviewing person or committee will look at all material involved in the prior decision, along with any new relevant material provided by the applicant and/or the chair or individual leading that stage.

RRA is a three-step process:

- **Reconsideration:** A request for this initial stage must be made within six months of the applicant being notified of the relevant decision. This timeframe allows the applicant to realise the impact of the decision. Reconsideration is by the original decision-maker.
- **Review:** If the decision is upheld at reconsideration, and the applicant remains dissatisfied and considers they are disadvantaged, review must be requested within three months of notification of the reconsideration outcome. Review is undertaken by nominees of the committee overseeing the original decision-maker, who have had no previous involvement in the decision and its reconsideration.
- **Appeal:** If the decision is upheld at both prior stages, and the applicant remains dissatisfied and considers they are disadvantaged, they may request an appeal within three months of having been notified of the review outcome. Each appeal committee is convened by the CEO and is chaired by the vice-president or another councillor appointed by ANZCA Council. Membership include two fellows, one from the area under consideration, the other from another subject area, and two non-fellows, a legal profession member and a community representative. None will have had any prior involvement with the decision under appeal. The CEO and college solicitor are secretary and legal advisor, respectively, to the appeals committee, but are not decision makers. As with preceding stages, the appeals committee can access subject matter expert advisors, and the applicant can submit further relevant material.

For ANZCA Council decisions, as there is no overseeing committee, the review nominees and appeal committee members are appointed by the CEO on the advice of the executive director of professional affairs (or their nominee if they were involved in the decision under appeal or its review and reconsideration), and usually include former councillors without a conflict of interest.

Evaluation of RRA processes

Table 1.3 shows RRA requests and outcomes for anaesthesia, pain medicine and DHM trainees, SIMG assessment and CPD. The small number of pain medicine and DHM requests makes it difficult to interrogate the data for themes or systemic issues.

Table 1.3 Reconsideration, review and appeals requests and outcomes 2019-2021

Please note there were no DHM, TAC, CPD or exams RRA requests in the past three years.

Reconsideration, review and appeal requests and outcomes 2019-2021				
Reconsideration requests and outcomes				
Reason	**Team**	**Number**	**Outcome**	
			Upheld	Overturned
Change commencement of training date	Training	1	0	1
Change to PFT start date	Training	2	2	0
Change to progression date	Training	1	1	0
Changing interrupted training to annual leave	Training	1	0	1
Deferment of training program requirements	Training	5	1	4
Exemption to count excess leave towards training	Training	1	1	0
Exemption to sit exam without meeting eligibility criteria	Training	1	1	0
Exemption to the hospital accreditation limit	Training	1	1	0
Extension to extended training time	Training	5	3	2
Interrupted training due to late payment of fees	Training	2	1	1
Reapplication to training program	Training	1	1	0
Refund of fees	Training	1	0	1
Reinstate training status	Training	8	5	3
Request to re-sit only viva component of primary exam	Training	1	1	0
Retrospective approval of part-time training	Training	1	0	1
Change in individual program requirements	SIMG	3	3	0
Extension of on hold period	SIMG	1		1
Not comparable outcome at interview	SIMG	5	4	1
Not comparable outcome at preliminary assessment	SIMG	14	12	2

Reconsideration, review and appeal requests and outcomes 2019-2021				
Reconsideration requests and outcomes				
Reason	**Team**	**Number**	**Outcome**	
	-		Upheld	Overturned
Outcome at interview and change in individual program requirements	SIMG	1	1	0
Termination of SIMG process	SIMG	1	1	0
No sunset clause to retire the FPM election to fellowship pathway	FPM	2	0	2
Exemption from fellowship examination and given fellowship	FPM	1	1	0
Reconsider exam result	FPM	1	Upheld	
Review requests and outcomes				
Reason	**Team**	**Number**	**Outcome**	
			Upheld	Overturned
Change to PFT start date	Training	1	0	1
Exemption to sit exam without meeting eligibility criteria	Training	1	1	0
Extension to extended training time	Training	1	1	0
Interrupted training due to late payment of fees	Training	1	1	0
Reinstate training status	Training	9	6	3
Change in individual program requirements	SIMG	1	1	0
Not comparable outcome at preliminary assessment	SIMG	4	2	2
Exemption from fellowship examination and given fellowship	FPM	1	0	1

Reconsideration, review and appeal requests and outcomes 2019-2021

Appeal requests and outcomes

Reason	Team	Number	Outcome	
			Upheld	Dismissed
Extension to extended training time	Training	1	0	1
Reinstate training status	Training	1	0	1
Not comparable outcome at interview	SIMG	1	1	0
Not comparable outcome at preliminary assessment	SIMG	1	0	1

Each overturned decision is reviewed by the relevant decision-makers to identify improvements in the area of the decision or in the RRA processes. The most common feature identified by these considerations is that new information not known to the original decision maker is revealed at the appeal process stage (e.g. illness or allegations of bullying that adversely affected the applicant's training performance). The DPA assessors discuss each overturned anaesthesia training decision to improve their decision-making processes and recommend amendment to any regulations that are a source of uncertainty. The DPA SIMG and SIMG manager review each overturned SIMG decision in a similar manner. These two groups cover the majority of RRA decisions.

Developments in the last five years

- Since 2017, the EEMC receives bi-annual training reports that include numbers of anaesthesia training RRA requests and their outcomes. As there are only one or two FPM decisions per year, these are not reported formally through FPM committees.
- Since 2018, advisors are used in the RRA process to ensure decisions do not conflict with other parts of the regulation under which the decision was made. Advisors are often the DPA assessors for training decisions. This has improved the veracity of RRA decision-making. These advisors are not decision-makers and are not present for discussion that leads to the final decision. Reconsideration and review remain under the departments involved in the original decision.
- For process consistency, appeals management is now a role of the corporate office.
- In 2022, regulations 30 and 31 governing the RRA processes are undergoing review. This was delayed by COVID-19. In 2021, an initial stage of the RRA review, data analysis, was undertaken and the resulting report is at appendix 1.21.

1.4 Educational expertise and exchange

The AMC accreditation standards are as follows:	
1.4 Educational expertise and exchange	
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.

Use of educational expertise in training and education functions

Educational expertise is used in the development, management and continuous improvement of college training and education functions by volunteer participation on substantive committees and project/working groups, through staff capability, by engaging external organisations and consultants with educational and project expertise. Staff capability is addressed in standard 1.5.

Volunteers

Each education committee and project/working group stipulates the knowledge and skills required for its members. A college strength is recruiting committee members with appropriate skills and experience in medical education and for stakeholder representation (e.g. trainees, community representatives, those in supervisory roles). A committee diversity matrix balances committee membership, with an example for PAEC at appendix 1.22.

The voluntary contribution of fellows and trainees is vital to ongoing development and delivery of educational projects and activities. Reliance on this contribution is also highlighted as a risk in the college risk register. The Education Quality Framework and strategic education and governance frameworks were introduced to promote positive engagement with contributors, supported by systematic and agreed approaches to new initiatives and ideas (standard 1.7).

To demonstrate its commitment to volunteerism and member engagement in recent years, the college has introduced a more consistent approach to recruitment to voluntary roles. Interested applicants respond in writing to an openly-advertised expression of interest. To align expectations, all new committee members are provided with college policies on conflicts of interest and bullying discrimination and harassment.

Anaesthesia

As the key ANZCA educational development committee, the EDEC TOR include educational expertise as a criterion for membership. Consequently, a majority of EDEC members have post-graduate medical education qualifications, with two current members (Professor Weller and Professor Forrest) holding university appointments as educational leaders.

ANZCA strategic education project and working groups TOR define the expertise required to achieve project outcomes. Members are invited to join groups based on their ability and capacity to fulfil required roles. For example, the TOR for the Training Program Evolution (Project) Exploration (TPEE) Implementation Group, the steering committee for phase 3 of this project (standard 3 *'Improvement opportunities and future plans'*) states that

membership may include members who are not fellows of the college and that appointment of members will take into account relevant expertise and committee roles.

The ANZCA educator skills project (standard 8.1) defines 'a fellow with educational expertise' and the skills and attributes required for different educational roles within the ANZCA training program. Implementation of the planned Educators Academy, an outcome of the same project, will further support volunteers with educational expertise and interests.

Pain medicine

As FFPMANZCA is a post-specialist qualification, many pain medicine fellows have links to other colleges which brings diverse thinking and experiences to education development, delivery and assessment. One of the challenges facing FPM is drawing on enough fellows to participate in its committees and other activities. Being a small fellowship, some specialist pain medicine physicians find themselves on committees or in supervisory and examiner roles early in their careers. Ensuring that fellows are not overcommitted has remained a challenge for FPM.

External consultants

The college engages external consultants to assist with scoping and development of education projects. In 2017, the Curio organisation was commissioned for strategic work, primarily a needs analysis, for a rural generalist anaesthesia qualification. It also has supported perioperative medicine developments – market opportunities including market segments, competitor products, pricing and interest (2019), and a model for an ANZCA POM diploma (2020). A qualified health librarian was engaged in 2019 for a scoping literature review of perioperative models of care. An educational consultant, Jodie Aitken, is currently engaged to support curriculum development for both the DRGA and the POM Diploma. See *Other training programs* towards the end of this standard.

MCNZ requirement: Māori subject matter experts

FPM fellows who identify as Māori are current or recent members of the Examination Committee and the Learning and Development Committee. Other Māori FPM fellows are examiners, long case assessors, mentors and SIMG reviewers. ANZCA fellows who identify as Māori are current and former directors of accredited sites, chair and members of the NZNC (which has one ex officio position for a fellow who identifies as Māori), former NZSA president, and past chair of the EO Network. Other Māori FANZCAs are current or former examiners, supervisors of training, SIMG assessors, members of Aotearoa New Zealand subspecialty-specific networks (e.g. obstetrics), and leaders and members of work such as the Indigenous health learning outcomes project ('*Improvement opportunities and future plans'* standard 3).

In 2021, the New Zealand Ministry of Health and FPM commenced a pain redesign project which aims to evaluate the model of care for pain medicine across Aotearoa New Zealand for greater equity of access. The project is facilitated by the Ministry and includes collaboration with Māori health providers and experts, currently involving fortnightly project meetings. This project was initiated by the Ministry following FPM advocacy efforts.

Collaboration with other educational institutions to benchmark education and training

Key mechanisms for external collaboration to benchmark college education and training programs include:

1. Formal educational collaborations through memoranda of understanding.
2. Consultation on specific projects and initiatives.
3. Networking through the various alliances and consortia, and with international educational providers.
4. Adoption of the pain medicine curriculum by other nations.

Formal educational collaborations

The key current educational collaborations are the DRGA and the POM diploma. See *Other training programs* towards the end of this standard.

Consultation on specific projects and initiatives

As part of the training program evolution project, the CBME project (standard 3) and the accreditation and learning environment project (standard 8.2) engaged with other bi-national colleges in our region and international educational bodies in the US, Canada, UK and Ireland. These engagements allowed benchmarking and informed recommendations on best-practice training and accreditation practices.

Networking

CPMC and CMC

ANZCA is an active participant and contributor to the Council of Presidents of Medical Colleges (CPMC), the unifying organisation for Australian specialist medical colleges. CPMC office accommodation is hosted at the ANZCA Australian Capital Territory office. Through its New Zealand national office, ANZCA is the secretariat for the Council of Medical Colleges (CMC), the forum for medical colleges in Aotearoa New Zealand.

The ANZCA Education and Research unit is actively engaged in inter-college staff networks including the College Educators Network, CPMC CPD managers network and CPMC SIMG managers network. Most workshops and meetings have been held online since 2020 due to the impact of COVID-19.

Tri-Nation Alliance

The Tri-Nation Alliance (TNA) is an international collaboration between five colleges across three countries – ANZCA, the Royal College of Physicians and Surgeons of Canada (RCPSC), the RACS, the Royal Australasian College of Physicians (RACP) and the Royal Australian and New Zealand College of Psychiatrists (RANZCP) – focused on medical education through shared learning and resources. From July 2021, ANZCA assumed the TNA secretariat function and the ANZCA president chairs the executive committee. In January 2022, members signed a new memorandum of understanding (MOU, appendix 1.23).

Annually, a college workshop and International Medical Leaders Forum are held prior to an open one-day International Medical Symposium in either Australia or Aotearoa New Zealand. Past workshop and forum topics include CBME, First Nations health and wellbeing, accreditation in an era of CBME, wellbeing, and medical education research. Symposium topics have included leading change (2017), health professional wellbeing and quality care (2018), and the impact of advanced technology on medical education (2019). ANZCA leaders also attend the International Conference on Residency Education in Canada, including satellite meetings on CBME in anaesthesia (2018), and associated TNA meetings.

While activities have been in abeyance since 2020, a virtual meeting on CPD and exams during COVID-19 was held in 2020. Alliance activities will resume in 2022 in Canada and 2023 in Australia and Aotearoa New Zealand.

Collaboration with Hong Kong College of Anaesthesiologists

Both ANZCA and FPM have a long history of support and expertise for the Hong Kong College of Anaesthesiologists (HKCA), including sharing educational policies, trainee and supervisor support materials, and supplying examiners. Although FANZCA training in Hong Kong, Singapore and Malaysia ceased in 2018, FPM still undertakes pain medicine training in Hong Kong and Singapore.

Due to COVID-19 travel restrictions from 2020 to the present, college fellows and staff are unable to travel to Hong Kong, impacting ANZCA support for their examinations. Planned joint events in Hong Kong, Australia or Aotearoa New Zealand have been curtailed. Collaboration with the HKCA has therefore been challenging, as it has relied on Zoom for ongoing exam support. ANZCA and the HKCA entered a new MOU in 2021 (appendix 1.24), further strengthening collaboration. ANZCA will provide its final exam MCQ to the HKCA in 2022, while also continuing joint meetings such as the FPM spring meetings. Resumption of face-to-face meetings will provide opportunities to foster our relationship and continue joint mutually-beneficial work.

International Academy of Colleges of Anaesthesiologists

ANZCA is a founding member of the International Academy of Colleges of Anaesthesiologists (IACA), established in 2021. Other founding members of the academy are the Royal College of Anaesthetists, UK, the College of Anaesthesiologists Ireland, the HCKA and the RCPSC. Dr Vanessa Beavis, ANZCA President to May 2022, is currently the honorary chair of the IACA. This collaboration aims to build a community of anaesthesia practice, creating a forum for collaboration and sharing best practice in training and lifelong learning, professional standards, collective advocacy and global health. Terms of reference, a strategic action plan and regular CEO and president meetings underpin good governance, actions and outcomes.

European Society of Anaesthesiology and Intensive Care

ANZCA is a member of the European Society of Anaesthesiology and Intensive Care (ESACI), with an updated and refreshed MOU signed in January 2022 by ANZCA, the ASA and the ESAIC (appendix 1.25). The aim is scientific and educational collaboration for the benefit of clinical anaesthesia, fostering international co-operation and exchange. The MOU covers research, educational and scientific exchange between members, and patient safety.

Pain medicine

FPM has been an international leader in professional and educational developments in pain medicine. A number of colleges and institutions have, with the permission of FPM, based their curriculum on that developed by FPM in 2015. These organisations include:

- The Faculty of Pain Medicine of Ireland, College of Anaesthesiologists of Ireland.
- The European Pain Federation.
- The Philippine Board of Pain Medicine.
- Sackler School of Medicine, Tel Aviv University.

1.5 Educational resources

The AMC accreditation standards are as follows:	
1.5 Educational resources	
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.

Resources and management capacity for training and education functions

The college acknowledges the notes to the AMC standards define resources as financial, human, learning resources, information and records systems, and physical facilities.

Education and Research unit

The Education and Research unit oversees management and delivery of education, training, research and assessment and ensures cross over and representation with FPM to facilitate skills and resource sharing. The unit works collaboratively across the college and with external stakeholders to ensure the effective development and delivery of education programs, assessments and research for trainees, fellows, SIMGs and the broader college environment. The unit is made up of three teams: Training and Assessment, Learning and Innovation and ANZCA Foundation:

- **The *Training and Assessment* team's** key functions include support for training program delivery (anaesthesia, advanced DHM), facilitation of the ANZCA and DHM hospital accreditation processes, management of the SIMG assessment process, overseeing trainee assessment activity including examinations, and committee and working group support.
- **The *Learning and Innovation* team's** key functions include driving and delivering strategic projects (such as DRGA and POM), managing the CPD program, educational program development and delivery (including eLearning), maintenance of regulatory requirements and reporting for delivery of specialist medical education, coordinating and implement training curriculum changes, monitoring and evaluation activities, and committee and project group support.
- **The ANZCA Foundation** 'supports medical research and education that saves lives, helps people to optimise their health, and works to make life as pain-free as possible'. Further detail on research and the foundation is in section 1.6 and information on research governance is in appendix 1.13.

Leadership and resourcing

Resourcing of educational staff has remained consistent over the last five years, while accommodating two restructures. A table outlining staff resourcing across Education units from 2016-2021 is at appendix 1.26.

In August 2017, the Education unit was restructured, merging the former Education unit, the Training Assessment unit and Accreditation unit into one. This involved disbanding the dean of education role, undertaken by a director of professional affairs. The unit has current input from the DPA education, an experienced clinician educator (a role introduced in 2019).

In October 2020, the Education unit underwent a realignment, including an update of the unit's name to the Education and Research unit. The responsibilities and tasks of the disbanded Quality and Strategy unit were divided between the newly established Learning and Innovation team and the Training and Assessment team. The ANZCA Foundation, which previously reported directly to the CEO, was also brought into the unit. This realignment aimed to better reflect the core activities undertaken by the unit and allows for more central operationalisation of strategic activities in accordance with the college strategic plan (standard 1.1).

The leadership team for Education and Research is now established, with the current executive director of Education and Research appointed in October 2019, the new Learning and Innovation manager appointed in November 2020, and the Training and Assessment manager in April 2021. Through this restructure the focus has been on appointing staff with knowledge and experience in medical education, and skillsets required to increase the capacity and expertise of the unit.

In August 2020, following an analysis of business-as-usual activities, projects and activities across Education and Research following the restructure in 2020, support was given by ANZCA Council and senior management to recruit additional staff for delivery of projects and activities underway and planned. In 2021, the new roles established within the Learning and Innovation team are an education projects and standards officer (1.0 FTE), an education projects officer (1.0 FTE) and a senior research officer (0.6FTE). With these additional staff in place, the unit is better placed to deliver on its strategic objectives, in particular long-standing projects. The recent approach to staffing has been to recruit candidates with experience in medical education and project management, as well as in administration.

Directors of Professional Affairs

DPAs are fellows employed by the college for their professional expertise in specific areas, along with clinical expertise, knowledge of the settings in which fellows, trainees and SIMGs practice and understanding of Australian, Aotearoa New Zealand and international health systems. The DPAs are all medically qualified and work for the college part-time, with most also working as specialist anaesthetists and/or specialist pain medicine physicians. Two are previous ANZCA presidents (Dr Wilson and Dr Roberts), and one a previous FPM dean (Professor Cohen).

The current DPA unit is:

- Executive DPA, head of unit and DPA (SIMG assessment): Dr Leona Wilson ONZM (0.6 FTE, Wellington Aotearoa New Zealand).
- DPA (FPM): Professor Milton Cohen AM (0.2 FTE, Sydney NSW).
- DPA (FPM Education): Dr Melissa Viney (0.3 FTE, Geelong Vic).
- DPA (Assessor): Dr Vaughan Laurensen (0.4 FTE, Christchurch Aotearoa New Zealand).
- DPA (ASM): Dr Nicole Phillips (0.1 FTE, Sydney NSW).
- DPA (Education): Dr Lindy Roberts AM (0.3 FTE, Perth WA), a role introduced from 2019 to provide educational and accreditation advice and support (formerly Dr Roberts was a DPA assessor).
- DPA (Professional Documents): Dr Peter Roessler (0.4 FTE, Melbourne Vic).

- DPA (Assessor): Dr Maggie Wong (0.2 FTE, Melbourne Vic).

DPAs support the efficient and effective function of the college through their significant institutional knowledge, expertise and clinical backgrounds in staff (not governance) roles including:

- Advising the CEO and the ANZCA Council, FPM Board and other groups. DPAs are members of many committees and project groups.
- Working across staff units to provide specialised knowledge and expertise. While attached to a specific area of college business, they may be requested to work in other areas that require their input.

A key recent change in the DPA staffing structure is the newly created position of FPM DPA – education. The paid staff position covers responsibilities previously undertaken by the FPM assessor, a voluntary fellow role. Primary focus areas include supporting FPM training, particularly custodianship of the curriculum, applying FPM training and SIMG assessment by-laws, and educational advice on pain medicine matters across the college. Dr Melissa Viney was recruited into this role in March 2022.

DPA staffing is stable, with the only other anticipated changes within the next three years being the retirement and replacement of one or two positions. The CEO has a confidential succession plan to ensure continuity of all DPA roles. Any requirement for extra DPA work on specific projects will be met by short-term appointments.

Co-operation and collaboration

A significant amount of cross unit co-operation occurs to drive the day-to-day functions of the Education and Research unit's strategic priorities. Examples of collaboration across units within the college include:

- **Lifelong learning project (standard 4):** From initiation this project has progressed as planned due to significant interaction and collaboration between education and corporate services staff at all levels. The working group includes representatives from the Corporate Services ICT team, Education and Research, FPM and Fellowship Affairs, while the steering committee includes representation from both ICT and Education.
- **Trainee Wellbeing Project Group (TWPG) (standard 7.4):** Required collaboration between Education and Research unit and the Fellowship Affairs unit.
- **FPM pain management health practitioner education strategy (standard 1.6):** Representation from Education and Research on the FPM pain management health practitioner education strategy project group (2021).

Resources supporting educational activities

Activities of the Education and Research unit are well supported by other business units:

- **Finance:** The finance team provides day-to-day support to ensure effective financial management across all education activities including payroll, forecasting, budgeting and management of accounts payable and receivable.
- **Human resources:** The People and Culture team provides exceptional day-to-day support to ensure effective staff recruitment, retention and development. The People

and Culture team has a strong understanding of the Education and Research unit's resource needs, leadership and growth.

- **Information and records systems:** In 2020, the college embarked on a major strategic review of its ICT, developing an ICT strategy. The component dedicated to education is known as the lifelong learning project (standard 4). The design and consultation for this are complete and include specifications that will support educational governance.
- **Facilities:** The facilities team maintain the office space at ANZCA House, facilitate meetings in the building and support effective delivery of educational programs and courses.
- **Fellowship affairs:** The knowledge resources unit provides support through the library and the library guides (standard 4), as well as support for the ANZCA Foundation, Clinical Trials Network (CTN) and other research activities including the research tool kit. Regional and national office staff support exams and courses inclusive of exam refresher courses. The in-house events team support delivery of education meetings and CPD, and the membership team supports trainee and fellow health and wellbeing (standard 7.4).

Faculty of Pain Medicine

Volunteers

While FPM has a small fellowship, it has strong engagement by its fellows in supporting education and training. FPM currently has just over 400 active fellows across Australia and Aotearoa New Zealand and 38 accredited training units. Of these 400 fellows, 61 fellows have an official supervisor role, 52 are examiners, 15 are long case assessors, 27 are reviewers for training unit accreditation visits, and 30 participate as members of FPM education and training committees.

FPM unit

Being part of a large college, FPM has access to a broad range of educational expertise and resources. FPM utilises staff expertise from the Education and Research unit to develop, deliver and monitor its training program and to deliver the joint CPD program (standard 9) and joint SIMG assessment process (standard 10). Staff from the Fellowship Affairs unit provide excellent library support, organise pain medicine conferences and other CME activities, support FPM regional and national committees, and provide membership services. The FPM unit has staff who manage and administer the specific functions of FPM and who liaise extensively with the broader college to ensure the optimum application of educational resources.

Administrative and technical staff support

Committee support officers

In 2018, a review of standardised committee documents was undertaken to address inconsistencies in use and format. A suite of resources including agendas, action lists, annual work-plans, conflict of interest registers, cover pages, minutes and TORs was implemented. These align to the new college branding that was rolled out in January 2020.

To ensure effective support of the college's complex committee structure, the committee support officer (CSO) community of practice network was established in Q4 2019. All CSOs across the organisation were engaged in business and system improvements to enhance

committee support across the organisation. The network facilitates adherence to information governance and standardisation of committee procedures, reporting, documentation and sound records management practices. It provides peer support and training for the CSOs who administer the work of all college committees.

Staff representation on committees is outlined in their TOR, with both CSOs and senior staff in attendance. Staff representation on educational committees varies between 'in attendance' and 'member'. Key resources for CSOs and committee chairs are in development and due for finalisation in Q2 2022. These include a dedicated CSO handbook and guidelines, and a committee chair orientation handbook.

College policies and document management

The college has a number of policies which guide its governance and management activities:

- The ANZCA Constitution (see standard 1.1).
- Regulations.
- FPM By-laws.
- Handbooks for training, CPD and SIMG assessment.
- Professional documents.
- Endorsed guidelines.
- Corporate policies.

Professional documents and endorsed guidelines

College professional documents, statements and guidelines are vital in promoting the safety and quality of patient care for those undergoing anaesthesia for surgical and other procedures, and for those receiving pain medicine treatment. These documents contain information relevant to the clinical, administrative and ethical practice of anaesthesia and pain medicine. There are currently 47 professional documents, each with an associated background paper of evidence. Many have been developed in collaboration with other colleges or professional societies. In addition, there are over 40 endorsed guidelines, joint statements and position statements. Professional documents are consistently among the most frequently visited pages of the college website and a highly regarded source of professional guidance for trainees and fellows. Many are used for accreditation of sites for training (standard 8.2).

Document Framework Policy

Since the last AMC/MCNZ accreditation process, there has been an evolution and transition from archives to business records and information management, with increased hours for a records and information management advisor. This role provides expert knowledge for managing the physical records of the organisation, guiding and supporting staff on appropriate management of digital records, and advising college projects about information management best practice. As part of improving vital records and documentation consistency and accuracy, the records and information management advisor provides support to the CSOs through a CSO community of practice, templates, a process manual, and rules of engagement.

A framework of non-financial KPIs provides regular reports to ANZCA Council on the currency of college professional documents. In 2020, a working group of fellows and key staff was established to address the backlog of professional documents for review and to standardise document processes. A Document Framework Policy was developed that outlines the principles of document development, processes for review, a new labelling system, a glossary of common anaesthesia, pain medicine, and document management terms. This new classification system creates a consistent structure across the college, facilitating integration across the units.

1.6 Interaction with the health sector

The AMC accreditation standards are as follows:	
1.6 Interaction with the health sector	
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.

Maintaining effective relationships with health-related sectors

Policy and Communications unit

Led by the Policy and Communications unit, engagement with the health sector occurs across many levels of the college. Recognising the role of communications in the policy and advocacy cycle, in 2018 the college's previously separate policy and communications units were merged under the leadership of an executive director for policy and communications. With a senior policy advisor and communications manager based in the New Zealand office, the unit undertakes both anaesthesia and pain medicine policy and communications activities across Australia and Aotearoa New Zealand. The broad areas of responsibility of the unit include:

Policy, safety and quality

- Advocacy and engagement.
- Professional documents.
- Endorsed guidelines and joint statements.
- Position statements.
- Safety and Quality Committee.
- Perioperative Allergy Sub-committee.
- Australian and New Zealand Tripartite Anaesthetic Data Committee (ANZTADC).
- Global Development Committee.
- Lifebox Australian and New Zealand.
- Essential Pain Management (EPM) Steering Committee.
- Indigenous Health Committee.
- Mortality Sub-committee.

Communications

- Publications including the *ANZCA Bulletin* (quarterly), *ANZCA E-Newsletter* (monthly), *Australasian Anaesthesia* (bi-ennially) and *Acute Pain Management: Scientific Evidence* (five-yearly).
- Media: On average the college issues 30 media releases per year and continues to build a network of media contacts.
- ANZCA website: For the 12 months to October 2021, the website averaged nearly 350,000 page views (118,000 unique page views) per month, with the most popular webpages being the ANZCA Library, members' portal, training and exams, events and courses, and policies, statements and guidelines (professional documents).
- Digital and social communications including Facebook (over 6600 followers), Twitter (over 9500 followers for ANZCA and FPM), YouTube (over 970 subscribers), LinkedIn (over 2000 followers) and Instagram (over 1000 followers).
- Patient information including fact sheets, videos and National Anaesthesia Day.

Over the past decade, the college has enhanced skills and resources with experts in policy, media, design and digital communications, commensurate with significant growth in the number and breadth of external bodies seeking college advice. In 2021 the college:

- Made over 50 written submissions to external enquiries and consultations (compared with 28 in 2011).
- Attended or participated in over 80 meetings with external stakeholders.
- Responded to over 40 enquiries from internal and external stakeholders about college professional documents, statements and guidelines.
- Had representatives on over 30 boards, committees and working groups of external organisations, including other colleges and major health sector organisations in both countries.

Health sector interactions occur through face-to-face and online meetings, working groups, submissions to consultations, social and print media, training site accreditation visits, invited guests to ANZCA Council and FPM Board, and college representation on external organisations. In late 2021, a review of ANZCA fellows representation on external committees commenced to improve transparency, procedures, administration processes and reporting.

The NZNC and Australian regional committees maintain links with jurisdictional departments of health both formally (for example, through jurisdictional review of Specialist Training Program training posts), and in response to specific issues and requests. Aotearoa New Zealand's Accident Compensation Corporation (ACC) considers FPM a strategic partner and quarterly meetings are held, in particular to discuss the funding of access to pain services. FPM fellows are asked to sit on ACC expert advisory groups and are regular contributors to ACC consultation processes. Appendix 1.27 lists key external stakeholders and regular engagement with them. Other engagement with the health sector occurs in response to specific issues or inquiries. Appendix 1.28 lists the written response made by the college to consultations and enquiries in 2021 (note two written responses have been removed for privacy or confidentiality reasons). International relationships are described in standard 1.4.2 and training site accreditation visits in 1.6.2 and 8.2.

Other colleges, anaesthesia and pain societies

The Anaesthesia Continuing Education (ACE), a tripartite partnership between ANZCA, the ASA and the NZSA, supports CME and events as well as shared knowledge, education and training. SIG and CME meetings, courses and workshops promote the diversity of the specialty across private, public, regional and remote areas of practice, as well as specialty disciplines, for example airway management and obstetric anaesthesia. There are 17 SIGs, with ANZCA administratively responsible for 14 and the ASA for three. Each SIG has an executive committee which requires support. The college also provides support for professional conference organisation. The college also supports seven Australian regional CME committees. The New Zealand national office supports activities in that country.

The college had conjoint major conferences with RACS in 2014 and 2018, supporting collaborative education opportunities and knowledge sharing. The college collaborated and co-badged the 2019 ASM in Kuala Lumpur with the Malaysian Society of Anaesthesiologists, Malaysia College of Anaesthesiologists, Royal College of Anaesthesiologists (UK) and the College of Anaesthetists of Ireland.

Since 2019, the ANZCA Library has provided fee-for-service library resources to the College of Intensive Care Medicine. This has increased shared resources and strengthened college relationships. For more information on the library see standard 4.

FPM works collaboratively with Australian and New Zealand pain societies on advocacy, education and health promotion activities. Both societies are multidisciplinary and interprofessional, supporting patients experiencing pain and pain-related researchers. FPM leaders meet regularly with leaders of the two societies.

FPM is a founding member of Painaustralia, a consumer-focused organisation. FPM contributed to development of the National Strategic Acton Plan for Pain Management, led by Painaustralia and with the Australian Pain Society. This calls for a nationally co-ordinated effort to address effective care for Australians living with chronic pain. The action plan was endorsed by the Australian Government in 2021.

Relationships with training sites (for high quality teaching, supervision, professional development)

College interactions with training sites to support high quality teaching, supervision and professional development occur predominantly through the training accreditation process (standard 8.2). To facilitate training delivery, ANZCA and FPM accredit and maintain effective relationships with training sites throughout Australia and Aotearoa New Zealand. Australian regional committees and the NZNC are important in this process, through advocacy with jurisdictions, by monitoring training sites and anaesthesia rotations, and through the ANZCA accreditation officer role on each committee.

ANZCA TAC and FPM TUAC work with anaesthesia departments and pain medicine units, respectively, to ensure high quality teaching and supervision are achieved and appropriate CPD opportunities provided. Accreditation identifies deficiencies in teaching, supervision, workplace assessment and continuing professional development and ways that these areas can be further improved. The college assists training institutions in achieving training and education standards, within the limits of its own regulations and policies. Examples include:

- Working with hospitals to ensure specialists have sufficient clinical support time for supervisory roles (standard 8.1) and their personal CPD (standard 9).
- Running national and regional SOT meetings (standard 8.1), led by education officers, supporting dissemination of college resources and promoting feedback from supervisors on planned training developments.
- Ensuring departments have quality assurance programs with opportunities for input from all trainees and fellows for continuous care improvement.
- Ensuring hospital management provides adequate resources, space and support for each pain medicine unit. Post-visit letters to the hospital identify further support needed for the pain unit to provide an appropriate training environment.
- Most pain medicine units have small specialist pain medicine physician numbers. When one leaves the unit it often means remaining staffing is inadequate for quality training. A period of suspension provides units with time (up to 12 months) to rectify staffing shortfalls. FPM maintains engagement with the unit throughout this time, monitoring and supporting progress.

ANZCA and FPM fellows in the regions/both countries understand the specific healthcare needs of their region, including any unmet needs. They also understand local capacity to train, as well as opportunities to develop and improve education, quality assurance and research activities. The NZNC and Australian regional committees are best placed to advocate for their regions, and their trainees, and to collaborate with trainee committees and jurisdictions. These national and regional committees support improvement and advocacy initiatives, including:

- Coordinating regional formal education programs for trainees (standard 4).
- Coordinating, with jurisdictions, regional selection processes for new trainees (standard 7.1).
- Oversight of anaesthesia rotations, ensuring training needs remain met as health services change, and facilitating collaboration between training sites (standard 8.2).
- Expanding regional or national training opportunities, for example approving new anaesthesia rotations in NSW and Victoria that better support regional and rural training (standard 8.2).

- Advocating for improved patient safety, through regional audit and quality improvement initiatives, for example anaesthesia morbidity and mortality committees.
- Advocating for new clinical services, for example identifying and advocating for improved pain medicine services.
- Providing feedback about proposed new services and legislative changes, for example new voluntary assisted dying legislation in some Australian states, or changes to medicines regulations.

Working with training sites and jurisdictions on areas of mutual interest

Broadly, college interactions with the Australian and Aotearoa New Zealand health sectors centre on:

- Education, training (including training capacity) and research.
- Providing safe and high quality care.
- Trainee, fellow and SIMG safety and wellbeing (see standards 1.1 and 7.4).
- Broader community health and wellbeing.

Education, training and research

While accreditation is the key mechanism for training site engagement (standards 1.6.2 and 8.2), there are many other relationships between the college and health sector stakeholders which enhance education, training and research. Some of these include longstanding collaborative input to training general practitioner anaesthesia and more recently for rural generalist anaesthetists, the backbone of perioperative care for Australian communities (see *Other training programs*, standard 1).

Specialist Training Program

Under the Australian government Department of Health Specialist Training Program (STP), the college receives funding for around 54 training posts under different streams of the program – STP, Integrated Rural Training Pipeline (IRTP) and Training More Specialist Doctors in Tasmania (TMSDT). The distribution of anaesthesia and pain medicine STP-funded posts in regional and rural and private facilities is in table 1.4.

Table 1.4 Distribution of anaesthesia and pain medicine STP-funded training posts

	Anaesthesia	Pain medicine	Total
Regional and rural	35.7	5	40.7
Private	11.7	2.2	13.9
Total	47.4	7.2	54.6

The college meets with the Department of Health regularly to discuss progress and raise any program issues. STP is also a mechanism for engagement with Australian jurisdictional health departments as they must approve all new training posts under the program. The

college works closely with many regional training hubs to develop regional and rural training pathways though the IRTP initiative.

In June 2021, the college hosted an STP stakeholder forum. Participants included representatives from the Australian Department of Health, specialist medical colleges, state health services, metropolitan and regional trainings sites, regional training hubs, training hospitals, and universities. The forum included a departmental update on the program, with discussion of important aspects of training such as accreditation, recruitment, selection and trainee wellbeing.

Currently the college has eight IRTP rural training pathways and is working with the Department of Health, regional training hubs and college regional committees to develop up to three more in the coming years (subject to available funding). This builds non-metropolitan training opportunities that benefit both our trainees and regional and rural communities.

Regional and rural workforce strategy

The college recognises the uneven geographic distribution of anaesthetists and specialist pain medicine physicians in both Australia and Aotearoa New Zealand. Addressing this is a key goal of the 2018-2022 college strategic plan (standard 1.1). Rebalancing workforce supply and distribution is also a key priority of the Department of Health National Medical Workforce Strategy 2021-2031, which the college has contributed to through written submissions, face-to-face consultations and in stakeholder consultation forums.

While much of the college's efforts to develop regional training pathways and increase regional training in Australia is STP-supported, other activities foster and support the regional and rural workforce. In 2021, the college launched a regional and rural workforce strategy, reflecting a commitment to improving both health outcomes for rural, regional and remote communities and the health and wellbeing of college fellows, trainees and SIMGs living and working in these areas (appendix 1.29). The objectives of this strategy are:

- Engaging with government and other stakeholders to secure support via funding and placements and advocate for equitable healthcare access.
- Developing a diploma of rural generalist anaesthesia in consultation with ACRRM and RACGP (See *Other training programs* at the end of each standard).
- Promoting the benefits and rewards of working in regional and rural areas to anaesthetists and specialist pain medicine physicians.
- Developing holistic support, leadership and research opportunities in regional and rural areas.
- Supporting college commitment to gender equity and implementation of the gender equity action plan in regional and rural areas.
- Supporting the wellbeing of anaesthetists, specialist pain medicine physicians and SIMGs in regional and rural areas.

The college continues to build relationships with rural health stakeholders, particularly the Australian Department of Health, regional health services and regional training hubs. In 2021, meetings were held with the Tasmanian, northern New South Wales and Flinders Northern Territory regional training hubs. The college also has representation on the RACS Rural Health Equity Steering Committee, the Rural Locum Assistance Program Steering Committee and is a member body of the National Rural Health Alliance.

Research relationships

Supporting high quality research drives continuous improvement in the quality, resource-effectiveness, and accessibility of healthcare outcomes. College-supported research contributes to the wider global community of researchers in our specialties, stimulating scientific inquiry, encouraging further investigation and increasing the evidence supporting improved clinical practice and patient outcomes.

College-supported published research delivers major educational content to fellows and trainees through scientific meetings, seminars, webinars, events and presentations each year, and via the ANZCA Library (see standard 4.2). Increasing research literacy and recognition of how important this evidence base is for high-quality clinical practice supports college CPD and training programs. From 2012 to 2021, nearly 200 ANZCA-funded and peer-reviewed studies in anaesthesia, pain medicine and perioperative medicine were undertaken. Key research relationships include:

- Peak research organisations

  The college is a member of the Australian Society for Medical Research and regularly attends director and stakeholder meetings. ANZCA Clinical Trials Network representatives attend meetings of the Australian Clinical Trials Alliance of which the college is a member. These provide opportunities to raise issues and discuss strategies for increasing the level, quality, translation, implementation and impact of research.

- Royal College of Anaesthetists and British Journal of Anaesthesia (BJA)

  During 2018 and 2019, the ANZCA Foundation and ANZCA Research Committee developed a memorandum of understanding with the Royal College of Anaesthetists (UK) and the British Journal of Anaesthesia (BJA) to offer a collaborative international anaesthesia research grant over three years. The college and the BJA have each pledged GBP100,000, with the first grant to be awarded in late 2021.

- Medibank Better Health Foundation

  In 2017, a collaborative research funding relationship was developed with the Medibank Better Health Foundation to support research projects on improved quality and value in healthcare and patient outcomes. From 2019, the collaboration has delivered funding for studies including dataset analysis to identify indicators of adverse outcomes in orthopaedic surgery, preoperative documented COVID-19 screening in two major Melbourne hospitals and multi-hospital intraoperative COVID-19 testing.

- CSL Behring

  In 2017, a grant-funding relationship with CSL Behring, the Australian government's assigned national blood fractionator, provides a biennial grant of $80,000 to the ANZCA Foundation for research into blood product use in perioperative medicine or any project of mutual interest in major surgery. The third biennial grant (due 2021) was cancelled due to COVID-19-related uncertainty.

- Universities and medical schools

  Growth in college research grants and support of academic anaesthesia and pain medicine through these and learning resources such as the ANZCA Library, research support tool kit, and research consultation service, has increased support not only for research departments, teams and specialists within teaching hospitals,

but also for the universities and medical schools with which those hospitals are affiliated. College support also fosters new academic appointments within these institutions. An important outcome is encouraging fellow and trainee enrolment in higher research degrees, expanding their careers into the academic realm and making additional contributions to quality and safety of patient care.

Providing safe and high quality care

The college mission statement on fostering safety and high quality patient care in anaesthesia, perioperative medicine and pain medicine is at the heart of all activities.

The college has built strong relationships with manufacturers, government agencies (particularly the Therapeutic Goods Administration in Australia and MedSafe in Aotearoa New Zealand) and many other health sector stakeholders, ensuring early awareness of issues allowing timely responses to anything that may impact patient safety and quality.

Patient safety and quality information is publicised to members on our website and through publications including the *ANZCA Bulletin*, e-newsletters, *Australasian Anaesthesia*, *Acute Pain Management: Scientific Evidence*, as well as through social media channels and safety alerts. Regular engagement with all jurisdictional health departments includes obtaining data for the triennial perioperative mortality sub-committee report "Safety of anaesthesia".

The college is a member of the Choosing Wisely initiative in Australia and Aotearoa New Zealand that aims to promote a national dialogue on unnecessary tests, treatments and procedures and support health consumers to choose healthcare that is supported by evidence. In conjunction with NPS MedicineWise, FPM has utilised the Choosing Wisely initiative to engage with other medical practitioners and develop opioid education. In 2021, FPM added a sixth Choosing Wisely recommendation on medicinal cannabis products for chronic non-cancer pain and also developed a plain language version of the FPM professional document *PS10(PM) Statement on "medicinal cannabis"*.

National Anaesthesia Day is a patient-focused initiative celebrating the anniversary of the day in 1846 that ether anaesthetic was first demonstrated in Boston, Massachusetts. Each year, many hospitals across Australia and Aotearoa New Zealand set up foyer booths with displays of equipment and mannequins, with anaesthetists on hand to answer questions from the public. This initiative complements extensive website patient information resources including fact sheets and videos.

In 2020, FPM hosted a workshop with key pain management stakeholders in Australia to consider how to deliver the National Strategic Action Plan for Pain Management. The workshop was attended by representatives from the federal Department of Health, universities, medical colleges, associations and researchers. FPM was subsequently awarded a grant from the Department of Health's Public Health and Chronic Disease Program to develop a pain management education strategy for Australian health practitioners. Following a comprehensive literature review, the project team have focused on broad consultation during 2021 ahead of the final submission of the strategy in mid-2022.

While the primary purpose of these activities and initiatives is enhanced patient care and outcomes, many have additional education or CPD benefits for trainees and fellows. Examples include:

- Safety alerts, for example from the Therapeutic Goods Administration (Australia) and MedSafe (Aotearoa New Zealand) on supply issues with medicines medical devices or outcomes of investigations. Average of 10-12 per year.
- Airway leads network rolled out across Australia in 2019 and earlier in Aotearoa New Zealand. As perioperative airway events remains a major cause of morbidity and mortality, aims are to enhance patient outcomes and improve support for junior doctors.
- Web-based anaesthetic incident reporting system (webAIRS), jointly funded and governed by the college, the ASA and the NZSA through the Australian and New Zealand Tripartite Anaesthetic Data Committee (ANZTADC). The latest webAIRS report is at appendix 1.30.
- ANZCA involvement in the neural connector changeover process with the Australian Commission on Safety and Quality in Health Care, an example of a major systems change at hospital and supply levels to improve patient safety by reducing the risk of inadvertent cross-device connection.
- Better Pain Management (BPM), a series of 12 online pain management education modules designed by FPM for a range of healthcare professionals. Since 2017, over 12,000 healthcare workers across Australia and Aotearoa New Zealand have enrolled in the program. Other organisations have used selected BPM modules in their education offerings, including Deakin University, Geelong, in their undergraduate medical education, the Australian Physiotherapy Association as a pre-reading requirement for their post-graduate pain level 1 course, and the Department of Defence for Medical officer training. FPM was awarded a Therapeutic Goods Administration grant to allow 10,000 healthcare professionals across Australia to access six of the BPM modules on pain management and opioids. This has huge community impact potential, given concerns about opioid use in non-cancer pain.
- An opioid calculator developed by FPM that is available as an app for Apple and Android devices and as a website. Designed for medical practitioners, medical students, nurses and allied health practitioners, the tool simplifies the calculation of total oral morphine equivalents daily dose of other single and combined opioids. This app has been downloaded over 150,000 times and is used 14,000 times per month on average.

Broader community health and wellbeing

The ANZCA Constitution tasks the college to "*advocate on any issue that affects the ability of members to meet their responsibilities to patients and to the community*" (object 1.1.4). College leaders take this role as a trusted and authoritative pillar of civil society seriously and in 2019 developed a statement outlining principles of the role of the college in advocating for the health and wellbeing of all people. The 2021 ANZCA and FPM fellowship survey (standard 6) found over two-thirds of respondents agreed that the college should advocate on social justice issues that impact community health and wellbeing.

ANZCA Health Equity Projects Fund

In 2019, the college established the ANZCA Health Equity Projects Fund to support its activities in global development and Aboriginal and Torres Strait Islander and Māori health. This fund supports a competitive grant process open to all college fellows for projects that

support the aims and activities of the ANZCA Global Development Committee and ANZCA Indigenous Health Committee.

Environmental sustainability

The college is committed to minimising the health impact of climate change and promoting environmental sustainability. It has taken measures to reduce its environmental impact.

During 2020 and 2021, the Environmental Sustainability Working Group undertook preliminary research activity, published 13 articles in the *ANZCA Bulletin*, developed the environmental sustainability library guide, delivered two successful webinars with leaders in the field and supported a closed loop recycling program in the Melbourne office.
The environmental sustainability audit tool was launched on World Environment Day in 2020 to assist departments and practitioners develop and maintain practices that promote environmental sustainability, in line with ANZCA professional document *PS64: Statement on environmental sustainability in anaesthesia and pain medicine practice*.

A college councillor was appointed to the RACP Climate Change and Health Research Project Advisory Committee. This multi-college initiative focuses on the impacts of climate change on Australian healthcare systems and how best to adapt to and mitigate climate change risks. The 2021 report 'Climate change and health' was endorsed by ANZCA Council.

In 2021, the Environmental Sustainability Working Group evolved into a broader Environmental Sustainability Network of fellows, trainees, SIMGs and members from outside the college. The purposes include to advocate, collaborate and promote environmental sustainability initiatives within anaesthesia, perioperative medicine and pain medicine.

Global development

Through the Global Development Committee and its associated Lifebox Australia and New Zealand initiative and Essential Pain Management (EPM) Steering Committee, the college is committed to improving education and training capacity in anaesthesia and pain medicine in response to the needs expressed by low and middle income countries. In October 2018, the committee released a new five-year strategic priorities plan that outlines the activities for the college to help build workforce capability and capacity in low and middle-income countries. These centre on education and training, equipment and safety initiatives, engagement and advocacy, and evaluation.

Other advocacy issues

College advocacy includes other issues that impact on the health and wellbeing of particular individuals, groups of individuals or the population at large. Examples are a 2015 statement on the health of people seeking asylum and in 2017, prior to the legalisation of same sex marriage in Australia, a marriage equality statement.

Partnerships in the Aboriginal and Torres Strait Islander and Māori health sector

See also standard 1.1 which overviews college governance of initiatives in Aboriginal and Torres Strait Islander and Māori health, including the 2018-2022 ANZCA Indigenous Health Strategy, draft Innovate Reconciliation Action Plan, Hui and Te Whare Tohu o Te Hau Whakoara**.** All of these initiatives have included key input from Aboriginal and Torres Strait

Islander and Māori fellows and trainees, as well as increasingly from Aboriginal and Torres Strait Islander and Māori organisations and communities as outlined below.

Aotearoa New Zealand

The college introduced the concept of a Hui at Aotearoa New Zealand events. This involves engaging with local community groups, broadening the understanding of a Māori way of sharing skills and knowledge, and creating a more holistic perspective on meetings as fair and respectful discussions. See standard 1.1 for development of Te Whare Tohu o Te Hau Whakoara and '*Improvement opportunities and future plans*' (at the end of this standard) for the proposed Treaty of Waitangi strategy.

Australia

The college committed to continue working with the Australian Indigenous Doctors Association (AIDA) on the Specialist Trainees in the Medical Workforce project and is participating in a consortium with AIDA and other medical colleges on a four-year proposal to the Department of Health under the Flexible Approaches to Training in Expanded Settings program. The project will establish a multi-college support network for Aboriginal and Torres Strait Islander and Māori trainees as well as developing cultural safety resources and other support initiatives. The project will also work with colleges to develop tailored strategies to support trainee selection (see standard 7.1).

Other key initiatives implemented by the committee include a pilot project in collaboration with the Australian National Aboriginal Community Controlled Health Organisation (NACCHO) to develop a program that gives college trainees the opportunity to deliver pain management training in Aboriginal medical services. Project outcomes also include increasing the number of health practitioners, including Aboriginal health workers, with the skills to assess and treat pain and train other professionals, and creating stronger links between Aboriginal health services and local specialist healthcare providers.

FPM is leading a project to develop a pain management education strategy for Australian health practitioners. Funded by the Federal Department of Health, the project supports a key goal of the National Strategic Action Plan for Pain Management to ensure health practitioners are skilled in best practice, evidence-based care and are supported to deliver this care. The strategy is being developed through a broad stakeholder consultation process. In 2021, members of the project group completed Aboriginal-owned and led cultural safety training in preparation for broader sector engagement in 2022.

1.7 Continuous renewal

The AMC accreditation standards are as follows:	
1.7 Continuous renewal	
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.

Policies and processes for review of structures and functions

The college and faculty routinely review structures and functions. This includes regular monitoring and evaluation processes (standard 6) and more extensive reviews (see below).

To date, review has occurred in both a planned way and in an ad hoc fashion when issues are identified.

The Educational Governance and Strategic Education frameworks set out the structured approach undertaken to govern and maintain continuous quality improvement across college training programs:

- The **Strategic Education Framework** (appendix 1.31) outlines ANZCA and FPM mission, vision, educational values and strategic priorities. These act as a guide for trainees, SIMGs and those within our training community who contribute to education where this encompasses selection, workplace training, educational offerings, supervision, assessment and accreditation of hospital and other learning environments.
- The **Education Governance Framework** (appendix 1.32) is a guide for trainees, SIMGs, fellows and college staff who contribute to the delivery of training programs that are overseen by the college to understand how they can function most effectively within their roles.

Regulation 35 sets out the college's high-level process for developing new certificates and diplomas.

Anaesthesia training program

Learning outcomes

From 2013 to 2019, a subgroup of EDEC annually reviewed the anaesthesia training curriculum learning outcomes to ensure relevance and best practice, including consideration of feedback received from stakeholders in the prior 12 months. EDEC membership changes in 2020 and 2021 resulted in loss of the members of this subgroup. In February 2022, EDEC agreed to re-establish this group for regular learning outcome review.

Training regulations and handbooks

An annual review process timeline is coordinated to ensure related documents are released at the same time. Amended documents are published at the end of each year. Further information regarding communication of training program changes to trainees is in standard 7.3. The aim of this annual process is consistency and predictability for stakeholders. Documents are typically published at least two months before changes come into effect. Consultation with key stakeholders is undertaken from the commencement of the review process, and relevant education committees are involved in reviewing and contributing to these updates.

Pain medicine training program

FPM regularly reviews training program components. These reviews are informed by evidence, feedback received through evaluation activities (standard 6) and from experience of committee members and staff. FPM has recently completed a review of the pain medicine curriculum and is commencing a review of its assessment philosophy and structure (see standard 5).

FPM committees each have terms of reference and a regular review cycle. A significant number of FPM fellows participate on FPM committees and so are able to inform training, strategy and other FPM activities. Key FPM roles such as supervisors of training, examiners and committee members have a maximum duration of 12 years to ensure succession

planning occurs. An area identified by FPM as an opportunity for improvement is training and mentorship of new committee members. New FPM board members have an orientation program. A standard orientation program for all new committee members is planned.

ANZCA and FPM CPD standard and program renewal arises primarily in relation to changes in MBA and MCNZ policies and guidelines (standard 9). However, the college also links CPD review to other strategic priorities (e.g. embedding wellbeing in CPD planning and activities in 2021).

Anaesthesia and pain medicine SIMG assessment review has been primarily for consistency with regulatory requirements and in light of external review findings. As the SIMG assessment process is based on comparability with FANZCA and FFPMANZCA graduate outcomes, training program changes also trigger review of the SIMG assessment process (see standard 10).

Review of resource allocation to education and training functions

Education strategy (anaesthesia)

In Q4 2021, the Education and Research unit commenced development of an education strategy. Set across four pillars, the strategy underwent consultation with key stakeholders including EDEC and EEMC. The strategy complements the broader college strategic plan and is due for ratification by EEMC and ANZCA Council in Q3 2022.

Initiating and delivering educational projects and activities

In early 2021, an internal analysis of how anaesthesia educational projects and activities are initiated and delivered was undertaken. Subsequent to this analysis, for improved controls around educational projects and activities, the following goals were established:

- Increased visibility across projects and activities (committees and staff).
- Ensure projects are adequately resourced (staffing) to deliver them on time and to a high standard.
- Ensure a consistent approach to education development and project support, including risk tracking.
- Explore opportunities for simplifying governance where possible.
- Transition from ‘project’ to ‘business as usual’ to form part of the project scope and early planning.
- Prioritise projects strategically, ensuring they are responding to a genuine need, are not duplicating effort and are aligned to strategy and regulatory requirements.

These measures will be achieved through the development and implementation of an *Education Quality Framework* (EQF), maintenance of a projects and activities planner, and implementation of an education strategy. These complement the Education Governance and Strategic Frameworks drafted in 2020 which established expectations about processes and behaviours to guide the work of volunteer trainees, SIMGs and fellows, working alongside college staff on educational committees and projects.

Education Quality Framework

The EQF is in development and aims to include guidance and principles for onboarding new projects, including approval pathways and go/no-go points to ensure projects are adequately

supported and relevant, aligned to strategy and respond to a genuine need. The EQF will include a suite of tools and resources including templates and guidance that are educationally based, and a structured pathway for projects and activities to follow. The draft EQF will be circulated for feedback to relevant key stakeholders in mid-2022, for finalisation in late 2022. The draft EQF is at appendix 1.33.

The EQF will complement the strategic education framework and education governance framework documents that underpin the function of EEMC (appendix 1.31 and 1.32), with an emphasis on ensuring that innovation continues to be fostered. Underpinning principles in the EQF include a focus on educational quality assurance (using robust frameworks, models, policies and processes to ensure educational offerings reflect best practice) and educational quality improvement (cycles of continuous improvement).

Projects and activities planner

An outcome of the analysis into initiating and delivering educational projects and activities relating to the anaesthesia program was the establishment of a central projects and activities planner. This resource is live and continues to be updated to accurately reflect progress across the myriad projects and activities underway. The ANZCA Council, EEMC and EDEC receive updates twice a year on high-level progress of these activities. The planner is administered and maintained by the Learning and Innovation team.

Planned reviews

The following reviews are planned:

- Review of anaesthesia trainee selection (standard 7.1).
- Review of overarching monitoring and evaluation framework (standard 6.1).
- Review of FPM committees.

Impacts of COVID-19

Governance and operational continuity

In March 2020, at the commencement of the COVID-19 first wave in Australia, the executive leadership team held daily video conferences to address all college and faculty operational requirements, with the president and vice-president joining when possible. These meetings worked to meet the immediate operational requirements of the college and to support fellows, trainees and SIMGs. All operations continued, albeit with staff working remotely, with communication to staff, fellows, trainees and SIMGs paramount during the uncertain times that were unfolding.

Concurrently, a number of governance executive advisory groups were formalised to manage the core functions of the college, as follows:

- A COVID-19 **Clinical Expert Advisory Group (CEAG)** to provide an expert and regional view of the college response to the pandemic (see health sector relationships below).
- A **Governance Executive Advisory Group (GEAG)** which met twice weekly for as long as was required. This group closely monitored the college's financial position, with close scrutiny of investments due to the volatility of the global market. Meetings were scheduled at least fortnightly and as required, to monitor cash flow and respond to any major fluctuations in the market when such advice was received from the college financial advisors, JBW. The last GEAG meeting was held on 24

September 2020, with actions then reverting to the FARM committee. The outcomes were that despite an initial negative impact on the college investment portfolio taking a hit of $2.171m in March 2020, by the end of the year the portfolio was up by $939k compared to 31 Dec 2019.

- **Education and training groups** formed to consider all implications associated with ANZCA training and exams. FPM decisions on training and exams were handled by standing committees. Further details of this work are in standards 3 and 5.
- **Events planning and fellow support** were addressed by usual committees with these responsibilities. These committees provided input to the specific COVID-19 groups.
- Decisions on the **SIMG assessment process** continued to be handled by the SIMG committee, taking note of guidance issued by the AMC and MCNZ. A COVID-19 SIMG Decision Group was delegated authority by the EEMC to make decisions about SIMGs that were an exception to regulation 23 but in line with COVID-19 guidance issued by the MBA in a timely and fair manner. The group consisted of the DPA SIMG, SIMG Committee chair and the director of professional affairs – professional documents. More recently, the SIMG Committee chair was replaced by a DPA assessor. The decisions made by the group were limited to requests for consideration in relation to SIMG processes that were directly impacted by COVID-19. These decisions are reported to each meeting of the SIMG committee and to EEMC, and are eligible for reconsideration, review and appeal under the provisions of regulations 30 and 31 RRA. This decision-making group remains in place at the time of this submission.
- **The ANZCA and FPM CPD Committee** continued to meet at the same frequency for decisions regarding COVID-19 impacts on the CPD program. See standard 9.

During the course of 2020, the established groups met regularly in response to the emerging issues each group was addressing and developments in the external environment. By the end of 2020, these groups had largely reverted to the established ANZCA and FPM committee structures to maintain the ongoing work that was required.

Educational groups

ANZCA Council approved delegating decisions on exceptions to the regulations related to COVID-19 training impacts to the DPA and education meeting (the DPA education, DPA assessors, and executive director of professional affairs, with other educational and training and assessment unit staff members in attendance). This enabled this group to make decisions for all affected trainees, mitigate the effects of COVID-19 on trainees and training in a timely fashion. The group had delegated authority to approve deferral of EMAC course completion for trainees affected by COVID-19 related disruptions to course provision. See Standard 10 for SIMG assessment delegations.

Videoconference technology

The college moved quickly to online meetings by fast tracking the implementation of a fully enterprise grade, penetration tested and encrypted version of Zoom. As a result of COVID-19, all committee meetings were held via Zoom from mid-March 2020 and have continued through the course of 2021 and into 2022, with very few face-to-face meetings. In 2021, the college hosted over 32,000 Zoom meetings and hosted over 58,000 participants in webinars. The 2021 ASM, attended by more than 2600 delegates, was delivered virtually, including an online workshop program (standard 4).

ANZCA Council and its committees functioned as usual, albeit meetings took place via Zoom. At times additional meetings were required to respond to impacts of COVID-19 on college operations. This included exams and training planning, and safety and quality, as the college regularly responded to requests for expert advice related to the frontline management of COVID-19.

One additional FPM Board meeting was scheduled for the first half of 2020 to address COVID-19 related impacts. All other board meetings were held as per the annual schedule via Zoom. FPM committees moved their meetings and workshops to Zoom.

Annual General Meeting

The Australian Charities and Not-For-Profits Commission Act 2012 and the ANZCA Constitution (section 5) requires that the annual AGM occurs by the end of May. As in-person meetings were not recommended due to the pandemic situation, the college AGM was held electronically (via Zoom) for the first time. Similar arrangements occurred for the 2021 AGM.

Constitutional amendments

In November 2021, college members approved a constitutional amendment (clauses 8.1 – Composition of Council and 10 – Office Bearers) to ensure that the president or president-elect cannot lose their council membership if their three-year term expired while holding the office bearer position. This change was made due to the identified risks during the COVID-19 pandemic of potential instability of council office bearers. The constitutional change means that the president or president-elect might potentially serve a term longer than the usual three years, although the extension would only last while they occupied an officer role.

Staff management

On 17 March 2020, Victorian college staff transitioned to working from home, due to the evolving COVID-19 situation. This continued throughout 2020 and 2021, in accordance with periods of lockdown, totaling 245 days. In jurisdictions across Australia and Aotearoa New Zealand, work from home arrangements were implemented as required, responding to local outbreaks of COVID-19 and relevant government guidelines. The rollout of Zoom videoconferencing technology across the college in early 2020 facilitated remote communication, playing a large role in ensuring continuity of all college operations.

Staff wellbeing has been at the forefront of this approach with regular CEO communications and development of a dedicated staff portal (‘Thrive Wellbeing Toolkit’) in Networks, including extensive information and resources on staff physical and mental wellbeing. On 7 September 2021, an expert clinical psychologist delivered a wellbeing session to ANZCA staff, talking about living with the prolonged pandemic and what it means for wellbeing.

RRA

There was a 22 per cent increase in the number of RRA requests during the COVID-19 period (data for 1 January 2020 to mid-December 2021) compared to the pre COVID-19 comparison period (2018-2019). The analysis included requests lodged by ANZCA trainees, SIMGs and FPM trainees. Data from CPD participants were excluded because no CPD participants lodged a formal request during the entire study period. More information is included in the interim RRA quantitative data analysis report in appendix 1.21. A more in-depth analysis, comprising qualitative and quantitative data, of the impact of COVID-19 on RRA requests and decision outcomes is currently underway. This includes analyses of

COVID-19-approved exceptions to the regulations as well as a comparative analyses of pre- and post-COVID-19 decisions.

Research program

2021 research grants deferral: In 2020 the Research Committee noted COVID-19's adverse impact on the capacity of many researchers and teams to progress existing and new research, due to factors such as redeployment of research staff to front-line clinical duties and difficulty accessing and recruiting patients. This included significant delays to college funded research and CTN-supported major clinical trials. The decision was therefore made to defer the entire 2021 college grants round for most new grant applications to 2022.

COVID-19-specific audits: Despite the grants round deferral, the foundation collaborated with Medibank Better Health Foundation to provide funding support for two specific quality improvement studies relating to COVID-19 patient perioperative screening and testing. The first study examined rates of COVID-19 documented preoperative screening at two major Melbourne hospitals. The second co-funded by Medibank Better Health Foundation and Safer Care Victoria, looked at intraoperative COVID-19 testing and incidence rates at eight Melbourne hospitals.

CSL Behring: CSL Behring cancelled $80,000 in previously-agreed grant funding for 2021.

Health sector relationships

Anaesthesia

Being experts in airway management and resuscitation, anaesthetists were at the forefront of the COVID-19 pandemic from the beginning. The pandemic dominated much of college advocacy efforts in 2020 and, to a lesser extent, in 2021.

Access to personal protective equipment (PPE), guidelines for appropriate fitting and use of PPE, preparing the hospital system in terms of medicines, equipment and workforce for a surge in critically ill patients, the suspension of elective surgery, access to MBS telehealth items and the health and wellbeing of frontline professionals were all issues on which the college worked to ensure the expert advice of anaesthetists and specialist pain medicine physicians was acted on by governments and health services.

Early in the pandemic, the college established a COVID-19 Clinical Expert Advisory Group to guide the selection of clinical resources relevant to anaesthesia and pain medicine, respond to clinical queries and share information. The group was supported by the policy team and produced a daily (then weekly) COVID-19 update for ANZCA Council and management. The ANZCA Safety and Quality Committee provided guidance on the college's strategic response to the pandemic and associated hazardous threats to members, with a view to embedding lessons learned into professional documents and operating procedures. One of the first tasks of the group was the development of the college's personal protective equipment statement, which has been subsequently revised to reflect the latest evidence, particularly in relation to airborne transmission of the virus and fit-testing of masks.

In the first few months of the pandemic the advisory group considered over 200 queries from fellows and trainees and the college organised numerous webinars including one with Australia's Deputy Chief Medical Officer Dr Nick Coatsworth and one with the New Zealand Ministry of Health Chief Medical Officer Dr Andrew Simpson.

The college also responded quickly to concerns about supply chains and drug shortages, and amended professional document *PS51 Guidelines for the safe management and use of medications in anaesthesia*, to allow for safe ampoule splitting in defined circumstances. The ANZCA and FPM CPD Committee also moved quickly to develop and approve a COVID-19 airway management emergency response standard.

Since the beginning of the SARS-CoV-2 pandemic the college has sought to engage constructively with governments at all levels to inform and contribute to the development of information and actions to address the spread and the treatment of COVID-19. The college continues to provide expert advice to government through forums such as the Australian National COVID-19 Clinical Evidence Taskforce. The college president is a member of this taskforce's national steering committee which continues to meet regularly to provide cross-disciplinary consensus on the clinical care of patients with COVID-19. The president, and the chair and deputy chair of the NZNC met with the Director General of Health, Dr Ashley Bloomfield, in August 2020 to reiterate concerns about PPE and medicine supply, open communications lines and equity in treatment of chronic pain across Aotearoa New Zealand.

The chair of the ANZCA Safety and Quality Committee joined a National Clinical Taskforce established by the Australian Commission on Safety and Quality in Health Care. Past chair of the committee, Dr Phillipa Hore, was appointed as co-chair of the new Australian Infection Prevention and Control Panel, formed to strengthen capacity for emerging evidence and frontline clinical experience to inform national infection prevention and control guidance for healthcare workers.

The college engaged with Australia's Chief Medical Officer Professor Paul Kelly, the Australian Technical Advisory Group on Immunisation and all state and territory chief medical officers to ensure frontline anaesthetists and anaesthetists in training were included in the priority 1a group for vaccination. The college also wrote to Aotearoa New Zealand's Director-General of Health seeking clarification on the vaccination roll-out plan.

As the pandemic has continued and evolved, issues such as preparing the hospital system for the end of lockdowns, doctors' workload and wellbeing issues and the ongoing impact on patients and healthcare workers of the freeze in elective surgeries have been the focus of advocacy efforts. The college will continue to be at the forefront of discussions and decisions that relate to SARS-CoV-2, COVID-19 and associated matters of healthcare workers' safety and standards of practice as they arise.

Lessons learned:

- Adoption of public health measures to limit the impact of transmissible disease.
- Revised guidelines on the use and implementation of PPE for all staff managing hazardous patients.
- PPE fit-testing as part of employee on-boarding, and regular re-checks.
- Investment in remote patient consultations in pre-assessment clinics.
- Re-prioritisation of planned surgery in a constrained economic model.
- Less tolerance of "presenteeism" – "stay home if you're sick!"
- Fewer face-to-face meetings and better use of IT for communication and education.
- More robust supply chains for essential equipment.

- Use of simulation to train for disaster scenarios.
- Improved craft-group collaboration (anaesthesia/ intensive care unit/ emergency department).
- Re-design of hospital intensive care and operation room facilities to accommodate hazardous patients in isolation.
- Enhanced wellbeing and mentor networks that are interdisciplinary.

Pain medicine

When COVID-19 struck and pivoting delivery of activities was required, FPM reached out to the Faculty of Pain Medicine, Royal College of Anaesthetists (RCOA) and several Australian-based colleges to learn how they had delivered oral examinations remotely. Based on the experiences of these colleges, FPM concluded that it would be feasible to conduct the pain medicine exam over videoconference while maintaining standards. Technical concerns delayed the exam by three months. This collaboration with FPM, RCOA will be extended in future to include observation of each other's exams as well as potential resource sharing.

FPM Procedures Endorsement Program

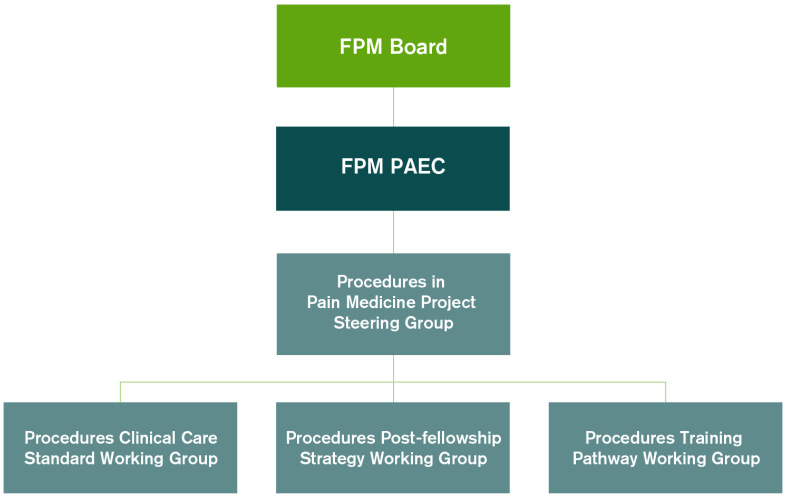
Unlike other training programs offered by the college, the Procedures Endorsement Program does not lead to a formal qualification such as a fellowship or diploma.

Leading the development of standards and training for procedural interventions in pain medicine is a key goal articulated in the college Strategic Plan 2018-2022. In 2018, the Procedures Working Group finalised the Position Statement on Procedures in Pain Medicine which articulated three statements of intent:

1. FPM will develop clinical standards that will reflect optimum standards of practice for procedures.
2. FPM will provide training in and endorsement of procedural skills.
3. FPM will collaborate with other bodies to promote judicious use of procedures.

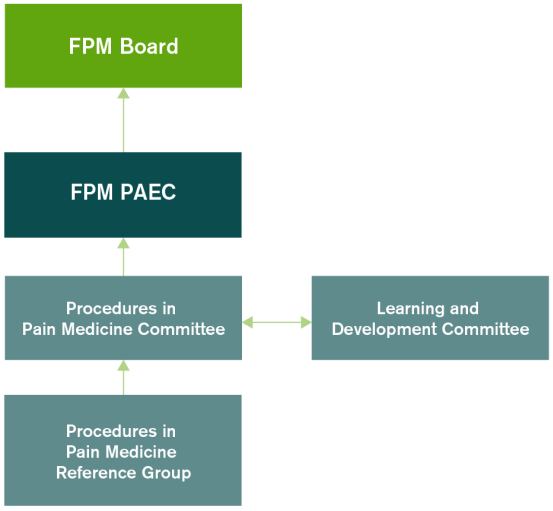
Over 2019-2021, three working groups (terms of reference – appendix 1.34) under the oversight of a project steering group progressed initiatives to deliver against the statements of intent. The project was delivered by staff in the FPM unit and completed in 2021. The governance structure for that project outlined below.

Figure 1.5 Procedures in pain medicine project governance structure



Following the completion of the procedures in pain medicine project the ongoing governance structure is as follows:

Figure 1.6 FPM Procedures Endorsement Program governance structure



1. Procedures in pain medicine clinical care standard

In July 2020 *PS11(PM): Procedures in pain medicine clinical care standard* was promulgated after wide consultation with internal and external stakeholders. This clinical care standard addresses clinicians, healthcare services and consumers.

The clinical care standard contains 10 quality statements that address patient selection, assessment, consent, equipment, facilities, record keeping, governance, ancillary services such as imaging and sedation, outcome measurement and provision for contingencies such as complications or emergencies.

This component of the project was prioritised as the basis of the program for training and CPD activities.

2. Procedures Endorsement Program

The Procedures Endorsement Program was developed over 2019-2020. The program has a stand-alone curriculum and is governed by FPM by-law 20 and its accompanying Procedures Endorsement Program Handbook. The program includes two distinct pathways:

- The supervised clinical experience pathway is open to FPM fellows and trainees in the practice development stage (PDS) who elect to expand their practice by gaining workplace-based experience in planning, performing and managing pain procedures under the supervision of an FPM-accredited procedural supervisor.
- The practice assessment pathway, which will remain open from 2022 until the end of 2026, requires fellows to demonstrate competence in pain medicine procedures and adherence to *PS11 (PM) Procedures in pain medicine clinical care standard* through submission of a written application followed by peer review.

3. Supervised clinical experience pathway

The supervised clinical experience pathway follows an apprenticeship model. In 2021, this pathway was piloted by five accredited procedural supervisors based in New South Wales, Queensland, Victoria and Hong Kong. Participants in the program are referred to as 'endorsees' rather than 'trainees' reflecting that many already hold two specialist qualifications. Of the seven endorsees who participated in the 2021 pilot, five were fellows of FPM and two were pain medicine trainees.

As with all college programs the reconsideration, review and appeal processes outlines in ANZCA regulations 30 and 31 apply to the Procedures Endorsement Program and this is covered in

Other training programs

Joint Consultative Committee on Anaesthesia (JCCA)

Some stakeholders use the terms general practice anaesthetist and anaesthesia (GPA) and others use rural generalist anaesthetist and anaesthesia (RGA). These terms are used interchangeably in this submission, although the college recognises the nuances around general practice and rural generalism. Please note also that this is one of the few college activities that is not bi-national, with the JCCA and planned DRGA only applicable to Australia.

The JCCA commenced in 1994 with ACRRM joining in 1998. The JCCA governs GPA training and CPD, with four ANZCA representatives and two each from RACGP and ACRRM, meeting at least bi-monthly. The RACGP provides administrative support. All three college councils must approve policy and educational changes.

The JCCA reviews all candidates to confirm training requirements are met and issues a letter of training completion. There is limited external stakeholder input to this qualification. The JCCA reviews its curriculum from time to time, most recently in 2018 and 2020. Trainees may request reconsideration or review of an outcome and these are considered by the JCCA committee. However, there is no formal JCCA reconsideration, review and appeals processes.

The curriculum (standard 3), assessment forms (standard 5), supervisors (standard 8.1), the accreditation process (standard 8.2) and CPD standard (standard 9) are available on the JCCA website.

Diploma of Rural Generalist Anaesthesia (DRGA)

In 2021, the college signed an MOU with ACRRM and RACGP to develop a one year diploma of rural generalist anaesthesia (appendix 1.35). Under this MOU the three colleges will establish a diploma to actively cultivate and maintain the highest principles and standards in the training, practice and ethics of RGAs. ANZCA is responsible for the clinical standards in the diploma curriculum, while ACRRM and RACGP are each responsible for standards and requirements for their respective general practice and rural generalist fellowship programs. To be launched in 2023, the DRGA aims to deliver RGA graduates who can deliver safe anaesthesia and perioperative care in rural and remote settings for specific in-scope patients. This new diploma will supersede the JCCA qualification.

The Tripartite Committee of Rural Generalist Anaesthesia (TC-RGA) was formed in late 2021. Its terms of reference, embedded in the MOU, are overseeing the DRGA curriculum, training resources, policies and standards for accreditation and CPD. The TC-RGA makes recommendations for decisions to ANZCA EEMC, ANZCA Council and for information and noting to the ACRRM and RACGP boards. Membership includes four ANZCA representatives, two ACRRM representatives, two RACGP representatives, a graduate representative and a rural consumer representative. The chair of the TC-RGA is appointed annually by the committee and rotated equally between college representatives.

The colleges have been working towards diploma development for a number of years. Significant work on the curriculum including assessments has already been completed by a curriculum project group with fellow and staff representatives from all three colleges. Other work on related policies and procedures is also underway, in accordance with a project plan. While there has been continuous improvement of the existing JCCA training program, the planned DRGA adopts a more contemporary education model. The diploma will benefit clinicians and communities by providing:

- Standardised graduate outcomes.
- Access to educational resources as adjuncts to learning in the clinical environment.
- A contemporary suite of assessments for all candidates including standardised examinations.
- Linkage of ongoing CPD to qualification currency.

Staff management will be by the ANZCA Training and Assessment unit. Regular review is planned in accordance with the draft ANZCA Educational Quality Framework.

Diploma of Advanced Diving and Hyperbaric Medicine (DHM)

Following the initial formation of a DHM special interest group in 1994, the college has offered a DHM certificate for many years. In 2016, this was redeveloped into a diploma of advanced DHM (DipAdvDHM, hereafter 'DHM diploma') by a DHM project group. The DHM diploma is a post-specialisation qualification implemented from 2017. Award of the diploma requires completion of DHM training requirements and a specialist qualification acceptable to the ANZCA Council, current medical registration and declaration of fitness to practice. Although the diploma does not lead to specialist registration or registration in a vocational scope of practice in DHM (which is not recognised in either country), the qualification is the only one of its kind in Australia and Aotearoa New Zealand.

The DHM diploma is managed by the DHM Sub-committee (DHM SC) reporting to the EEMC. In accordance with its terms of reference (appendix 1.36), DHM SC roles include all aspects of development and implementation of the DHM curriculum and training program. Staff support is through the training and assessment unit and the diploma is partially resourced by training fees. All trainees have access to the ANZCA reconsideration, review and appeals processes (standard 1.3).

Globally, there are few comparators for the DHM diploma. In 2016, the DHM Diploma Project Group consulted with those responsible for DHM training and qualification in both the USA and western Europe. The core document informing the ANZCA curriculum was the guideline document for those seeking accreditation of training courses in DHM by the Undersea and Hyperbaric Medical Society in the USA and the formal training courses developed locally are designed to satisfy training requirements in both the US and Europe.

Ongoing quality of the training program is managed by the DHM Sub-committee and involves both mandated five-yearly formal accreditation assessments of individual training sites (standard 8) and regular review of the content and conduct of approved training courses for delivery of training material in both diving and hyperbaric elements of the discipline (standard 4). In line with other programs, regulation 36 and the Handbook for Advanced Diving and Hyperbaric Medicine Training have been progressively revised and improved since diploma introduction in 2017, with more changes planned over the next couple of years.

Diploma of Perioperative Medicine (POM)

The college is leading a multi-disciplinary collaboration which has developed an integrated perioperative care model. Associated with this, a formal POM qualification is being developed for launch in 2024. The Perioperative Medicine Steering Committee, overseeing this work, includes ANZCA and FPM representatives as well as from:

- College of Intensive Care Medicine.
- Royal Australasian College of Physicians (including the Australian and New Zealand Society for Geriatric Medicine and the Rehabilitation Medicine Society of Australia and New Zealand).
- Royal Australasian College of Surgeons.
- Australian College of Rural and Remote Medicine.
- Royal Australian College of General Practitioners.
- Royal New Zealand College of General Practitioners.

- A community representative.

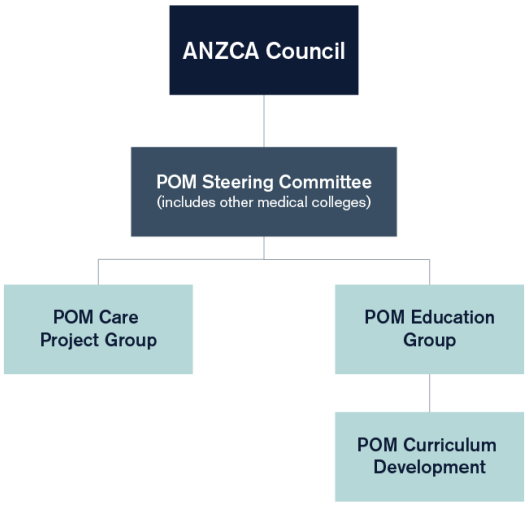
A Perioperative Medicine Education Group is responsible for a graduate outcome statement and a curriculum comprising six modules, while the Perioperative Care Working Group has developed a care framework which maps the perioperative journey of surgical patients.

Expected outcomes are qualified perioperative specialists who will help patients navigate the healthcare system and co-ordinate their care from a wide range of healthcare professionals through shared-decision making to improve patient experiences, reduce postoperative complications, reduce inpatient hospital days and reduce early re-admissions following surgery. This will lead to better quality care for patients and considerable costs savings for hospitals and health systems more broadly.

POM governance structure

The perioperative medicine governance structure is outlined on the college website and in figure 1.7 below.

Figure 1.7 Perioperative medicine governance structure



Resourcing

Project managed by the strategic projects team in the Learning and Innovation team, the project is in three streams:

1. Communication and advocacy – led by the Policy and Communications unit.
2. Diploma development and delivery – led by the Education and Research unit.
3. Professional standards – collaboration across both units.

Staff resources include a dedicated project support officer (education team), project coordinator (education team), policy officer (policy team) and input by other senior staff across the two departments. With the high volume of projects underway, a dedicated project coordinator will be recruited in April 2022 to focus solely on diploma development and

implementation. A training administration officer has been appointed to support the day-to-day running of both the DipPOM and DRGA, including developing business processes ahead of their launches.

Other achievements include:

- Curio business case (2020).
- Established governance structure.
- Established project management and team meetings.
- Literature review.
- Diploma grandparenting pathway and process drafted.
- Communication and advocacy strategy with regular communications underway (e.g. in the *ANZCA Bulletin*, POM communique and FAQ on the college website).
- Engagement with the POM SIG.
- Surveys of key stakeholders.

Dual FANZCA-FCICM pathway

In 2020, ANZCA commenced preliminary work with CICM on the feasibility of a dual fellowship training program in anaesthesia and intensive care medicine. This demonstrates commitment to addressing inequitable access to specialists, specifically in rural and regional areas in both Australia and Aotearoa New Zealand. The next stage is endorsement by both colleges through a MOU and then designing the training curriculum and associated processes. At its February 2021 meeting, ANZCA Council gave in-principle support for ongoing development of this pathway. The communications departments of both colleges are collaborating to develop and implement a communication strategy to routinely update key stakeholders on progress.

Through the MOU, both colleges will establish and participate in a conjoint committee for delivering on a dual training pathway, the details of which are being finalised at the time of this report being prepared. A Dual Training Pathway Curriculum Working Group is being formed (appendix 1.37 draft terms of reference), reporting directly to the ANZCA EEMC, with updates provided to ANZCA Council and the CICM Education Committee and Board. Once the conjoint committee is established, the Dual Training Pathway Curriculum Working Group will report to that group. Membership of the curriculum working group will include representation of trainees, dual fellowship holders, fellows with medical education experience, heads of department (training sites), Aboriginal and Torres Strait Islander and Māori doctors.

Resourcing

In 2021, both colleges agreed that ANZCA would lead the project coordination, with input from education staff of both colleges. DPAs from both colleges have been collaborating in the design and development of the dual pathway, and will continue their involvement as development progresses. This project is managed through the Learning and Innovation team of the ANZCA Education and Research unit. A project co-ordinator within the Learning and Innovation team is assigned to coordinate and progress the initiatives of this project, with ongoing guidance and input from senior education staff. The implementation plan is at appendix 1.38.

Australasian College for Emergency Medicine diploma of pre-hospital and retrieval medicine

Led by the Australasian College for Emergency Medicine, the college is part of the Conjoint Committee of Pre-Hospital and Retrieval Medicine, along with ACRRM, CICM and the RACGP. In 2021, the conjoint committee launched the Diploma of Pre-hospital and Retrieval Medicine (DipPHRM). The DipPHRM is a six-month postgraduate training program aimed at appropriately experienced doctors who wish to work within pre-hospital retrieval medicine services and actively participate in missions.

Strengths

Solid governance with flexibility to manage the pandemic challenges (across standard 1)

Management of COVID-19 related impacts has been challenging but the college has pivoted to the use of technology to maintain business continuity and good governance. Allowances have been made to ensure delivery of training assessments, support trainee progression and communicate widely with trainees, SIMGs and fellows. Many projects have continued, despite these additional priorities and constraints. An example is the FPM consultation and collaboration with respect to delivery of virtual summative assessments and the training program evolution project streams which, while delayed, have produced final recommendations for change (standards 3, 5, 6 and 8). COVID-19 has also strengthened relationships with the health sector as the college and its fellows have provided significant expertise to support governmental responses to the pandemic.

Reconsideration, review and appeals (standard 1.3)

Approximately one third of decisions are overturned at both reconsideration and review stages, indicating a robust process that is open to varying outcomes. This proportion is consistent with benchmarks of appeals in legal jurisdictions.

Educational expertise of volunteers (standard 1.4)

The college values the voluntary and dedicated contribution of a large number of fellows with educational expertise and experience, some with higher educational qualifications, who contribute to its educational activities. Examples include the FPM curriculum review which was completed in recent years, despite COVID-19 constraints.

Australian funding for health sector pain education (standard 1.6)

FPM has obtained Commonwealth Department of Health funding to pursue development of a pain management education strategy for health practitioners.

College communications (standard 1.6)

Over the past 10 years, the college has also recognised the importance of digital communications and employed a digital communications manager in 2016, then in 2020 employed a digital designer and a digital communications officer. This team supported the development of a state-of-the-art website, launched in 2020 and an expansion on the college's other digital communications, including electronic direct mailing and social media.

Improvement opportunities and future plans

A Treaty of Waitangi strategy (standard 1.1)

Addressing Māori health is an area for growth that is distinct for Aotearoa New Zealand. It must address structural and cultural racism at all levels from institutions to practitioners. The college needs an explicit statement for Aotearoa New Zealand on its commitment to the

principles of the Treaty of Waitangi and equity of health outcomes for Māori. The Indigenous Health Committee is considering a proposal for a steering group to oversee the development of a Treaty of Waitangi strategy for the college. This strategy will consider what actions the college can take under each of the principles set out by the Waitangi Tribunal Health Services and Outcomes Inquiry and endorsed by the Ministry of Health in its *Whakamaua: Māori health plan 2020-2025*. Other avenues include active recruitment of Māori trainees (standard 7.1), support for research aimed at improving Māori anaesthesia, pain medicine and perioperative care (standard 1), along with support for Māori fellows (standard 6). All such initiatives should be Māori-led where possible or in collaboration with Māori.

Terms of reference (standard 1.1)

An area of improvement for the college to explore is the systematic and consistent review of committee terms of reference. The terms of reference were first developed in 2011 and over time there has been progressive ad hoc revision of these to reflect evolving functions and needs. The corporate office commenced a review of college TOR in Q4 2021, noting that an overarching review of education-related committee TOR is due to ensure consistent alignment, and is scheduled to commence in late 2022.

Integrated anaesthesia assessment governance (standard 1.2)

Given college commitment to a programmatic assessment approach, oversight and integration of assessment activities is under review. Currently, the ANZCA Primary and Final Examination Sub-committees function independently with each reporting to EEMC. Until recently, no committee had operational oversight of programmatic assessment processes, such as work-based assessments. There is an opportunity to house governance of ANZCA assessment processes within a single oversight committee, as previously occurred with the Examinations Committee (1992-2010) and the Assessments Committee (2010-2013). Broadly speaking such a governance committee could potentially have oversight of assessment relating to all college related qualifications such as the FPM fellowship, the SIMG program, the DRGA, the POM Diploma and the dual CICM and ANZCA fellowships. The TOR of the current Examination Advancement Advisory Group are being reviewed to enable this review in 2022.

A college-wide systematic approach to analysing and reporting RRA (standard 1.3)

The college recognises that it needs a process for evaluating RRA to identify systems issues. The planned 2020 RRA review was delayed due to the urgent need to respond to COVID-19 and its effect on trainees and the training programs. Two reviews commenced in late 2021:

1. Review of regulations 30 and 31, to improve clarity with plain English and amalgamate the two into a single regulation covering the entire three-stage process.
2. Formal systematic review of RRA applications and decisions from 2018 to 2020 for trends, decision types that progress to appeal and systemic issues, as RRA decisions are typically high-stakes.

Staff turnover and recruitment (standard 1.5)

In recent years there has been high turnover of staff, and subsequently, loss of corporate knowledge within the Education and Research unit. This has slowed more recently, maintaining a stable team with moderate staff turnover.

Recruitment into key roles has focused on employing staff with specific skill sets (such as medical education and assessment experience) with a long-term plan to strengthen the professional role of staff to collaborate with fellows and progress the ambitious and growing volume of work.

Due to the impact of COVID-19 and external pressures on employment, there have been some delays in recruiting into key roles. Occurring concurrently with the pandemic, this has resulted in some delays in project deliverables.

A key challenge for council, EEMC, EDEC and staff is to manage expectations around initiating 'new projects', emphasising the need for ensuring sufficient resourcing to support these going forward both during project phase, and at implementation.

Prioritising college-wide project requests (standard 1.5)

With significant projects due for completion and implementation in 2023 and 2024 (DRGA, POM and the dual FANZCA FCICM fellowship), significant resourcing will be required to ensure that these projects are effectively delivered and embedded into business as usual. Preparations are underway to ensure effective planning and recruitment takes place to ensure the success of these programs at implementation, including the appointment of a program officer to coordinate the day-to-day activities of the new POM and DRGA diplomas. Recruitment for this role commenced in March 2022. A new process has been introduced to ensure future resourcing requirements are considered for all new project requests. This will ensure sufficient resourcing is planned for to successfully transition activities from 'project' to 'business as usual'. This is a step included in the draft Education Quality Framework, refer standard 1.7 for more information.

Lifelong learning project (standards 1.5 and 4)

The lifelong learning project will provide significant improvements for the pain medicine training program by introducing a number of systems. Once these are in place, there will be timely data available to monitor trainee progression through the program, rather than waiting for the three-monthly progress reports to be submitted. It is anticipated that these new ICT systems will provide access to contemporaneous data highlighting so far unseen areas for improvement. This will be particularly important for pain medicine training which is currently a paper-based process, creating barriers to systematic data analysis for monitoring and evaluation (including for accreditation standard 8.2).

College health sector relationships (standard 1.6)

While there has been significant growth in the college's engagement with health sector stakeholders over the past decade, advocacy work is often reactive rather than proactive. Accreditation visits follow a planned cycle and while in recent years ANZCA has developed written strategic plans for many specific issues (such as gender equity, Indigenous health, global development and the regional and rural workforce), the college currently lacks an overarching advocacy plan to coordinate and prioritise activities.

To address this, and strengthen the college's external engagement activities, we are currently recruiting an advocacy manager to lead the development and implementation of the college's policy and advocacy agenda, and build and maintain strong relationships with key external stakeholders. The advocacy manager will engage with all college business units, regional committees and other stakeholders to develop an in-depth understanding of current and emerging policy and advocacy issues for the college. Key issues include implementation of the Reconciliation Action Plan and continued rollout of Aboriginal and

Torres Strait Islander and Māori health initiatives, the regional and rural workforce and rural health strategy, safety and quality for both patients and trainees, improved pain services and the National Strategic Action Plan for Pain Management.

Standard 2

The outcomes of specialist training and education

ANZCA
FPM

Standard 2: The outcomes of specialist training and education

Overview

The college recognises the dynamic and changing environment and is responding by ensuring guiding strategies are contemporary and agile to this changing environment. College educational purpose is expressed through the ANZCA Constitution, the ANZCA and FPM Reconciliation Action Plan (RAP) (in development), the ANZCA and FPM Strategic Plan 2018-2022, the planned 2023-2025 strategy (in development), and the ANZCA and FPM Strategic Education Framework (in development). This is underpinned by organisational purpose, expressed in the mission 'To serve the community by fostering safety and high quality patient care in anaesthesia, perioperative medicine and pain medicine' (standard 1).

Graduate and program outcomes are overseen by the ANZCA Education Executive Management Committee (EEMC) (for anaesthesia training) and the FPM Training and Assessment Executive Committee (TAEC) (for pain medicine training).

The program outcomes are defined by community need and relate to the roles of specialist anaesthetists and specialist pain medicine physicians in the delivery of healthcare.

All college training programs have adapted the CanMEDS roles, with permission from the Royal College of Physicians and Surgeons of Canada (RCPSC), to the ANZCA roles in practice and the FPM roles in practice. High-level descriptions of these roles are the basis of **graduate outcomes** for each program.

Key resources:

- ANZCA Constitution.
- ANZCA and FPM Reconciliation Action Plan (in development).
- ANZCA and FPM Strategic Plan 2018-2022.
- ANZCA and FPM strategic education framework (in development).
- FPM by-law 20: Procedures Endorsement Program.

See also: Standard 1 (vision, educational governance, draft Reconciliation Action Plan), Standard 3 (curriculum frameworks and content).

2.1 Educational purpose

The AMC accreditation standards are as follows:	
2.1 Educational purpose	
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.

Educational purpose

The educational purpose of the college is to support the training, assessment, and continuing professional development (CPD) of practitioners for the delivery of high quality and safe anaesthesia, pain medicine and perioperative medicine for the Australian and Aotearoa New Zealand communities. This purpose is reflected in:

- The ANZCA Constitution.
- The ANZCA and FPM Reconciliation Action Plan (in development).
- The ANZCA and FPM Strategic Plan 2018-2022 (note the 2023-2025 strategy in development).
- The ANZCA and FPM education governance and strategic frameworks (standard 1.7).

ANZCA Constitution

Relevant objectives within the current ANZCA Constitution are articles:

1.1.1 Promote and encourage the study, research and advancement of the science and practice of anaesthesia, perioperative medicine, and pain medicine.

1.1.2 Promote excellence in healthcare services and cultivate and encourage high principles of practice, ethics and professional integrity in relation to medical practice, education, assessment, training, and research.

1.1.3 Determine and maintain professional standards for the practice of anaesthesia, perioperative medicine and pain medicine in Australia and New Zealand.

1.1.6 Conduct and support programs of training and education leading to the issue of membership or other certification attesting to the attainment or maintenance of appropriate levels of skills, knowledge and competencies commensurate with specialist practice in anaesthesia, perioperative medicine and pain medicine in Australia and New Zealand.

1.1.7 Disseminate information and advise on any course of study and training designed to promote and ensure the fitness of persons who wish to qualify for recognition by the college.

1.1.8 Conduct and coordinate examinations and other assessment processes and to grant registered medical practitioners recognition in anaesthesia, perioperative medicine and pain medicine, either alone or in cooperation with other relevant bodies or institutions.

1.1.9 Hold or sponsor meetings, lectures, seminars, symposia or conferences, within or outside of Australia and New Zealand, to promote understanding in medicine and related subjects and professional relations among members of the college, members of other health professions, scientists and the wider community.

1.1.10 Facilitate the advancement of specialist education and training in anaesthesia, perioperative medicine and pain medicine through the support for and conduct of projects and research.

1.1.11 Ensure that members undertake CPD and participate in effective, ongoing professional activities.

1.1.13 Advance public education and awareness of the science and practice of anaesthesia, perioperative medicine and pain medicine.

1.1.15 Work with governments and other relevant organisations to achieve the provision of adequate, well-qualified, experienced and capable workforces in Australia and New Zealand and to improve health services.

In 2021, references to ‘intensive care medicine’ were changed to ‘perioperative medicine’ to emphasise the college’s recognition of this growing discipline; community needs; and college identification as a leading medical specialist college for perioperative care. Notably, while the ANZCA Constitution doesn’t currently mention educational objectives in terms of Aboriginal, Torres Strait Islander, and Māori health outcomes, a proposed constitutional amendment to address this is outlined in the following section.

ANZCA and FPM Strategic Plan 2018-2022

Within this plan, the key expressions of educational purpose include both ANZCA and FPM visions (standard 1.1), and the following goals:

- Support the rural, regional and remote workforce.
- Support and promote a diverse workforce.
- Utilise best available technology for contemporary lifelong education and training in anaesthesia and pain medicine.

College educational purpose addresses Indigenous health

While the **ANZCA Constitution** currently lacks reference to Aboriginal and Torres Strait Islander peoples and Māori, constitutional amendments will be presented to a vote of members at the May 2022 annual general meeting (AGM). The proposal includes the following draft new object (yet to be approved by the ANZCA Council):

- Advance public education and awareness of health equity and cultural safety of Aboriginal, Torres Strait Islander, Māori and Pacific peoples.

A further draft constitutional amendment addresses culturally safety in a different context:

- Facilitate medical education, medical aid and support, cultural competence, and cultural safety to developing nations.

ANZCA and FPM Reconciliation Action Plan

Key expressions of educational purpose are in the Reconciliation Action Plan (RAP) vision:

Our vision for reconciliation is to lead safe and high quality patient care in anaesthesia, perioperative medicine, and pain medicine that's culturally safe and equitable, and to empower Aboriginal and Torres Strait Islander peoples to train and have flourishing professional careers in these fields. We hope to achieve this by:

- Reflecting on how historical and ongoing social, cultural, and political structures shape the college, our relationship with Aboriginal and Torres Strait Islander peoples, and our training and specialties in Australia. This is a necessary foundation for improvement.
- Engaging and collaborating with Aboriginal and Torres Strait Islander peoples and organisations.
- Growing the Aboriginal and Torres Strait Islander college workforce and the Aboriginal and Torres Strait Islander anaesthesia, perioperative medicine, and pain medicine workforce.
- Advocating for culturally safe training and work environments for the Aboriginal and Torres Strait Islander health workforce, and for Aboriginal and Torres Strait Islander college staff.
- Strengthening culturally safe patient care in anaesthesia, perioperative medicine, and pain medicine.
- Strengthening the anaesthesia and pain medicine training program curricula to have substantive understanding of Aboriginal and Torres Strait Islander histories, cultures and health.

While the college **2018-2022 strategic plan** mentions supporting a diverse workforce, Aboriginal and Torres Strait Islander peoples and Māori aren't specifically mentioned in the goals and key strategies. The 2023-2025 strategic plan is in development and Aboriginal, Torres Strait Islander and Māori perspectives will be incorporated.

The **draft ANZCA and FPM Strategic Education Framework** includes the value of 'In our approach to education we uphold a commitment to support First Nations doctors to participate and thrive in our training programs'.

See also *'Improvement opportunities and future plans'*, particularly in relation to Māori.

Internal and external stakeholder input to educational purpose

The college notes the AMC definition of internal stakeholders being trainees, supervisors, fellows and committees, and of external stakeholders being training sites, specialty societies, health workforce bodies, jurisdictions, regulatory authorities, other health professions, consumers, Aboriginal and Torres Strait Islander peoples and Māori. College internal and external stakeholders contribute to the expressions of educational purpose as shown in table 2.1. More detail on the constitution, RAP, strategic plans and strategic education framework are in standard 1.

Table 2.1 Internal and external stakeholder input to college educational purpose

	Internal stakeholders	External stakeholders
Constitution	ANZCA Council members including FPM dean and new fellow councillor Council observers including ANZCA trainee committee co-chairs Vote of fellows at AGM	Nil
Draft ANZCA and FPM Reconciliation Action Plan	Reconciliation Action Plan Working Group, fellows, trainees, CEO, other staff (half members identify as Aboriginal or Torres Strait Islander) Indigenous Health Committee including fellows who identify as Aboriginal and Torres Strait Islander and Māori Council members and observers FPM Board	Consumer representative on RAP working group Leaders in Indigenous Medical Education (LIME) Reconciliation Australia
ANZCA and FPM Strategic Plan 2018-2022	Council (including new fellow councillor) and observers (including ANZCA trainee committee co-chairs) FPM Board College committees and subcommittees including regional and national committees ANZCA fellows and trainees Research community FPM fellows College staff	ACRRM, ACEM, CICM, RACGP, RACS, CPMC International anaesthesia colleges Australian Society of Anaesthetists New Zealand Society of Anaesthetists SPANZA Philanthropic supporters Jurisdictions, regulators
ANZCA and FPM Strategic Plan 2023-2026	Council members FPM Board Fellow and trainee surveys Executive leadership team Senior leadership team	Nil
ANZCA and FPM Strategic Education Framework	EEMC including trainee and supervisor representatives	EEMC consumer representative

2.2 Program outcomes

The AMC accreditation standards are as follows:	
2.2 Program outcomes	
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 healthcare 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 healthcare.

The college compares its anaesthesia and pain medicine programs to those of international education providers when considering SIMG assessment (standard 10). Other opportunities for benchmarking and exchange are created through the educational collaborations described in standard 1.4. Under the Tri-nations collaboration, CMBE leads from the various countries share ideas during regular meetings at the International Conference on Residency Education (ICRE).

Anaesthesia training program

Specialist anaesthesia practice requires a unique range of clinical knowledge and skills in anaesthesia and sedation, regional anaesthesia, airway management, pain medicine, perioperative medicine, resuscitation, trauma and crisis management, and quality and safety in patient care. The anaesthesia training program 2013 curriculum articulates the full scope of practice required by a specialist anaesthetist in a general hospital setting including breadth and depth of knowledge, range of skills, and professional behaviours necessary for quality care. The college has developed definitions of ‘anaesthesia’ as part of the Document Framework Policy work described in standard 1.5.

Anaesthetists in Australia and Aotearoa New Zealand work in a range of clinical environments, from isolated rural environments to large metropolitan teaching hospitals in both public and private practice, and the armed services. Anaesthetists apply their knowledge and skills to caring for patients in a variety of clinical contexts, providing anaesthesia and sedation for surgery and other procedures, providing pain management and periprocedural care, working in resuscitation, trauma and retrieval teams and working with specialists in intensive care medicine. There are sub-specialised areas of practice based around patient groups such as paediatric anaesthesia and obstetric anaesthesia, or surgical sub-specialties such as anaesthesia for cardiac surgery, medical perfusion and neurosurgery. The ANZCA training program provides education and training for all clinical environments and contexts, including foundation knowledge and skills for sub-specialised areas of practice.

Since 2012, key developments in terms of program outcomes include:

- Recognition of the unique place of perioperative medicine within anaesthesia practice and overlap with other scopes of practice. This has informed changes to the anaesthesia training program and the development of a new qualification.
- Recognition of the consolidation and expansion of the specialty of intensive care medicine and the need for a dual fellowship of ANZCA (FANZCA) and fellowship of

the College of Intensive Care Medicine (FCICM) training pathway particularly to serve communities in rural and regional areas with dual-qualified specialists.

- A need to update and strengthen the general practice anaesthetist training by introduction of the Diploma of Rural Generalist Anaesthesia (DRGA) to replace the existing Joint Consultative Committee on Anaesthesia (JCCA) program.

For more information, see *'Other training programs'* at the end of this standard. The anaesthesia program outcomes haven't changed since the last reaccreditation.

Pain medicine training program

The specialty of pain medicine arose out of recognition that pain can be a condition in its own right, irrespective of its origin or cause, one that frequently is not well addressed in the usual biomedical paradigm. The field spans three major clinical areas:

1. **Acute pain** – post-operative, post-trauma, acute episodes of pain in medical conditions.
2. **Cancer pain** – pain due to tumour invasion or compression; pain related to diagnostic or therapeutic procedures; pain due to cancer treatment.
3. **Chronic non-cancer pain** – comprising many conditions including musculoskeletal, neurological and visceral, now recognised in ICD-11.

In its approach to training in pain medicine, FPM has adopted a sociopsychobiomedical paradigm, a unique conceptual stance in this field. This comprises the traditional biomedical dimension (what is happening to the person's body), the psychological dimension (what is happening to the person) and the social dimension (what is happening in the person's world), deliberately inverted from the "biopsychosocial" perspective. Clinically this incorporates the evaluation, treatment and rehabilitation of persons whose pain has become persistent, complex or severe.

The pain medicine curriculum articulates the scope of practice of a specialist pain medicine physician, including breadth and depth of knowledge, range of skills and professional behaviours necessary for quality patient care.

To the best of our knowledge the FPM remains the only truly multidisciplinary academy world-wide for the delivery of education and training in pain medicine. The faculty's curriculum has been used to inform that of other institutions including the Faculty of Pain Medicine of the Royal College of Anaesthetists, the Faculty of Pain Medicine of the College of Anaesthetists of Ireland, the Royal College of Physicians and Surgeons of Canada and the European Federation of Chapters of the International Association for the Study of Pain (EFIC).

The college recognises that the number of specialist pain medicine physicians will never be sufficient to care for all the population experiencing chronic pain. The FPM has sought to address this shortfall through advocating for additional funding for training positions, increasing the variety of specialty backgrounds of doctors who can enter the training program (particularly the inclusion of general practitioners) and actively providing education to primary healthcare practitioners and allied health staff who are critical to managing chronic pain in the community.

The FPM Board is exploring whether a training pathway to fellowship that does not require a primary specialist qualification is needed to serve our communities. With changing medical

student demographics and medicine as a postgraduate qualification, training in a post-specialist qualification may be a barrier for some interested doctors. Currently, it is envisioned that this primary pathway option would be additional to the post-specialist training option; this requires significant consultation, analysis and planning.

There is currently a shortage of FPM fellows who work in rural areas, which means that there are few training opportunities outside of major city centres. Developing pathways for second year trainees to work in regional areas should they be interested in a regional based career is something the FPM would like to pursue.

Key changes since the 2012 reaccreditation include:

- Introduction of the revised pain medicine training curriculum and program in 2015.
- Review of this curriculum in 2019-2021.
- Development of a procedures endorsement program, implemented in 2020, to ensure safe and high-quality procedural pain medicine (see standard 3 for more details).

2.3 Graduate outcomes

The AMC accreditation standards are as follows:	
2.3 Graduate outcomes	
2.3.1	The education provider has defined graduate outcomes for each of its specialist medical programs including any sub-specialty programs. These outcomes are based on the field of specialty practice and the specialists' role in the delivery of healthcare and describe the attributes and competencies required by the specialist in this role. The education provider makes information on graduate outcomes publicly available.

Since 2004, the college has used the CanMEDS framework which recognises the high-level specialist roles of medical expert, communicator, collaborator, leader and manager, health advocate, scholar and professional. With Royal College of Physicians and Surgeons of Canada (RCPSC) permission, the roles are adapted for all current training programs and are fundamental for designing new programs. The ANZCA roles in practice also form the foundation of the ANZCA and FPM CPD program (standard 9).

Anaesthesia training program

The **ANZCA roles in practice** are in figure 2.1. The ANZCA graduate outcomes are expressed through these roles in practice (table 2.2). These outcomes are supported by explicitly stated learning outcomes under each of these seven roles, expressed in the curriculum framework (standard 3.1). A key principle of the 2013 curriculum redesign was an emphasis on trainee development across all these professional roles.

Figure 2.1 The ANZCA roles in practice

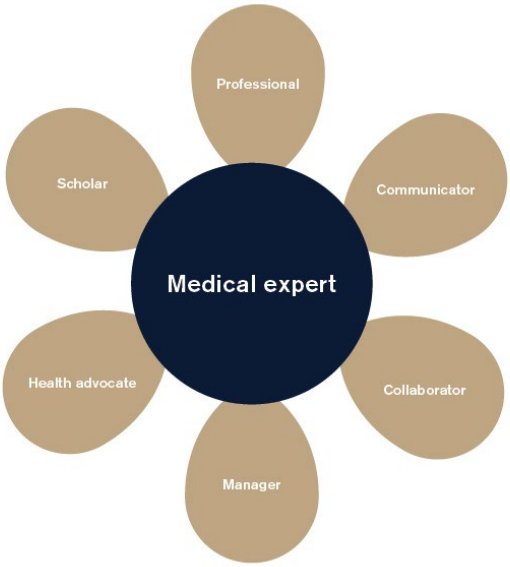


Table 2.2. The anaesthesia training program graduate outcomes

Medical expert Graduates of the ANZCA anaesthesia training program respond to the needs of the community for safe, efficient and effective anaesthesia care for surgery, perioperative management of co-morbidities, rapid response in the event of life-threatening emergencies, and management of pain.
Communicator Graduates communicate with patients with empathy and cultural awareness to identify patient goals and negotiate appropriate management plans.
Collaborator Graduates are part of an interprofessional healthcare team and work proactively to build effective and resilient teams through development of shared mental models of patient management plans, mutual trust and respect of team members, and effective communication strategies.
Leader and manager Graduates of the program provide effective and inclusive leadership within their own work team, their department, and the wider health system, and support others to develop as leaders.
Health advocate Graduates support and actively promote sustainable healthcare delivery and advocate for the rights of all members of the communities they serve.

Scholar

Graduates are fluent in research methods, able to critique published literature and undertake evidence-based practice. Graduates nurture and educate future generations of anaesthesia trainees, medical students and colleagues.

Professional

Graduates practise to a high ethical standard, work with integrity and commitment to their patients and colleagues, and protect their own and their colleagues' wellbeing. They proactively call out racism, bullying and harassment in the workplace, and promote the values of the profession.

Pain medicine training program

During the 2019 review of the curriculum, we developed the following graduate outcome statement for the pain medicine training program and incorporated it into the curriculum, published in November 2020.

'A specialist pain medicine physician practises within a sociopsychobiomedical paradigm to provide both direct care to patients whose main challenge is the management of pain, and leadership in, coordination of and advocacy for such care.'

The FPM roles in practice are in figure 2.2. For each role there is a high-level graduate outcome (table 2.3). For pain medicine, the CanMEDS central concept of the 'medical expert' role is amended to 'specialist pain medicine physician', and an extra role-in-practice is added, namely 'clinician'. This addresses three key philosophical issues: not claiming to be 'expert' in a diverse developing multidisciplinary field, not prioritising 'knowing about' over 'knowing how' and 'doing', and moving away from 'medical' implying 'biomedical'. The 'clinician' role articulates the scope of specific clinical knowledge and skills to be acquired in this nascent specialty in an explicit sociopsychobiomedical paradigm.

Figure 2.2 The FPM roles in practice

Table 2.3 The pain medicine training program graduate outcomes

Clinician As a *clinician*, the specialist pain medicine physician (SPMP) dynamically applies high-level knowledge, skills and professional attitudes in the practice of pain medicine across stable, unpredictable and complex situations. The clinician role describes in particular the skills and knowledge to be acquired during the course of pain medicine training.
Professional As a *professional*, the SPMP has a unique role arising out of their advanced knowledge of the phenomenon of pain and its complex expression in people. Such work requires mastery of a complex skill set and the knowledge underpinning this, in addition to the art of medicine. The SPMP is committed to the health and wellbeing of individuals and society through ethical practice, characterised by high personal standards of behaviour, accountability and leadership.
Scholar As a *scholar*, the SPMP demonstrates active commitment to learning, to the creation, dissemination, application and translation of knowledge relevant to pain medicine, and to the education of their patients, students, colleagues and within the community.
Communicator As a *communicator*, the SPMP offers the patient a relationship with a professional who has particular interest and expertise in the pain, which is the focus of their concern and suffering. The SPMP is able to listen, interpret and explain the predicament and concerns of the patient in a broad sociopsychobiomedical framework.
Collaborator As a *collaborator,* the SPMP effectively works in a healthcare team to achieve optimal patient care.
Leader and manager As a *leader and manager*, the SPMP has the ability to make and manage decisions about resource allocation as may apply personally, professionally and at an organisational level, to provide leadership and to contribute to the effectiveness of the healthcare system.
Health advocate As a *health advocate*, the SPMP responsibly uses their expertise and influence to advance the health and wellbeing of patients, colleagues, communities and populations.

Impacts of COVID-19

The pandemic hasn't altered the college's educational purpose, although it has exacerbated health inequities, particularly for vulnerable communities. This strengthens college resolve to train specialists who both reflect and serve the community. It has heightened difficulties in engaging internal and external stakeholders, both because of the resultant clinical and organisational demands and also as engagement processes have been compromised, especially for those communities where face-to-face interaction is preferred.

While the pandemic has promoted wider recognition of the key role of anaesthetists within the health system, it hasn't resulted in changes to program outcomes in either anaesthesia or pain medicine.

While graduate outcomes haven't changed, trainee redeployment, elective surgery cancellations, and community behaviours and stresses, might reduce the feasibility of achieving them within usual timeframes. The college continues to monitor this (see standards 3 and 6).

As resources have been redeployed to address immediate challenges, the pandemic has delayed work on other training programs.

FPM Procedures Endorsement Program

To ensure patient safety and optimal practice by fellows, FPM has articulated what it considers to be the appropriate and safe use of procedures in the practice of pain medicine in *PS11(PM): Procedures in Pain Medicine Clinical Care Standard*.

The Procedures Endorsement Program Curriculum includes the following graduate outcome statement for the program:

An endorsed fellow is capable of providing unsupervised care encompassing the selection, performance and follow-up of procedures within the sociopsychobiomedical paradigm. This practitioner combines sound foundational knowledge, technical skills and clinical governance with an ethical and patient-centred approach to provide treatment of pain within the medical systems of Australia and New Zealand, as stated in the Procedures in Pain Medicine Clinical Care Standard (PS11(PM)).

Information about the Procedures Endorsement Program is available on the college website.

Other training programs

Joint Consultative Committee on Anaesthesia

The JCCA supervises and examines GP registrars from RACGP and ACRRM who are undertaking a 12-month Advanced Rural Skills Training (ARST) or Advanced Specialised Training (AST) post in anaesthesia. The following principles govern JCCA activities:

- Large areas of Australia, mainly small rural towns and provisional cities, require GPs to administer anaesthesia and to provide front-line critical care.
- GPs providing such services must have appropriate training and provide safe anaesthesia.
- GPs providing such services must maintain their skills and knowledge by committing to ongoing CPD.

Diploma of Rural Generalist Anaesthesia

The Diploma of Rural Generalist Anaesthesia (DRGA) will produce graduates who can deliver safe anaesthesia and perioperative care in rural and remote settings for some elective and emergency surgery, including obstetric and paediatric procedures, and the resuscitation and stabilisation of patients for transfer when required. The diploma recognises the critical role GPs with advanced training in anaesthesia play in many rural and remote communities where it may not be possible to access specialist anaesthetists. The diploma also recognizes the contribution that a robust qualification in anaesthesia will make

towards recruitment and retention of the rural and remote general practice workforce more generally.

The graduate outcomes of the DRGA are based on CanMEDS and the FANZCA curriculum, expressed as the **RGA roles in practice**. A primary focus of is that graduates can assess the resources available to them in any given geographical environment, and make appropriate, context-specific decisions on the safe delivery of anaesthesia services for individual patients and local communities, with appropriate consultation and transfer if indicated.

Advanced Diploma of Diving and Hyperbaric Medicine

The program outcomes of the DHM diploma take account of community need by producing graduates who can deliver high quality and safe care in DHM. The graduate outcomes of DHM diploma are based on CanMEDS and are expressed as the **DHM roles in practice**: medical expert, communicator, collaborator, leader and manager, health advocate, scholar and professional.

Diploma of Perioperative Medicine

POM is in the first pillar of the 2018-2022 college strategic plan. The college is committed to leading the development of a collaborative, integrated and effective model of perioperative medicine to improve patient care.

The Perioperative Medicine Steering Committee and ANZCA Council have agreed the following POM Graduate Outcome Statement:

A medical specialist who has undertaken further relevant learning in Perioperative Medicine to provide multidisciplinary, integrated care to patients from the moment surgery is contemplated through to recovery. The practitioner can demonstrate advanced leadership, teamwork and advocacy skills to coordinate care provided by other medical specialists and allied health professionals, with the focus on applying evidence-based practice to optimise health and wellbeing and individualise care to improve patient outcomes.

Dual FANZCA-FCICM pathway

The proposal for a dual training pathway addresses access and equity issues for regional and rural communities in both countries. While larger centres employ specialist anaesthetists and specialist intensivists in separate departments, the requirement for specialists to cover **both** anaesthesia and intensive care medicine in regional and rural centres is a major barrier to staffing for intensive care units in these settings. Furthermore, as intensive care medicine (ICM) has become more specialised and mandated ICM experience within FANZCA training has reduced, relying on FANZCA graduates to cover ICU is increasingly difficult.

Patients, regardless of geographical location, require access to appropriately-trained anaesthetists and appropriately-trained ICM specialists. It is highly advantageous to Australian and Aotearoa New Zealand rural and regional centres if the same doctor can work in both vocational scopes. In 2022 and 2023, ANZCA and CICM will work together with key stakeholder groups to develop this dual training pathway by formulating the details of the selection eligibility, curriculum design, training requirements, assessments and regulations governing its administration. ANZCA has factored the necessary resources required to progress dual training pathway in its work flow.

It is anticipated that the graduate outcomes for this dual pathway will be based on the CanMEDS framework, describing abilities required of physicians to competently meet the health needs of the communities they serve. CanMEDS is the existing framework for both current college training programs.

Strengths

College educational purpose (standard 2.1)

The college educational purpose is expressed in multiple current documents and in others in development, providing strong links to college mission, vision and strategy. The educational purpose in relation to Aboriginal and Torres Strait Islander health is expressed in the draft RAP.

Program and graduate outcomes clear for all disciplines (standards 2.2 and 2.3)

There are clearly defined program and graduate outcomes in all disciplines, expressed in curriculum frameworks and mapped to learning outcomes and assessments.

Improvement opportunities and future plans

Māori health (standards 2.1 and 2.2)

As outlined in standard 1, the college is committed to the health of Māori. Development of a Treaty of Waitangi Strategy through partnerships with Māori will make this commitment more explicit and strengthen educational purpose.

A more systematic approach to external consultation (standard 2.1)

Whilst the college has strong health sector relationships and community representation across educational committees (see standard 1.6), a more systematic approach to consulting with these and other external stakeholders is required. This applies not only to standard 2 but to other standards also.

Standard 3

The specialist medical training and education framework

ANZCA
FPM

Standard 3: The specialist medical training and education framework

Overview

Each training program offered by the college has a curriculum framework which expresses the graduate outcomes and is based on the roles in practice (standard 2). The framework is publicly available in the relevant curriculum document, supplemented and supported by a training handbook which has a broad overview of training program requirements, supervision and supervisory roles (standard 8.1). All programs are regulated by an ANZCA regulation or FPM by-law which is the basis upon which individual training decisions are made.

The content of each curriculum is expressed in terms of learning outcomes for each training stage and how these are assessed (standard 5). Each program builds on prior stages of medical training and prepares graduates for continuing professional development (CPD) (standard 9) and has provision for recognition of prior learning. All programs define progression requirements in terms of competence. While minimum timeframes are defined, there is flexibility both for longer training times if required, as well as flexible training options. Both anaesthesia and pain medicine programs have core and optional elements. Governance of each training program is in standard 1.

Key resources:

- ANZCA anaesthesia training program curriculum.
- ANZCA regulation 37.
- ANZCA handbook for training.
- FPM pain medicine training program curriculum.
- FPM by-law 4.
- FPM training handbook.
- Advanced diving and hyperbaric medicine curriculum.
- ANZCA regulation 36.
- Handbook for advanced diving and hyperbaric medicine training.
- See also: Standard 4 (teaching and learning resources) and standard 5 (assessment of learning).

3.1 Curriculum framework

The AMC accreditation standards are as follows:	
3.1 Curriculum framework	
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.

Fields of specialty practice

The college training program in anaesthesia is intended to produce a generalist in that specialty. The training program in pain medicine is towards an “add-on”, new and developing specialty, and intends to extend and broaden existing knowledge, skills and attitudes. The college offers FPM fellows and trainees an optional separate endorsement in procedural aspects of pain medicine.

Information on the joint programs in general practice/rural generalist anaesthesia, diving and hyperbaric medicine, perioperative medicine (in development) and the dual FANZCA-FCICIM pathway are at the end of this standard under other training programs.

Training program principles

The anaesthesia and pain medicine curricula are underpinned by the following principles and strategies of adult learning:

- Trainee-centred and planning learning.
- Relevance to clinical practice.
- Flexible learning.
- Spiral learning: areas of learning introduced early in training are revisited in greater depth later in training. Learning outcomes are described to reflect evolving knowledge, understanding, application and skills as trainees progress through training. Linking new ideas to already known concepts and principles leads to long term retention and the ability to problem solve in unfamiliar contexts subsequently.
- Experiential learning: learning occurs within the context of clinical practice, under supervision appropriate to training stage. Trainees are encouraged to explore the full breadth of the specialty.
- Self-assessment.
- Regular formative feedback.
- Reflection.
- Lifelong learning.

The pain medicine training program curriculum aims to:

- Articulate the scope of practice that defines pain medicine.
- Emphasise the sociopsychobiomedical conceptual framework of the specialty.
- Guide supervisors of training and other fellows involved in the training program with respect to suitable learning experiences for trainees.

- Promote regular and productive interaction between trainees and their supervisors.
- Provide consistency of standards and outcomes across different training settings.
- Provide a baseline for comparison with international training programs with respect to standards of experience, education and assessment.
- Provide a framework to inform the scope of CPD activities.

Curriculum frameworks

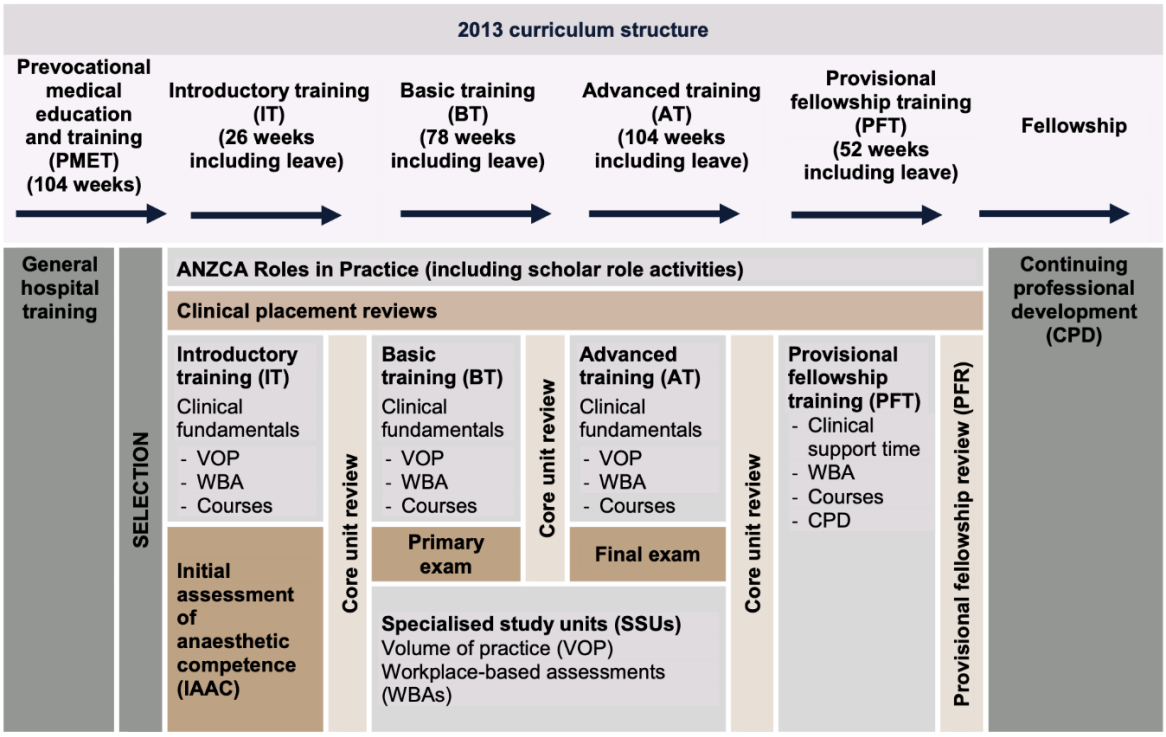
Curriculum frameworks and program structures

Graduate outcomes of each training program (standard 2) are expressed in a curriculum framework which is underpinned by more detailed learning outcomes mapped to learning opportunities and assessments. Curriculum frameworks build on the knowledge, skills and professional attributes that trainees initially develop during medical school, prevocational medical education and training, and in their primary specialist training (for pain medicine), and extend them into the context of anaesthesia or pain medicine.

Anaesthesia training program structure

The training program (figure 3.1) is a minimum of five years duration divided into four core units; introductory training (minimum 26 weeks); basic training (minimum 78 weeks); advanced training (minimum 104 weeks); and provisional fellowship training (minimum 52 weeks). Trainees must complete minimum requirements in each of the core units. These requirements include minimum training time (standard 3.4), volumes of practice (VOP) for cases and procedures (standard 4.2), courses (standard 4.2) and assessments (standard 5). There are also maximum training time periods allowed for completion of all requirements for each unit (see standard 3.4).

Figure 3.1 Anaesthesia training program structure



Important curriculum components are the:

1. **ANZCA roles in practice**, defining the curriculum framework.
2. **ANZCA clinical fundamentals (CFs)**, the fundamental specialty knowledge and skills of anaesthetists applicable across all areas of practice (table 3.1). These are revisited throughout training to allow spiral development of knowledge, skills and behaviours.
3. **Specialised study units (SSUs)**, defining further specialised knowledge and skills required for the anaesthetic management of patients in specific contexts (table 3.1). While all must be completed by the end of AT, the timing of completion of individual SSUs is flexible to allow for different sequencing of clinical placements. The volumes of practice for these may be contributed to during any stage of training prior to PFT and can occur concurrently.

Table 3.1 ANZCA training program clinical fundamentals and specialised study units

ANZCA clinical fundamentals	Specialised study units
General anaesthesia and sedation	Cardiac surgery and interventional cardiology
Airway management	General surgical, urological, gynaecological and endoscopic procedures
Regional and local anaesthesia	Head and neck, ear, nose and throat, dental surgery and electro-convulsive therapy
Perioperative medicine	Intensive care
Pain medicine	Neurosurgery and neuroradiology
Resuscitation, trauma and crisis management	Obstetric anaesthesia and analgesia
Safety and quality in anaesthetic practice	Ophthalmic procedures
	Orthopaedic surgery
	Paediatric anaesthesia
	Plastic, reconstructive and burns surgery
	Thoracic surgery
	Vascular surgery and interventional radiology

The ANZCA roles in practice, CFs and SSUs overlap, having some learning outcomes in common. For example, safe and efficient work practices are addressed in the leader and manager and professional roles, as well as in the safety and quality in anaesthetic practice CF.

Anaesthesia curriculum framework

The anaesthesia curriculum framework which expands the ANZCA roles in practice and the graduate outcomes (table 2.2) is in table 3.2. There have been no changes to this framework over the past five years.

Table 3.2 Anaesthesia training program curriculum framework

Anaesthesia training program curriculum framework
1.1 Medical expert
By the end of training, a trainee will be able to: 1. Practice medicine within their defined scope of practice and expertise. 2. Perform a complete patient centred clinical assessment and establish a management plan. 3. Demonstrate proficient and appropriate technical/procedural skills. 4. Demonstrate safe, effective and efficient patient-centred care. 5. Actively contribute to the continuous improvement of health care quality and patient safety.
1.2 Communicator
By the end of training, a trainee will be able to: 1. Develop rapport, trust and ethical therapeutic relationships. 2. Accurately elicit and synthesise relevant information. 3. Accurately convey and explain relevant information. 4. Develop a common understanding of issues, problems and plans. 5. Effectively convey oral and written communication.
1.3 Collaborator
By the end of training, a trainee will be able to: 1. Participate effectively and appropriately in an inter-professional healthcare team. 2. Effectively work with other health professionals to prevent and resolve inter professional conflict.
1.4 Leader and Manager
By the end of training, a trainee will be able to: 1. Contribute to the improvement of health care delivery in teams, organizations, and systems. 2. Develop efficient and effective work practices. 3. ANZCA Anaesthesia Training Program Curriculum. 4. Demonstrate leadership and effective management in professional practice.
1.5 Health Advocate
By the end of training, a trainee will be able to: 1. Advocate for patients and colleagues. 2. Promote health and respond to health needs of patients and the working environment.
1.6 Scholar
By the end of training, a trainee will be able to: 1. Engage in the continuous enhancement of their professional activities through ongoing learning. 2. Critically evaluate information and its sources, and integrate best available evidence into practice.

Anaesthesia training program curriculum framework
3. Contribute to the creation and dissemination of knowledge and practices applicable to anaesthesia and health care. 4. Teach others.
1.7 Professional
By the end of training, a trainee will be able to: 1. Demonstrate a commitment to patients through ethical practice. 2. Demonstrate cultural and bias awareness and sensitivity with patients and colleagues. 3. Demonstrate a commitment to society and the profession. 4. Demonstrate a commitment to own health, sustainable practice and supporting colleagues.

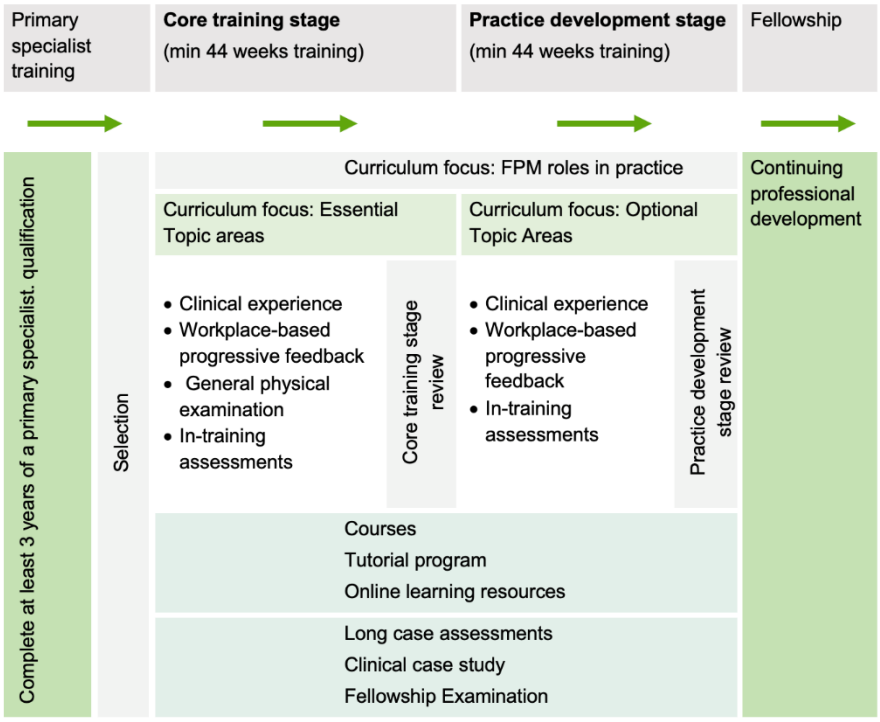
Pain medicine training program structure

The training program (figure 3.2) is a minimum of two years divided into two stages:

1. The core training stage (CTS), focusing on the learning outcomes covered in sections 1-3 of the FPM Curriculum.
2. The practice development stage (PDS), in which trainees are encouraged to define their own program and learning outcomes addressing their specific areas of interest.

The program comprises a minimum of two years (88 weeks) full-time equivalent (FTE) of approved clinical experience directly related to pain medicine, with each training stage comprising 44 weeks of clinical activity in multidisciplinary units. In order to be awarded fellowship of the faculty, a trainee must have a primary specialist qualification acceptable to the board of the faculty and complete the requirements of the training program. The approved list of primary specialist qualifications is included in by-law 3.1.3 Fellowship of the Faculty. As pain medicine is a post-specialist qualification, those entering the training program have a broad range of experiences, skills and expectations; thus the program does not mandate specific volumes of practice.

Figure 3.2 Pain medicine training program structure



Note: To be admitted to Fellowship of FPM the applicant must possess a primary specialist qualification acceptable to the Board in addition to completing the training program.

The FPM curriculum include four sections with the first three to be addressed in the core training stage.

1. **Conceptual basis of pain medicine** addresses major philosophical and conceptual principles informing the practice of pain medicine. Given the discipline's potential complexity, a thorough understanding of why a sociopsychobiomedical conceptual framework is preferred and critical appreciation of basic definitions and taxonomy are fundamental. The broad topics here recur throughout the curriculum.
2. **The pain medicine roles in practice** are designed to emphasise a sociopsychobiomedical orientation to practice, rather than a narrow biomedical one. A key principle of the curriculum is an emphasis on trainee development across all professional roles.
3. **Essential topic areas** were chosen as those in which the expertise of the specialist pain medicine physician should be paramount. They are not intended to be a comprehensive coverage of the discipline of pain medicine but rather to be integrative.
4. **Optional topic areas** outline sample learning outcomes for areas of pain medicine that may be a focus of the practice development stage of training. These are example areas of study and trainees are not limited to them. Trainees with an interest in one or more of these areas may utilise some or all of the suggested learning outcomes or develop their own outcomes.

Table 3.3 Essential and optional topic areas in pain medicine training

Essential topic areas	Optional topic areas
Mechanisms in the biomedical dimension of pain Acute pain Spinal pain Problematic substance use Visceral pain Pain related to cancer Headache and orofacial pain Complex regional pain syndrome Chronic widespread pain	Persistent pelvic pain Consultation liaison psychiatry Paediatric pain medicine Procedures in pain medicine

Pain medicine curriculum framework

The pain medicine curriculum framework which expands the FPM roles in practice and the graduate outcomes (table 2.3) is in table 3.4.

Table 3.4 Pain medicine training program curriculum framework

Pain medicine training program curriculum framework
Clinician
By the end of training, a trainee will be able to: • Undertake clinical assessment and formulation. • Prepare management plans. • Implement management plans.
Professional
By the end of training, a trainee will be able to: • Ensure ethical practice. • Practise with cultural awareness and sensitivity. • Incorporate legal and regulatory environment requirements in their practice. • Maintain own health and sustainable practice and recognise and respond to other professionals in need

Pain medicine training program curriculum framework
Scholar
By the end of training, a trainee will be able to: • Undertake ongoing professional learning. • Critically appraise information. • Teach others. • Incorporate new knowledge and practices into their pain medicine practice.
Communicator
By the end of training, a trainee will be able to: • Establish therapeutic relationships. • Obtain relevant information. • Share information with patients and relevant others. • Share information with other professionals.
Collaborator
By the end of training, a trainee will be able to: • Work with other health care professionals. • Effectively co-operate and mitigate conflict.
Leader and manager
By the end of training, a trainee will be able to: • Identify the characteristics for the provision of quality patient-centred pain management services. • Contribute to quality assurance processes. • Contribute to clinical governance forums and committees.
Health advocate
By the end of training, a trainee will be able to: • Advocate for patients. • Advocate in the community. • Advocate in the workplace.

3.2 The content of the curriculum

The AMC accreditation standards are as follows:	
3.2 The content of the curriculum	
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.

Alignment of content with graduate outcomes

Anaesthesia training

The curriculum is expressed in terms of learning outcomes each with a unique code and mapped to assessment modalities (standard 5). For each ANZCA role in practice, these are arranged under the domains outlined in table 3.2, describing more detailed graduate outcomes. The key process for ensuring alignment is regular review of the learning outcomes (standard 1.7).

Pain medicine training

The curriculum is expressed in terms of learning outcomes each with a unique code. For each FPM role in practice, these are arranged under the domains outlined in table 3.4, describing more detailed gradate outcomes. From 2019 to 2021, FPM reviewed and updated the 2015 curriculum. This was mainly driven by changing evidence in pain medicine over this period, which required a review to ensure the curriculum reflected contemporary practice. All learning outcomes were reviewed with respect to redundancy, relevance and assessability. A key focus was simplifying the curriculum to improve its utility for trainees and supervisors of training. Reviewing the curriculum during COVID-19 when travel was not possible was challenging given the number of Zoom meetings required. This review also identified changes required to the online study guides for each essential topic area within the curriculum (standard 4).

The next priority for FPM is to map each learning outcome to an assessment modality as part of a review of the training program assessment philosophy and strategy. This review will consider the experiences of trainees, supervisors and examiners with the assessment tools included in the 2015 training program.

Scientific foundations of the specialty

Anaesthesia training

The medical expert role includes the learning outcome AR_ME1.3 ‘Apply knowledge of the clinical and biomedical sciences relevant to anaesthesia’. The scientific foundations of clinical anaesthesia are applied physiology, pharmacology, anatomy, measurement, equipment and quality and safety. These are integrated across the CFs in introductory and basic training and assessed in the primary examination (standard 5).

Pain medicine training

The scientific foundations on which the specialty of pain medicine is built are biomedical and psychological, with a bias towards clinical over pre-clinical and towards integration across traditional divisions. Learning outcomes that are related to scientific foundations can be found within most sections of the pain medicine curriculum, including but not limited to learning outcomes 1.5, 1.6, 1.7, 1.8, 2.1.4, 2.1.12, 2.1.21, 2.1.22, 2.1.24, 2.3.5, 2.3.6, 2.3.7, 3.1.4, 3.1.5, 3.1.12, 3.2.12, 3.3.6, 3.3.7, 3.4.5, 3.5.3, 3.5.6, 3.6.6, 3.6.9, 3.7.8, 3.7.13, 3.8.4, 3.9.4 and 3.9.7.

The full scope of the curriculum is assessed across the different assessment tools of the training program. Trainees are also assessed on their ability to access and use current evidence in the development of management plans, and to comprehensively discuss cases and the rationale for their management approach.

Communication, clinical diagnostic, management and procedural skills for safe patient care

Anaesthesia training

The anaesthesia training program curriculum framework (standard 3.1) addresses communication, clinical diagnostic, management and procedural skills for safe patient care under the medial expert and communicator roles in practice. The CFs and SSUs address the key clinical diagnostic, management and procedural skills for safe patient care across fundamental areas and specific contexts. These form the foundation for work-integrated learning throughout training, supported by structured feedback from supervisors on a daily basis and more formally via workplace-based assessments (WBAs). The multi-source feedback (MSF) required for each core unit assesses trainee non-technical ability by diverse team members, including when they are working without the in-room presence of the supervisor. A patient-interaction component of the medical viva, currently under development, will more formally assess communication, diagnostic and management planning skills of advanced trainees (standard 5).

Pain medicine training

The FPM curriculum likewise builds communication, clinical diagnostic, and management skills reflected in learning outcomes, teaching and learning resources, and assessments. As in the anaesthesia training program, multi-source feedback is undertaken towards the end of each training period and includes feedback from members of the multidisciplinary team. Recognising the importance of communication skills for a specialist pain medicine physician, a communication station is a standard content area for the oral component of the fellowship examination (standard 5).

The clinician (learning outcomes 2.1) and communicator (learning outcomes 2.4) roles in practice address the communication, clinical diagnostic and management skills.

Basic psychotherapeutic techniques are addressed in clinical skills courses offered by the faculty.

Procedural skills are covered under the optional topic areas (learning outcomes 4.4) which trainees may elect to focus on during their practice development stage. Not all pain medicine trainees will practise procedures, but all are expected to understand the indications and evidence for procedures in pain medicine. Pain medicine trainees interested in gaining endorsement in pain medicine procedural skills may elect to join the FPM Procedures Endorsement Program during the practice development stage (see FPM Procedures Endorsement Program section in each standard).

Patient centred and goal-oriented care

Anaesthesia training

The anaesthesia training program curriculum framework addresses patient-centred and goal-oriented care under the **health advocate** role in practice (standard 3.1). Shared decision-making is increasingly recognised as an important part of specialist practice for the health and wellbeing of individuals. The communicator role project will address this for the 2023 version of the curriculum (standards 3 and 4).

Pain medicine training

The pain medicine training program curriculum framework addresses patient-centred and goal-oriented care under the clinician role in practice (learning outcomes 1.2, 1.3, 2.1.2, 2.1.15, 2.1.32, 2.1.33). Shared decision-making is a focus of the communication role in practice (learning outcomes 2.4) of the pain medicine curriculum.

Professionalism and leadership

Anaesthesia training

The anaesthesia training program curriculum framework addresses professionalism and leadership under the **leader and manager** and **professional** roles in practice (standard 3.1). The provisional fellowship training stage plays a key role in transition to specialist practice, with trainees expected to demonstrate efficient and effective work practices at a specialist level, broader leadership skills and commitment to upholding ethical and professional standards of the specialty upon completion of this training stage.

Pain medicine training

The pain medicine curriculum addresses professionalism and leadership under the **professional** (learning outcomes 2.2) and **leader and manager** (learning outcomes 2.6) roles in practice.

Contributing to an effective and efficient healthcare system

Anaesthesia training

The college has an ongoing commitment to quality and safety within the health systems in both countries. In training, this is primarily reflected in the leader and manager, health advocate and professional roles (standard 3.1). Combined with the clinical placement system of training in multiple hospitals, trainees are effectively oriented to the local health system. Scholar role requirements of clinical audit and at least 20 quality assurance meetings during training further support this area (standard 5).

Pain medicine training

The graduate outcome for the FPM leader and manager role in practice is articulated that by the end of training a trainee will be able to ‘contribute effectively to the healthcare system according to their context of practice’. The learning outcomes under this section of the curriculum (2.6) address this graduate outcome.

Scholarly activities in teaching and research

Anaesthesia training

The anaesthesia training program curriculum framework addresses professionalism and leadership under the **scholar** role (standard 3.1). There are five scholar role activities during anaesthesia training, with two of these required to progress from basic to advanced training, and all required for progression to PFT (ANZCA handbook for training, section 2.13.1; standard 5.2). They are:

1. Teach a skill.
2. Facilitate a group discussion or run a tutorial.
3. Critically appraise a paper published in a peer-reviewed indexed journal.

4. Critically appraise a topic.
5. Complete an audit, including a written report.

For completion of PFT, trainees must also have:

1. Attended two regional or greater conferences/meetings.
2. Participated in 20 quality assurance programs. Allowable programs include audit, critical incident monitoring, and morbidity and mortality meetings.

Scholar role activities support teaching, continuous quality improvement and research. In 2021, an option was included for trainees to complete the relevant units of the ANZCA Educators Program (standard 4), instead of teaching a skill and running a tutorial. Trainees are encouraged to present their research and quality improvement projects at the ANZCA Annual Scientific Meeting (ASM) trainee research prize and trainee quality improvement prize sessions, which each carry awards for the best presentation. The latter recognises exceptional work in critical appraisal of a topic, audit or a clinical practice improvement project. The Scholar Role Sub-committee has undertaken to review the resources available to trainees on critical appraisal and audit.

From 2013, trainees could complete a post-graduate qualification in education, research, leadership or management, replacing previous requirements for a formal project. This initiative has resulted in many new fellows graduating with educational qualifications. It was removed as an option in 2018, although existing trainees could still complete such qualifications to meet requirements. In the 2013 training program there was an option for trainees to undertake a piece of publishable research as an option for audit and critical appraisal; this was also removed in 2021.

There are currently limited pathways for trainees to undertake PhD studies within the ANZCA training program. Developing a pipeline of ANZCA academics is required. The ANZCA Research Committee has established the Emerging Researchers Sub-committee with a view to mentoring and encouraging academia (appendix 1.13 standard 1). The extent to which the current scholar role satisfies standard 3.2.8 is an area for future review and development.

Pain medicine training

The pain medicine training program curriculum framework addresses scholarly activities under section 2.3 scholar role. Scholar role competency is assessed via workplace based progressive feedback, in particular the professional presentation and through the clinical case study. In the practice development stage of training, trainees may elect to undertake up to 22 of the 44 weeks working in research. The requirements related to research as part of the practice development stage are outlined in section 5.3 of the FPM training handbook.

At the ASM, the most prestigious pain medicine prize is the FPM Dean's Prize which is awarded to the FPM trainee or new fellow who presented the most original pain medicine/pain research paper, of sufficient standard.

Substantive understanding of Indigenous health, history and cultures

The college recognises that the current anaesthesia and pain medicine curricula could better address Aboriginal and Torres Strait Islander and Māori health. See 'A values-based approach to Aboriginal and Torres Strait Islander and Māori health in all training programs'

(*'Improvement opportunities and future plans'* at the end of this standard) and the draft ANZCA Reconciliation Plan (standards 1 and 2).

Pain medicine training

The learning outcomes within the pain medicine curriculum that apply to Aboriginal and Torres Strait and Māori populations are 2.1.9 and 2.1.10. These will be reviewed as part of the values-based review (see *'Improvement opportunities and future plans'*). The FPM curriculum learning outcomes addressing the health of the Māori population are assessed and examined. Most recently the 2019 fellowship examination written paper included the following question: *'Discuss how the history and culture of Indigenous peoples impacts on their pain experience, and the potential difficulties in providing multidisciplinary pain management'*. Pleasingly, this question was passed by 95 per cent of candidates.

Understanding of the relationship between culture and health

Anaesthesia training

This is addressed under the professional role (see 3.1) with learning outcomes on understanding own biases and understanding of Aboriginal, Torres Strait Islander and Māori needs (page 38-39 of the ANZCA curriculum document). The revised ANZCA training program will include the key competencies of the MZNC domains of competence.

Pain medicine training

The curriculum aims to put engagement with the patient, family and their community at the centre of pain medicine. Learning outcomes across the curriculum focus on the cultural and social influences on the patient, with examples including 1.3, 2.1.2, 2.2.11, 2.2.12, 2.4.7, 3.2.5, 3.5.1, 3.6.1, 3.7.2.

3.3 Continuum of training, education and practice

The AMC accreditation standards are as follows:	
3.3 Continuum of training, education and practice	
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.

Purposeful design with horizontal and vertical integration

Anaesthesia training program

The 2013 curriculum was designed by a collaboration of clinicians, medical educators, trainees and a consumer representative, and was proceeded by an extensive curriculum review evaluating strengths and areas for improvement in the 2004 training program (the prior major curriculum redesign that introduced CanMEDS). There is deliberate integration with prevocational medicine education and training through pre-requisites, recognition of recent anaesthesia experience and selection guidelines (standard 7.1). To commence as an ANZCA trainee, the applicant must complete:

- At least 104 weeks FTE pre-vocational medical education and training (regulation 37.4.2.2); and
- At least 52 weeks FTE broadly based clinical experience in areas of practice other than clinical anaesthesia, intensive care medicine and pain medicine (regulation 37.4.3).

The required broadly based clinical experience aligns with the CF Perioperative Medicine (table 3.1) which is assuming increasing significance in specialist anaesthesia practice. The ANZCA guidelines on selection provide opportunities for applying the ANZCA roles in practice when developing selection criteria (as outlined in the ANZCA handbook for training section 1.7.3 and standard 7.1).

Participation by provisional fellows in the ANZCA and FPM CPD program, based on the ANZCA roles in practice (standard 9), promotes vertical integration with specialist practice and aids transition from training to fellowship. Return to anaesthesia practice guidelines are similar for trainees and fellows, while acknowledging that more junior trainees require a formal return to practice after shorter periods of time away (ANZCA handbook for training, section 3.2).

How the college is kept informed about the requirements of previous stages of medical training

Examples of mechanisms that promote awareness of developments in prior medical training stages include:

- ANZCA and FPM educational committees include members with university appointments and hospital responsibilities in prevocational education and training.
- Many committee members have roles on external education, accreditation and regulatory bodies in both countries, as well as in other parts of the health sector.
- The executive director of education and research is involved in Victorian prevocational accreditation.
- The current director of professional affairs (DPA) education has a role with the Australian Medical Council.
- The former dean of education was involved in the development of the Australian Curriculum Framework for Junior Doctors.
- The college responds to relevant enquiries and reviews in the sector (standard 1).

Capacity of the college to influence earlier stages of medical training

There is a limited capacity for the college to directly influence earlier stages of medical training, with the main influence being published pre-vocational medical education and training requirements for selection into the training program (standard 7.1). However, in 2022 the college will embark on the fourth stream of the training program evolution project, “trainee selection” (‘*Improvement opportunities and future plans’* standard 7). It is anticipated that findings from this work may have a greater impact on earlier (pre-vocational) medical training.

The Australian Curriculum Framework for Junior Doctors, together with the Prevocational Medical Accreditation Framework, has the potential to improve the quality of pre-vocational training of doctors. It provides opportunities for improved alignment between prevocational

and vocational curricula, with harmonisation of our processes (ANZCA and CPMEC). It is anticipated that the change to a two-year prevocational medical education and training program in Australia will have minimal impact on anaesthesia training, as training pre-requisites currently include 104 weeks prevocational time. However, this will depend on the proposed minimum requirements and mandatory components.

The college made submissions to the Australian Medical Council's National Prevocational Framework review in April 2021 and September 2021. In addition, through the Indigenous Health Committee, the college is also developing a proposal to pilot a one-year prevocational hospital-based critical care position for an Aboriginal or Torres Strait Islander doctor. It is intended that this one-year prevocational position will help support, prepare and position prospective Aboriginal and Torres Strait Islander trainees to apply for college training positions.

Changes to the specialist medical programs since the last accreditation due to changes or feedback

The 2013 curriculum was reviewed five years after its introduction with changes being made to reflect contemporaneous practice; some changes include altered caseload in paediatric anaesthesia (neonatal case requirement), vascular surgery (minimum volumes of practice of patients undergoing amputation) and Perioperative Medicine Clinical Fundamental coverage.

Pain medicine training program

As FFPMANZCA is a post-specialist qualification, there is an expectation that clinical experience and behaviours have been well developed prior to entering the program. As such, prevocational training and medical school experiences are less directly relevant. The pain medicine program aims to expand existing skills into a sociopsychobiomedical framework (horizontal integration) and to deepen pain medicine competencies by offering a series of nine essential topic areas of increasing complexity during the core training stage (vertical integration). During the practice development stage the trainee can choose whether to pursue further horizontal (breadth) or vertical (depth) integration, or both.

Recognition of prior learning

Anaesthesia training program

ANZCA allows recognition of prior learning (RPL) towards completion of the anaesthesia training program. This includes allowing trainees to transfer from other anaesthesia and anaesthesia-related training programs with appropriate credit. RPL information and applications forms are publicly available in section 1.6 of the ANZCA handbook for training and regulation 37.7. The number of RPL requests and their outcomes over the past five years are in table 3.5.

Table 3.5 Anaesthesia recognition of prior learning requests

Year	Number of requests	Number granted (%)	% granted
2017	39	36	92%
2018	52	50	96%
2019	41	41	100%
2020	40	40	100%
2021	36	36	100%

Pain medicine training program

Trainees entering the program can apply for up to six months (22 weeks) recognition of prior clinical experience gained in a faculty-accredited unit or a multidisciplinary unit where regular workplace-based progressive feedback equivalent to that in the FPM training program has been available. Any approved recognition of prior experience is credited towards time in the practice development stage, not the core training stage. FPM does not allow RPL from any academic pain management courses. Trainees who have been granted recognition of prior experience are nonetheless expected to complete the portfolio of workplace-based assessments. The number of RPL requests and their outcomes over the past five years are in table 3.6.

Table 3.6 Pain medicine recognition of prior learning requests

Year	Number of trainees	Number granted	% granted
2017	13	13	100%
2018	8	7	88%
2019	4	3	75%
2020	10	6	60%
2021	8	8	100%

3.4 Structure of the curriculum

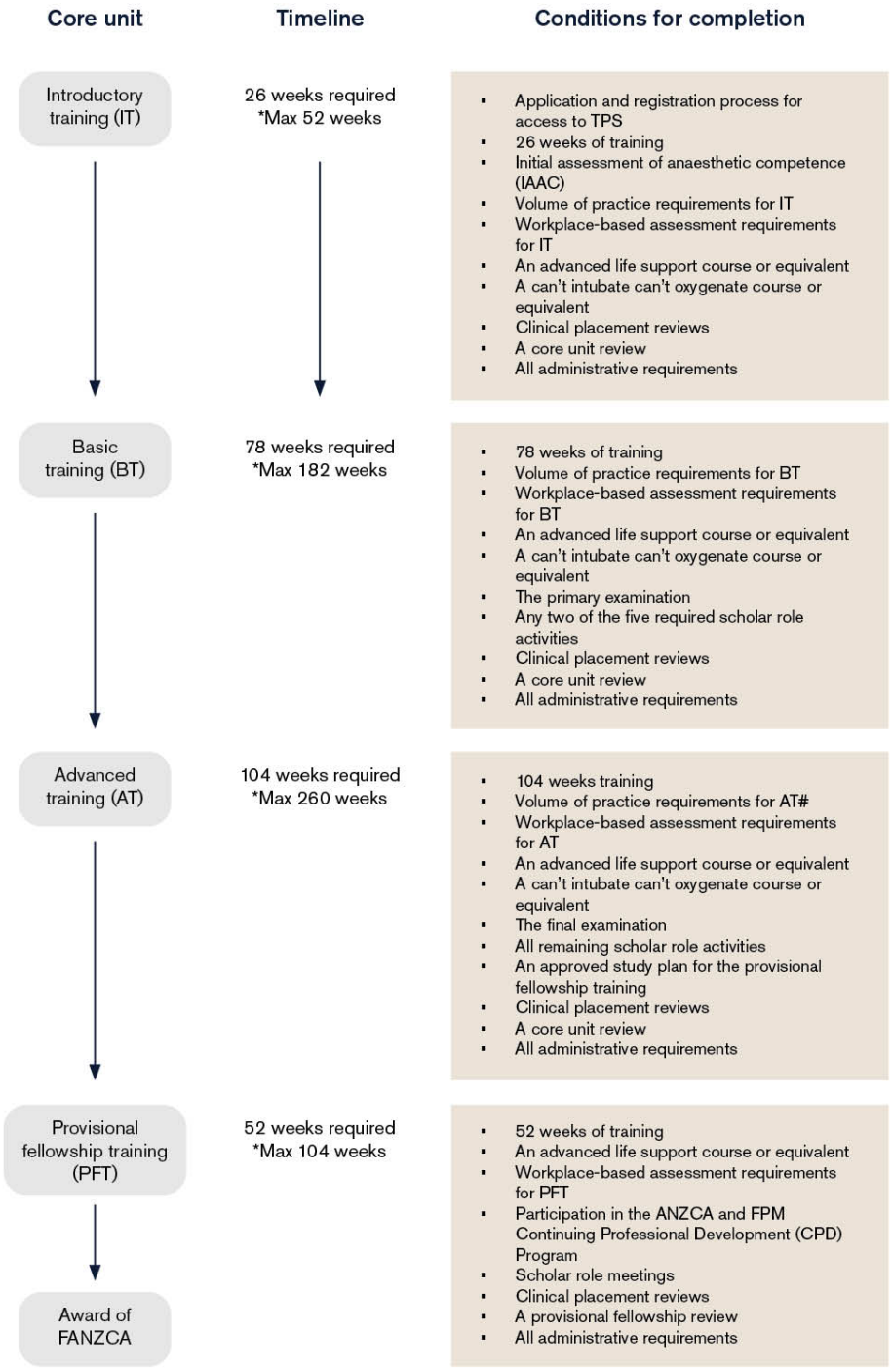
The AMC accreditation standards are as follows:	
3.4 Structure of the curriculum	
3.4.1	The curriculum articulates what is expected of trainees at each stage of the specialist medical program.
3.4.2	The duration of the specialist medical program relates to the optimal time required to achieve the program 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.

Expectations of each training stage

Anaesthesia training program

The curriculum defines the required level of performance in knowledge, skills and attributes across the seven ANZCA clinical fundamentals for each core unit. Progression between the stages of training occurs at the core unit review (CUR), with determinations of workplace competence made by the supervisor of training (SOT) in consultation with members of the department and consideration of feedback on the WBAs. Following SOT signoff, an ANZCA DPA assessor checks trainee compliance with progression requirements. Training requirements for each stage are in the figure below.

Figure 3.3 Training requirements for each ANZCA core unit



*The maximum total permitted time to complete the core unit.

#An Early Management of Severe Trauma (EMST) course is required, if the volume of practice has not been completed for the resuscitation, crisis management and trauma clinical fundamental.

Introductory training

The primary goal of introductory training is for trainees to be able to safely anaesthetise low-risk patients having low-risk surgery. This unit introduces the ANZCA roles in practice focusing on the development of basic knowledge and skills across the ANZCA clinical fundamentals and safe, patient-centred practice.

By the end of introductory training, trainees are expected to (p.45 ANZCA handbook for training):

- Establish positive relationships with patients characterised by trust.
- Synthesise and concisely convey patient assessment and plans to team members and supervisors.
- Comprehensively, concisely and legibly document patient assessment and plans.
- Identify the roles and responsibilities of, and demonstrate a respectful attitude toward, all the other members of the inter-professional healthcare team.
- Attend with time to adequately prepare for cases and check drugs, equipment and monitoring.
- Set priorities and manage their time to meet commitments.
- Identify patients in need of better pain management.
- Protect patient privacy and dignity, especially while unconscious.
- Identify learning needs and develop personal learning plans.
- Demonstrate willingness to consider feedback, advice, and instruction.
- Display the following values: altruism, honesty, respect, integrity, commitment, and compassion.
- Respect confidentiality of patients and colleagues.

Basic training

The primary goal of basic training is for the trainee to be able to anaesthetise patients safely with distant supervision, where there is moderate complexity based on patient or surgical factors. This unit further develops the ANZCA roles in practice. Trainees continue to expand their knowledge of basic sciences, anatomy and equipment, and their relevant application necessary to support safe practice across all the ANZCA clinical fundamentals.

By the end of basic training, trainees are expected to (p. 65 ANZCA handbook for training):

- Communicate with patients using a patient-centred approach.
- Document clinical encounters to adequately convey clinical reasoning and the rationale for decisions.
- Present verbal reports of clinical care and plans.
- Convey all relevant information when handing over responsibility of patient care.
- Appropriately consult with other healthcare providers and colleagues to optimise patient care and safety.
- Demonstrate organisational skills in the theatre environment.

- Facilitate timely patient access to surgery and other care.
- Promote selection of anaesthetic techniques which maximise patient benefit.
- Actively monitor their own learning, reviewing and updating learning plans as required.
- Apply the concepts of evidence-based medicine in their work.
- Formulate clinical questions from cases or scenarios.
- Respond appropriately to ethical challenges encountered in practice.

They will continue to accrue experience with cases across the ANZCA clinical fundamentals and start to accrue experience in the SSUs.

Advanced training

The primary goal of advanced training is for trainees to safely anaesthetise ASA 1-4 patients having complex procedures with distant supervision. By the completion of advanced training, trainees will demonstrate competency across all the ANZCA roles in practice, the ANZCA CFs and SSUs.

By the end of advanced training, trainees are expected to (p. 103 ANZCA handbook for training):

- Adapt their communication skills to a variety of contexts, including time-critical and stressful situations.
- Explain complex procedures to patients in language they can understand.
- Demonstrate effective leadership and organisational skills, for example by ensuring patient-safety checklists are completed meaningfully, and appropriate cases are prioritised.
- Delegate tasks and responsibilities in an appropriate and respectful manner.
- Balance safety, effectiveness, efficiency and equitable allocation of resources when determining anaesthetic technique.
- Intervene when a procedure cannot be completed without undue stress to a patient.
- Identify circumstances when development of advanced care directives should be discussed.
- Critically appraise evidence and integrate conclusions into clinical care.
- Utilise reflection and feedback to direct their own learning.
- Teach technical skills, lead small group discussions, and mentor junior staff.
- Adhere to relevant standards of professional practice promulgated by ANZCA and regulatory bodies.
- Recognise and support colleagues in need and help them access other available sources of support.
- Balance personal and professional priorities to ensure personal wellbeing and fitness to practice.

Provisional fellowship training

During provisional fellowship training, trainees continue to develop across all ANZCA roles in practice, refining their capability to provide quality patient care. The primary goal of this training period is for trainees to demonstrate maturity in identifying and anticipating their learning needs and seeking appropriate opportunities to enhance their abilities, acknowledging their ongoing personal responsibility to maintain and improve their practice. Upon completion of this training period, trainees are expected to demonstrate efficient and effective work practices at a specialist level (in line with graduate outcomes), exhibiting broader leadership skills and a commitment to upholding the ethical and professional standards of the specialty.

Pain medicine training program

During the CTS, trainees focus on learning within those roles in practice shaded in green in figure 3.4. In particular, they are encouraged to delve deeply into the nine essential topic areas (ETAs), which are essentially extensions of the clinician role and cover content that defines the specialty of pain medicine. The content resource (study guide) of each ETA is linked to one of the roles in practice. By concentrating on the learning outcomes discussed in the study guides, trainees and their supervisors can gauge progression towards the graduate outcomes in each section of the curriculum. The workplace-based progressive feedback (WBPF) assessments are orientated towards this end (standard 5). Ultimately, progression to the next stage depends on shared appreciation of progress by the trainee and their supervisor(s).

Figure 3.4 FPM roles in practice: focus of learning during core training stage

During the PDS, trainees are encouraged to broaden their learning by addressing the other roles in practice that are shaded in green in figure 3.5. By the end of this stage of training, it is expected that trainees will meet the graduate outcomes of the program, as determined by performance in summative assessments as well as, again, by shared appreciation of progress by the trainee and their supervisor(s).

Figure 3.5 FPM roles in practice: focus of learning during the practice development stage

Figure 3.6 Training requirements for each FPM training stage

Training stage	Timeline	Conditions for completion
Core Training Stage	44 weeks required	▪ 44 weeks of training ▪ Completion of the Better Pain Management program ▪ Completion of the general physical examination ▪ Quarterly in-training assessments (ITAs) with at least three having been assessed as satisfactory ▪ A minimum of two progressive feedback-clinical skills, assessed by at least two different assessors, demonstrating achievement of an overall rating of four or five ▪ A minimum of two progressive feedback-management plans, assessed by at least two different assessors, demonstrating achievement of an overall rating of four or five ▪ A progressive feedback-professional presentation ▪ A satisfactory multi-source feedback
Practice Development Stage	44 weeks required (maximum 260 weeks in program overall)	▪ 44 weeks approved training time ▪ Quarterly ITAs with at least two having been assessed as satisfactory ▪ A satisfactory final ITA ▪ A minimum of two progressive feedback-management plans, assessed by at least two different assessors, demonstrating achievement of an overall rating of four or five ▪ A minimum of two progressive feedback case-based discussions, assessed by at least two different assessors, demonstrating achievement of an overall rating of four or five ▪ One progressive feedback-professional presentation ▪ One satisfactory multi-source feedback ▪ Evaluation of the PDS proposal and the learning outcome achievement

Training duration relates to optimal time to achieve graduate outcomes

Anaesthesia training program

Volumes of practice (time)

The training program includes volumes of practice (VOP) requirements for each training period, encompassing time, cases and procedures. Case and procedural VOP is described in standard 4.2. Trainees record volumes of practice through the online ANZCA trainee logbook in the trainee portfolio system, which is accessed via the ANZCA website (standard 4). Time is divided into two areas; clinical anaesthesia time (CAT) and other clinical time (OCT) (table 3.7).

ANZCA recognises that a competency-based system provides the theoretical potential for trainees to advance more rapidly through the system if they demonstrate that they have acquired the required competencies. At present, the system of anaesthesia assessments (standard 5) would not fulfil the requirements of assessing workplace competence across all practice domains to graduate trainees early. This could be something to investigate in the future. ANZCA's ability to do this will be strengthened in the evolution of the training program over the next few years (see training evolution project, standards 3, 5, 6 and 8), for example with greater rigour of portfolio requirements for progression at core unit reviews. However, there is not wholehearted acceptance of the concept of shortened training if a trainee passes the prescribed assessments. There are still opportunities to mature, to learn more, to see more, and potentially undertake additional learning beyond the prescribed curriculum.

A breakdown of the minimum training times in each training period is included in table 3.7. Where a trainee is unable to achieve the volumes of practice, time and assessment requirements for each training period, they enter extended training until requirements are met. In extraneous circumstances, trainees may voluntarily or involuntarily enter interrupted training. There are generous limits on the duration of both extended and interrupted training.

Table 3.7 Time, leave and interrupted training in the anaesthesia program

	Introductory training (IT)	**Basic training (BT)**	**Advanced training (AT)**	**Provisional fellowship training**
Minimum amount of training time	26 weeks	78 weeks	104 weeks	52 weeks
Amount of normal leave included in the minimum training time	Three weeks	13 weeks	16 weeks	Eight weeks
Minimum clinical anaesthesia time	22 weeks	69 weeks (completed during IT and BT, excluding extended time)	138 weeks (completed during IT, BT and AT, excluding extended time)	*

	Introductory training (IT)	Basic training (BT)	Advanced training (AT)	Provisional fellowship training
Maximum other clinical time allowed	Four weeks	19 weeks (completed during IT and BT, excluding extended time)	38 weeks (completed during IT, BT and AT, excluding extended time)	*
Compulsory intensive care medicine time to be included in other clinical time			11 weeks (completed during BT and AT, excluding extended time)	
Maximium permitted extended training	26 weeks	104 weeks	156 weeks	52 weeks
Interrupted training	*Reg. 37.5.6.6 If training is interrupted for a continuous period of more than 52 weeks (full-time equivalent), subsequent training must include at least 52 weeks (full-time equivalent) continuous training time.* *Reg. 37.5.6.7 If training has been interrupted for a continuous period of more than 104 weeks, the trainee will be deemed to have withdrawn from the vocational training program. If there are special circumstances justifying the retention of training status beyond this time-point, prospective application requessting retention and providing full supporting information must be made to the DPA assessor.*			

Pain medicine training program

The pain medicine training program was designed as a post-specialist training program of two years. A minimum of 44 weeks of training is required for both the CTS and the PDS. All training program requirements must be completed within 260 weeks of commencing training. During the 2015 curriculum redesign, it was considered that two years dedicated to pain medicine training was the minimum required for an existing specialist or soon-to-be specialist to attain the standards required to practice as a SPMP. It is assumed that many competencies, experiences and attributes that all specialists attain are held by the pain medicine trainees before they enter the training program. FPM is considering alternatives to time-based requirements as part of programmatic assessment review for pain medicine training.

Flexible training

Anaesthesia training program

The college embraces flexibility for trainees who wish or need to train at less than full-time or take extended leave. Recognising the need for consolidated learning during training, part-time training requires a minimum commitment of 50 per cent of the duties of a full-time trainee, including after-hours work. Interrupted training allows a trainee to pause their training if they require more than the allowable eight weeks annual leave in training. Up to a maximum of 104 weeks interrupted training may be undertaken continuously. During interrupted training, trainees remain registered but cannot accrue time, volumes of practice or workplace-based assessments. Numbers of requests for and approvals of part-time and interrupted training from 2017 to 2021 are in tables 3.8 and 3.9, respectively. Application forms are available in the anaesthesia trainee toolkit under 'Individual trainee applications'.

Table 3.8 Part-time training in the anaesthesia program 2017-2021

Part-time training anaesthesia	Number approved (% of requests)				
	2017	**2018**	**2019**	**2020**	**2021**
All trainees	76 (100%)	94 (98%)	98 (100%)	128 (100%)	108 (100%)
Male	17 (100%)	24 (96%)	25 (100%)	40 (100%)	30 (100%)
Female*	59 (100%)	70 (99%)	73 (100%)	88 (100%)	78 (100%)
NSW/ACT	14 (100%)	26 (100%)	27 (100%)	32 (100%)	22 (100%)
NT	0	0	0	1 (100%)	1 (100%)
Qld	25 (100%)	20 (100%)	26 (100%)	23 (100%)	32 (100%)
SA	7 (100%)	6 (100%)	8 (100%)	6 (100%)	11 (100%)
Tas	1 (100%)	0	0	3 (100%)	0
Vic	5 (100%)	14 (100%)	19 (100%)	24 (100%)	9 (100%)
WA	16 (100%)	20 (91%)	13 (100%)	23 (100%)	19 (100%)
Aotearoa NZ	8 (100%)	8 (100%)	5 (100%)	16 (100%)	14 (100%)

**Please note from 2020, "Another identity" and "Prefer not to say" were included as options when collecting data on gender identity in college forms. Unfortunately, the college's membership database iMIS currently lacks capacity to include these options in reports.*

Table 3.9 Interrupted training in the anaesthesia program 2017-2021

Interrupted training anaesthesia	Number approved (% of requests)				
	2017	**2018**	**2019**	**2020**	**2021**
All trainees	197 (97%)	176 (97%)	181 (98%)	162 (98%)	175 (97%)
Male	69 (97%)	65 (96%)	63 (95%)	54 (98%)	70 (95%)
Female	128 (96%)	111 (97%)	118 (100%)	108 (98%)	105 (98%)
NSW/ACT	54 (98%)	40 (98%)	60 (95%)	50 (98%)	57 (97%)
NT	2 (100%)	0	0	1 (100%)	0
Qld	29 (100%)	40 (100%)	31 (100%)	35 (100%)	33 (92%)
SA	12 (100%)	11 (100%)	6 (100%)	16 (100%)	9 (100%)
Tas	1 (100%)	0	4 (100%)	1 (100%)	3 (100%)
Vic	30 (100%)	38 (93%)	37 (100%)	23 (96%)	25 (100%)
WA	10 (100%)	9 (90%)	13 (100%)	11 (100%)	16 (94%)
Aotearoa NZ	51 (100%)	29 (97%)	28 (100%)	25 (96%)	32 (100%)
Affiliated training regions (ATR)*	8 (89%)	9 (100%)	2 (100%)	0	0

** ATR are Hong Kong, Malaysia and Singapore*

Pain medicine training program

There are provisions in by-law 4, FPM Training Program for trainees to interrupt training or train part-time. Part-time training must be a minimum of 0.5FTE to allow for adequate exposure to build and consolidate skills. Trainees who interrupt their training must complete all training program requirements within five years of commencing training. Those trainees who do not complete all assessments while accruing the required clinical experience often do not have formal ongoing training roles once their time requirement is met. The faculty is concerned that these trainees then find it harder to achieve the assessment requirements. These trainees, in particular, are strongly encouraged to join the FPM mentoring program and develop relationships with FPM fellows who can support them as they complete their training outside a formal training position. Tables 3.10 and 3.11 show part-time and interrupted training requests and approvals, respectively. Further information and application forms are available on the college website.

Table 3.10 Part-time training in the pain medicine program 2017-2021

Part-time training pain medicine	Number approved (% of requests)				
	2017	2018	2019	2020	2021
All trainees	6 (100%)	6 (100%)	8 (100%)	11 (100%)	11 (100%)
Male	1(100%)	3 (100%)	4 (100%)	6 (100%)	6 (100%)
Female	5 (100%)	3 (100%)	4 (100%)	5 (100%)	5 (100%)
NSW/ACT	0	3 (100%)	1 (100%)	3 (100%)	4 (100%)
NT	0	0	0	0	0
Qld	3(100%)	2 (100%)	2 (100%)	2 (100%)	3 (100%)
SA	0	1 (100%)	0	0	0
Tas	0	0	0	0	0
Vic	0	1 (100%)	2 (100%)	1 (100%)	2 (100%)
WA	0	1 (100%)	2 (100%)	4 (100%)	1 (100%)
Aotearoa NZ	3 (100%)	0	1 (100%)	1 (100%)	1 (100%)

Table 3.11 Interrupted training in the pain medicine program 2017-2021

Interrupted training pain medicine	Number approved (% of requests)				
	2017	2018	2019	2020	2021
All trainees	8 (100%)	7 (100%)	5 (100%)	12 (100%)	7 (100%)
Male	2 (100%)	4 (100%)	4 (100%)	7 (100%)	4 (100%)
Female	6 (100%)	3 (100%)	1 (100%)	5 (100%)	3 (100%)
NSW/ACT	1 (100%)	1 (100%)	2 (100%)	3 (100%)	1 (100%)
NT	0	0	0	0	0
Qld	1 (100%)	1 (100%)	1 (100%)	4 (100%)	1 (100%)
SA	0	0	0	1 (100%)	0
Tas	1 (100%)	0	0	1 (100%)	0
Vic	4 (100%)	2 (100%)	0	2 (100%)	2 (100%)
WA	0	1 (100%)	2 (100%)	1 (100%)	1 (100%)
Aotearoa NZ	1 (100%)	2 (100%)	0	1 (100%)	2 (100%)

MCNZ requirement: Support for whanau and cultural obligations of trainees who identify as Māori

The college recognises the need for flexibility for trainees who identify as Māori. Framing flexible training options through whanau and a cultural obligation lens is an opportunity for the college to better support Māori trainees. The college broadly supports flexible learning options. While there are minimum time requirements for each training program, trainees have at least double this minimum time to complete each training program. There is a systematic expectation of up to eight weeks leave over the course of each training year and additional interruptions and part-time training options are readily available (refer to tables 3.8 to 3.11 which show that nearly all these requests are granted). There is also provision for training to commence at any stage throughout each hospital employment year (HEY). Additionally, the Māori Anaesthetists Network of Aotearoa (MANA) includes all fellows and trainees and can offer some support for the Māori trainees from Māori anaesthetists.

Flexibility for trainees to pursue studies of choice

Anaesthesia training program

Once trainees have completed advanced training and secure a suitable provisional fellowship position, they become provisional fellows. While they continue to develop across all ANZCA roles in practice, refining their capability to provide quality patient care as specialists, the PFT is an opportunity to further develop in specific areas of practice, either those identified in self-reflection as requiring strengthening or in areas of special interest. There are two types of provisional fellowship study plans:

1. **Pre-defined study plans**. ANZCA-accredited training sites seeking pre-approval for an ongoing study plan (predefined positions). Approval of these study plans is valid for five years and advertised on the college website.
2. **Individualised study plans**: Trainees may submit individualised proposals for prospective approval by the Provisional Fellowship Program Sub-committee. These plans are specific to a single trainee, can be for both a local or overseas placements and can be in a subspecialty.

Training outside Australia and Aotearoa New Zealand is supported within the anaesthesia training program with up to 52 FTE weeks allowed to count as time in any training stage, apart from IT. To join a non-ANZCA accredited training site, BT and AT trainees complete a training approval request form for approval by the DPA assessors. PFTs complete an individualised PF non-ANZCA accredited training site application, which is submitted to the Provisional Fellowship Sub-committee for approval.

Both application forms include arrangements for supervision, performing WBAs, undertaking and recording volumes of practice, and clinical placement reviews. Approval also requires nomination of an ANZCA SOT for remote guidance and support to the overseas supervisor on matters relating to the ANZCA training program and to confirm assessments in the training portfolio system (TPS). Overseas supervisors can complete WBAs online via the TPS but remaining documentation is paper-based with transcription by ANZCA staff or the ANZCA SOT. At the time of admission to ANZCA fellowship, trainees must have completed at least 156 weeks FTE approved vocational training in Australia and/or Aotearoa New Zealand. Overseas training is most often undertaken during PFT, although this has declined during COVID-19.

Pain medicine training program

The FPM curriculum includes optional topic areas that trainees may elect to pursue, depending on interests and training opportunities. The PDS promotes individualised development of advanced pain medicine knowledge and skills, as well as maturing of leadership and practice of self-management approaches, in preparation for specialist practice. During the PDS, trainees are encouraged to develop learning goals based on their particular interests within the field of pain medicine. The learning outcomes identified by trainees entering the PDS could be based on the learning outcomes in section four of the FPM curriculum or within a pain medicine-related topic of their choosing.

Key developments since 2012 reaccreditation

- A redesigned anaesthesia training program was launched in late 2012 in Aotearoa New Zealand and in 2013 in Australia.
- In 2014, consultation on the FPM curriculum framework and content occurred.
- In 2015, the pain medicine curriculum launched. The first phase of the anaesthesia program evaluation, including the time expert implementation project, was completed. An intercultural learning package was introduced on Networks. An FPM educational document on cultural competency was developed.
- In 2016, the ANZCA roles in practice were reviewed to reflect the CanMEDS 2015 revision (leader and manager replaced manager). A joint ANZCA and FPM statement on cultural competence was developed. The FPM annual basic clinical skills course was introduced. The 2015-2016 ANZCA scholar role review was completed, with five core activities implemented from December 2016.
- In 2017, regular learning outcomes review, led by the Education Development and Evaluation Committee (EDEC) and the FPM Learning and Development Committee, was implemented across the college. Following 2015 working group recommendations, perioperative medicine was strengthened in the anaesthesia curriculum. The Emerging Investigators Sub-committee was established with improved support for research by more senior trainees and new fellows. A draft Indigenous health strategy for Aotearoa New Zealand was developed with Te ORA. Anaesthesia RPL was reviewed with changes to credits and decision-making. An updated diving and hyperbaric medicine (DHM) qualification with transition award was implemented.
- In 2018, revised RPL forms were introduced. Paediatric, vascular and regional anaesthesia volumes of practice were amended. Requirements for clinical support time during PFT were clarified. TPS improvements were made. Altered allowances for interrupted training were introduced. The educational principles underpinning all programs were revised.
- In 2019, the training program evolution project was established for competency-based medical education (CBME, standard 3), programmatic assessment and group decision-making (GDM, standard 5), educator skills (standard 8.1) and accreditation and learning environment (standard 8.2).

- In 2021, the Indigenous Health Learning Outcomes Group was established. The FPM curriculum content review was completed. A new special consideration policy was introduced. Work on group decision-making (standard 5), the initial assessment of anaesthetic competence (IAAC, standard 5), a revised training portfolio (standard 4), training portal and accreditation and learning environment (standard 8.2) was completed with final reports tabled.

Impacts of COVID-19

In 2020, the college introduced guidance on completing training requirements in the face of redeployment, roster changes, need for more flexible training, travel interruptions preventing movement between training sites and cancelation of elective surgery.

- There has been no impact on the curriculum frameworks and articulation with prior and subsequent stages of medical training.
- There has been no impact on curriculum content, although reduced elective surgery may have delayed achievement of minimum volumes of practice for some trainees, particularly in areas of specialised practice.
- The college has increased flexibility to minimise training disruption. Allowances have been made for anaesthesia trainees to defer some training requirements to subsequent training stages and for backdating of progression dates following completion of delayed 2020 exams under defined circumstances (standard 5).
- There has been no change in studies of choice, although fewer trainees have been able to travel for overseas experience.
- Times to complete training already had significant flexibility. Trainees have been encouraged to consider flexible training options rather than training interruptions, where feasible. Increased uptake of interrupted and part-time training has occurred.
- Anaesthesia trainees have been a vital component of the intensive care unit (ICU) surge workforce with many increasing the time in ICU above that previously planned. Largely this has been absorbed within the flexibility of the training program and logged as other clinical time. The DPA assessors have overseen requests by trainees for modifications of their circumstances, such as requests for extended training or recognition of time while seconded to ICU as part of the surge workforce response. These have been possible within the parameters of existing relevant regulations. Flexibility was also introduced for introductory trainees who prior to COVID-19 were required to complete continuous anaesthesia time to complete this training period. Allowances have been made where circumstances were beyond the trainee's control.

The COVID-19 guidance on anaesthesia training webpage provided trainees and supervisors with information on potential pandemic impacts on training and guidance for completing requirements and potential allowances. The guidance covers exam changes (standard 5), exceptions to regulations, PFT and scholar role requirements, deployment, maximum time at training sites, continuous anaesthesia time requirement in introductory training, deferral of training requirements (VoP, WBAs, SRA, ALS course) to a subsequent training period, interrupted and part-time training; exceptions for progression delays with backdating for deferred exams (where progression was delayed solely due to the inability of the college to administer the examination process); and an effective management of anaesthetic crises (EMAC) temporary deferral pathway.

FPM Procedures Endorsement Program

The curriculum framework for the supervised clinical experience pathway is publicly available in the Procedures Endorsement Program curriculum document.

The supervised clinical experience pathway is open to FPM fellows and FPM trainees who are in the practice development stage. The procedures included in the program have been grouped into three categories that reflect the level of risk and complexity. Endorsees identify those procedures in which they seek endorsement. They do not need to seek endorsement in all the procedures, however the more complex procedures have pre-requisite procedures that endorsees need to master first, as outlined in the curriculum.

Endorsees may gain experience in procedures of different categories concurrently. The time frame of clinical experience expected to gain endorsement of all procedures in each category is:

- Category 1 procedures, 6-24 months FTE.
- Category 2 procedures, 6-24 months FTE.
- Category 3 procedures, 12-48 months FTE.

The Procedures Endorsement Program curriculum aims to:

- Articulate the scope of practice required by an SPMP proceduralist, including breadth and depth of knowledge, range of skills and professional behaviours necessary for quality patient care.
- Guide accredited procedural supervisors and other fellows involved in the training program with respect to suitable learning experiences for endorsees.
- Foster endorsees' self-directed learning by providing clear requirements.
- Promote regular and productive interaction between endorsees and accredited procedural supervisors, through formative workplace-based assessments and feedback.
- Provide consistency of standards and outcomes across different practice settings.
- Enable comparison with international training programs with respect to standards of experience, education and assessment.
- Provide a framework to inform the scope of continuing professional development activities.

The key sections of the Procedures Endorsement Program curriculum are:

- **Endorsed pain medicine procedures**: This section outlines the principles guiding FPM in selecting pain procedures for teaching and endorsement, and lists the selected procedures.
- Learning outcomes:
    - **Generic learning outcomes**: direct teaching and learning in relation to key aspects of pain medicine procedures within the context of a sociopsychobiomedical framework, and in line with *PS11(PM): Procedures in Pain Medicine Clinical Care Standard*.

    - **Procedure-specific learning outcomes**: outline particular knowledge and technical skills relevant to discrete procedures.

- **Assessment strategy**: outlines the assessment strategy developed to support this curriculum.

As there are no volume of practice requirements there is no formal recognition of prior experience process for endorsees. All program endorsees are required to outline their previous experience to the accredited procedural supervisor as part of the application process. However previous experience is not required to undertake the program.

Other training programs

Joint Consultative Committee on Anaesthesia (JCCA)

The curriculum document for JCCA training is publicly available with curriculum content as shown in table 3.12. The JCCA curriculum sixth edition, training regulations, guidance for registrars, enrolment form, training logbook (including procedure page), explanatory notes on paediatric policy, paediatric logbook, training supervisors report, checklist for online exams, and examination report are all available on the JCCA website.

Table 3.12 JCCA curriculum content

Learning outcomes	Areas of anaesthesia practice
• Communication skills and the doctor-patient relationship. • Applied professional knowledge and skills. • Professional and ethical role. • Organisational and legal dimensions.	• Preoperative and general medical care. • Core competencies. • Special considerations. • General anaesthesia. • Local and conduction anaesthesia. • Care related to surgery and anaesthesia. • Specific applications of care during surgery and anaesthesia. • Post-anaesthesia care. • Respiratory care. • The management of pain. • Resuscitation and emergency care.

Pre-requisites and assumed prior experience are outlined in the 2020 curriculum document (p4). Training is 12 months FTE, with up to six weeks leave for all purposes. This is the same duration as other special skills placements, the optimal time for skills development and equivalent to similar international qualifications. Training can be completed in two blocks. If these are more than six months apart, an additional month is added for every month in excess of the six months. Part-time training must comprise a minimum of 50 per cent of the commitment of full-time training, with both in- and after-hours duties, and is considered on an individual basis (JCCA training regulations). Recognition of prior learning is individually assessed by the JCCA, considering qualifications, training, training reports,

logbooks, prior practice, along with anaesthesia experience and educational activities in the prior two years.

Diploma of Rural Generalist Anaesthesia (DRGA)

The curriculum is purposefully designed in accordance with the following principles of learning:

- Aligned to community need.
- Focused on the rural and remote context.
- Based on identified competencies.
- Experiential and occurs in training sites accredited for the DRGA.
- Focused on achieving competency.
- Trainee-driven.
- Facilitated by feedback and reflection.
- Confirmed by summative assessment.
- A continuum, aligning with primary fellowship training and CPD.

The DRGA curriculum:

- Aligns with the specialist medical program and graduate outcomes (standard 2).
- Includes the scientific foundations of the specialty to develop skills in evidence-based practice and the scholarly development and maintenance of specialist knowledge.
- Builds on communication, clinical, diagnostic, management and procedural skills to enable safe patient care.
- 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 patients and their carers in clinical decision-making.
- Prepares specialists for their ongoing roles as professionals and leaders.

The key sections of the DRGA curriculum are the RGA roles in practice, CFs and SSUs. Content of the curriculum intersects and overlaps within and between these three sections and each section of the curriculum builds upon the previous one. The achievement of learning outcomes and completion of a program of assessments within the CFs are underpinned by development of the breadth of professional behaviours referred to within the RGA roles in practice. As trainees focus their attention on achieving learning outcomes within the SSUs, they will apply the knowledge and skills they have gained while working through the CFs. Outcomes include commitment to professional responsibilities, caring for personal health and wellbeing and the health and wellbeing of colleagues, and adherence to the principle of medical ethics.

Table 3.13 DRGA curriculum components

DRGA roles in practice	Clinical fundamentals	Specialised study units	Entrustable professional activities (appendix 3.1)
Medical expert Communicator Collaborator Leader and manager Health advocate Professional Scholar	General anaesthesia and sedation Airway management Regional and local anaesthesia Perioperative medicine Pain medicine Resuscitation, trauma and crisis management Safety and quality in anaesthetic practice	Paediatric anaesthesia Obstetric anaesthesia and analgesia	1. Assess patients for elective surgery 2. Provide obstetric analgesia 3. Provide general anaesthesia to stable ASA 1 and 2 patients 4. Provide perioperative pain relief for patients 5. Anaesthetise or sedate adult patients in the rural and remote context, including emergencies 6. Anaesthetise children 5 years and over in the rural and remote context, including emergencies 7. Provide obstetric anaesthesia and analgesia

The DRGA has been developed as a competency based medical education program. Curriculum competencies articulate the minimum level of competence to be achieved by all trainees who attain the diploma, linked to program and graduate outcomes. Training includes seven entrustable professional activities (EPAs) to:

- Combine various formative WBAs and VOP requirements as evidence of ability to complete specific clinical activities.
- Guide trainees and supervisors on the core elements of RGA practice for which trainees must demonstrate competency.

- Assess trainees' ability to apply knowledge and integrate the RGA roles in practice with medical expertise to provide quality care for patients.
- Provide a measure of progress with usual timing for completion of EPAs throughout training (appendix 3.2 program of EPAs in 12 months full-time training).
- Communicate to supervisors those activities that trainees can complete unsupervised.

Additional information about EPAs and DRGA assessments are in the trainee handbook and DRGA curriculum (appendix 3.3).

The curriculum is structured to build on primary specialist training to ensure feasibility for the minimum duration of 12 months, the optimal time to achieve program and graduate outcomes. An example is understanding of Aboriginal and Torres Strait Islander and Māori health, and the relationship between culture and health, which are anticipated to be covered in the primary curriculum but applied in the anaesthesia context. Likewise, it is anticipated that research literacy and evidence-based practice skills are acquired in the primary training program.

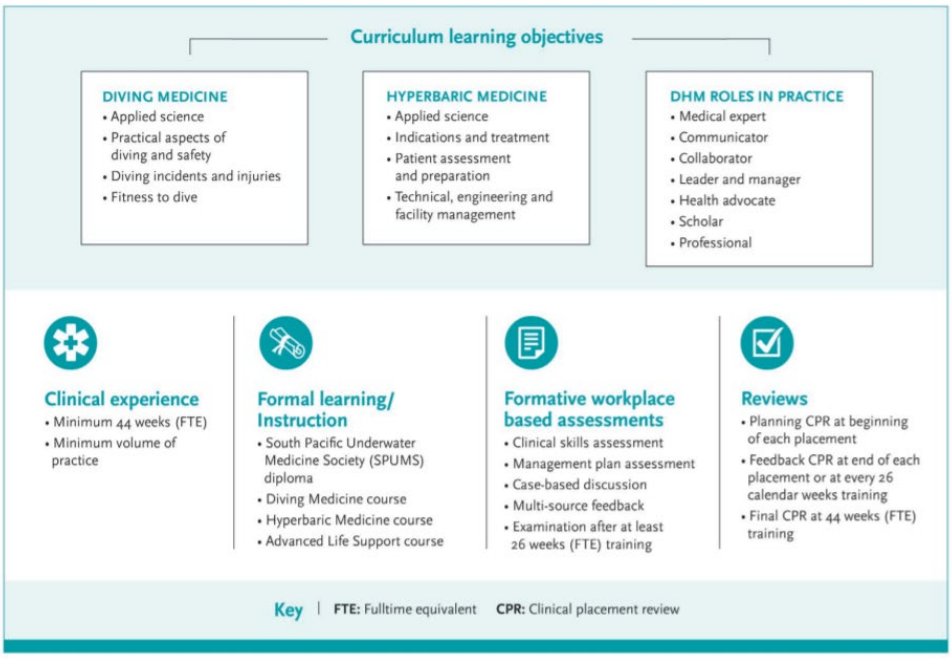
An RPL policy is yet to be developed. Flexible training will be supported, with policies in development.

The curriculum and all other documentation for the DRGA will be made publicly available on the ANZCA website from August 2022. Until final program documents are published, ANZCA will maintain the DRGA webpage with FAQs and updated information.

Diploma of Advanced Diving and Hyperbaric Medicine (DHM)

The curriculum framework for the DHM diploma is publicly available in the DHM diploma curriculum document and the training structure is in figure 3.7. The curriculum content aligns with program and graduate outcomes (standard 2) with learning outcomes described for each role in practice as well as for diving medicine and for hyperbaric medicine. These latter two areas are primarily knowledge outcomes assessed by the DHM exam. As in the anaesthesia curriculum, each learning outcome is linked to its assessment. This defines what is expected of trainees at the end of the one-year program which is the optimal minimum time to achieve the program and graduate outcomes.

Figure 3.7 Diploma of Advanced Diving and Hyperbaric Medicine training structure



The curriculum covers all aspects of the requirements of standard 3.2, as evidenced in the following examples:

- Applied science outcomes for both diving medicine and hyperbaric medicine.
- Communication, clinical, diagnostic, management and procedural skills for safe patient care throughout the curriculum.
- Patient-centred and goal-oriented care and shared decision-making is part of the medical expert and communicator roles.
- Professional and leader is primarily in the professional and leader and manager roles.
- Effective and efficient healthcare delivery is in resource allocation in the leader and manager role, and continuous improvement contributions in the medical expert role.
- Teaching and supervision of others, research literacy and evidence-based practice is in the scholar role.

An area for improvement is the understanding of Aboriginal and Torres Strait Islander and Māori health, and the relationship between culture and health in the curriculum. These are both briefly mentioned in the communicator role and ‘demonstration of cultural awareness and sensitivity with patients and colleagues’ under the professional role. There is a reasonable expectation that these are addressed by the primary specialist qualification and that the diploma promotes their application to the DHM context.

There is purposeful curriculum design with vertical and horizontal integration, with links to prior medical education phases and CPD as follows:

- Under each DHM role in practice, the curriculum indicates the competencies that trainees are expected to demonstrate at the commencement of the diploma.

- Preparation for lifelong learning through the scholar role requirements.

The RPL policy is described in section 10 of the handbook for advance diving and hyperbaric medicine training. At the time of diploma introduction, a transitional pathway was established for existing DHM practitioners, allowing for award of the diploma for those with the ANZCA DHM certificate (now retired) and recency of relevant practice, and recognition of prior experience (RPE) for those without the certificate who had relevant experience and training. Some practitioners were required to complete training time and/or examination components.

Diploma of Perioperative Medicine (POM)

The DipPOM aims for improved care of patients throughout the surgical journey, from the moment the primary care provider refers for consideration of surgery until the completion of rehabilitation and return to the community. The goal is to improve focus on patient-centred outcomes, which may involve decisions not considered when the prospect of surgery is first raised. This will be achieved by providing access to the DipPOM for a variety of disciplines and specialities, including surgeons, geriatricians, general physicians, intensivists and anaesthetists.

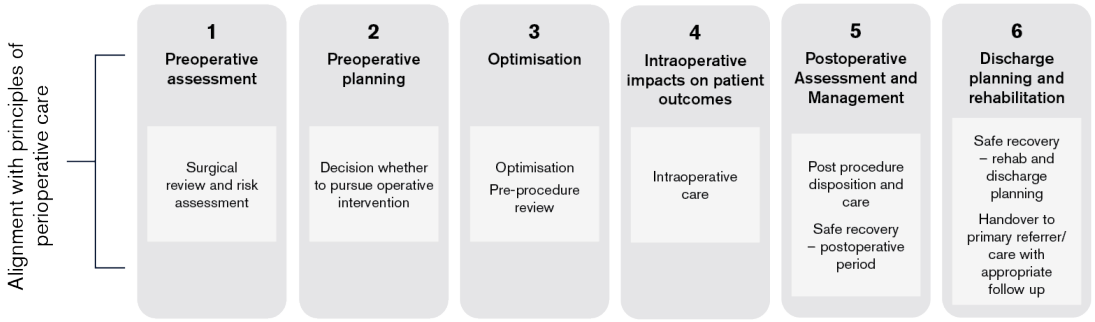
A DipPOM curriculum outline is drafted and is scheduled for submission to June 2022 ANZCA Council for ratification. The outline includes details of the delivery model, target audience, assessment approach, teaching and learning activities, and facilitation approach. Some aspects of the POM qualification are yet to be developed or require finalisation, including the curriculum framework, curriculum content, training structure, vertical and horizontal integration, curriculum RPL and RPE policies and flexible training arrangements.

The curriculum for the Diploma of Perioperative Medicine:

- Aligns with the specialist medical program and graduate outcomes (standard 2).
- Includes the scientific foundations of the specialty for skills in evidence-based practice and the scholarly development and maintenance of specialist knowledge.
- Builds on communication, clinical, diagnostic, management and procedural skills to enable safe patient care.
- 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 patients and carers in clinical decision-making.
- Prepares specialists for their ongoing roles as professionals and leaders.

The curriculum is divided into six topic areas, illustrated in figure 3.8.

Figure 3.8 Perioperative medicine curriculum topic areas



Draft learning outcomes (appendix 3.4) are developed for all six topic areas and across the ANZCA roles in practice (standard 2). The curriculum design phase is almost complete. The next phase is the curriculum development stage which includes online resources and content, and supporting teaching and learning plans.

Diploma delivery structure is being finalised. It will likely run over three trimesters through a combination of online content, face-to-face workshops and supervision in the hospital setting. The draft DipPOM curriculum outline document (appendix 3.5) includes a graphic outlining the trimester structure. Candidates completing the diploma will have the option to complete the course in one year or up to three years.

A pathway for recognition of prior learning will be established to permit participants to be exempted from completing diploma components and still achieve certification. It is anticipated that participants may be exempted from completing assessment tasks but still required to engage in interactive activities within each exempted module. A legacy process for experienced practitioners is described in standard 8.

Dual FANZCA-FCICM pathway

The dual fellow of ANZCA-fellow of College of Intensive Care Medicine (FANZCA-FCICM) curriculum and associated training requirements (volumes of practice, mandatory courses, summative and formative assessments, regulations) are yet to be developed. It is anticipated that the curriculum framework and content will encompass those for each current fellowship. The dual pathway will ensure appropriate content as per standard 3.2, and alignment to program and graduate outcomes of the primary training programs. A dually-qualified specialist is expected to practice at the same high standards in either vocational scope.

There will be purposeful design with vertical and horizontal integration, appropriate RPL provisions, flexible training arrangements and recognition of prior experience (RPE) for existing specialists in one discipline who wish to enter the pathway after achieving one fellowship. A key will be seeking training efficiencies by identifying overlapping curriculum content and skills transferability between these two acute care disciplines to optimise the time to achieve program and graduate outcomes. There will also need to be clear articulation of expectations of trainees at each stage in the pathway, depending on the sequencing of their anaesthesia and intensive care medicine clinical placements and progressive achievement of outcomes.

Strengths

Curriculum framework for all disciplines (standard 3.1)

All curricula use the same internationally-recognised specialist framework with clearly defined program structures and learning outcomes mapped to assessments.

FPM program structure (standard 3.1)

The FPM program was recently streamlined to ensure it reflects contemporary practice and was simplified in 2019 and 2020 to improve utility for trainees and their supervisors.

ANZCA scholar role components (standard 3.2)

ANZCA scholar role learning outcomes, learning resources and assessments are well developed and aligned to prepare graduates for their roles as teachers and supervisors, and to support their research literacy. The Scholar Role Sub-committee regularly reviews and updates components, with more improvements planned.

Improvement opportunities and future plans

Training program evolution project (standard 3.1)

In July 2017, the college commenced a comprehensive review of the 2013 Anaesthesia Training Curriculum. This training program evolution (TPE) project aimed to describe best practice and make recommendations for change. The TPE oversees four key streams:

1. CBME, programmatic assessment and entrustment project with subgroups working on standardisation of the IAAC and group decision-making (standard 5).
2. Educator skills project (see standard 8.1) (scope included pain medicine).
3. Accreditation and Learning Environment Project Group (ALEPG) (scope included pain medicine) (see standard 8.2).
4. Trainee selection (see standard 7.1, noting this stream will start in 2022).

While the ANZCA curriculum is aligned well with CBME principles, the project was implemented to further enhance programmatic assessment, including assessment *of* learning and assessment *for* learning. Other issues identified included variability of IAAC implementation between sites, SOT concerns about their competing roles as coach and assessor, concerns about standardisation of progression decisions, practical difficulties in viewing all WBA results at trainee performance reviews, and alignment with educational best practice.

To date, the project has unfolded over three phases:

1. Phase 1 (July 2017-November 2018) undertaken by the Training Program Evolution and Managing Change Project Group and the Entrustable Professional Activities Exploration Group, coordinated by EDEC.
2. Phase 2 (Dec 2018-Jul 2021) focused on research and reporting on outcomes. Each stream conducted literature research and stakeholder consultation to develop recommendations for what best-practice may look like in the context of ANZCA and FPM. Final reports of the CBME project (appendix 3.6) and educator skills project (standard 8.1) were submitted in November 2020, and of the ALEPG in mid-2021 (standard 8.2). The reports on group decision making are referenced in standard 5.

3. Phase 3 (Jul 2021-Dec 2023) aims for successful implementation and transition into 'business as usual' (technology and business processes). Current work on the project is focusing on the feasibility of implementing these best practices.

Pain medicine training (standard 3.1)

Given the recent completion of the three-year review of the pain medicine curriculum there is no immediate plan to adjust the education framework. Attention is now focused on review of the assessment philosophy and structure, and considering general quality improvements. FPM will also continue to be involved in the broader college evolution project, review of the Indigenous health learning outcomes and the lifelong learning project (standard 4).

In reflecting on the AMC standards, FPM can recognise significant differences between training in a primary specialty over a five-year period such as in anaesthesia and training in a post-primary or "add-on" specialty such as pain medicine over a two-year period. These differences carry implications for meeting these standards, in which we would highlight three challenges. First is actualising trainee involvement in a short program where trainees themselves face the demanding task of translating any horizontal integration they may have achieved in their primary specialist training into the multidimensional world of pain medicine, while simultaneously addressing the vertical integration of delving into the novel content of this broad and evolving field. The organisation of section three of the curriculum into "essential topic areas" is designed to ease that integrative task.

Second is the major dependence of a small specialist group on its own members to develop and deliver resources for the next generation of trainees. This dependence is likely to ease in the medium term, as more graduates of the revised program and curriculum reach that stage in their careers in which they can contribute to teaching and supervision (standard 8). Thirdly, again taking into account the effect that even a short program has on increasing total time and expense as a trainee, FPM deliberately designed the practice development stage to allow flexibility and tailoring of program and supervision, partly to emphasise horizontal integration in the sociopsychobiomedical framework, and partly to respect the adult learner who is well down that path. It has to be noted, however, that to date most trainees have not taken as much advantage of that flexibility as hoped. This is an aspect that can be refined.

A values-based approach to Aboriginal and Torres Strait Islander and Māori health in all training programs (standard 3.2)

In July 2020, the Indigenous Health Learning Outcomes (IHLO) Project Group, including Aboriginal and Māori members, met to review Aboriginal and Torres Strait Islander and Māori culture and health learning outcomes in the anaesthesia and pain medicine training curricula and to determine how related trainee learning is best supported. Their terms of reference (appendix 3.7) were to make recommendations on revisions to curriculum learning outcomes to EDEC and the Education Executive Management Committee (EEMC) for anaesthesia, and the Learning and Development Committee and Training and Assessment Executive Committee (TAEC) for pain medicine. The project group met on five occasions to April 2021.

In reviewing the learning outcomes, it became clear that a more fundamental redesign of Aboriginal and Torres Strait Islander and Māori health learning outcomes was required. Also imperative was input from Aboriginal and Torres Strait Islander and Māori medical educators and Elders. Following review of the second edition of *Indigenous health values and principles statement* by the Indigenous Health Writing Group of the Royal College of

Physicians and Surgeons of Canada, the IHLO Project Group recommended college curricula be reviewed through a values-based principles lens. It was also agreed that the work be embedded in the ANZCA Reconciliation Action Plan (RAP), provided that a bi-national, considered approach to include culturally-safe Māori health learning outcomes was also incorporated (standards 1 and 2). This approach has been endorsed by ANZCA and FPM governance groups. The ANZCA RAP Working Group is developing an action plan which includes reviewing the ANZCA and FPM trainee curriculum through a values-based principles lens to address inequity and advance cultural safety in each training program.

Review of the communicator role learning outcomes (standards 3.2 and 4)

The ANZCA Communicator Role Project Group was established to develop teaching and learning resources for this role within the anaesthesia training program (standard 4). Early work of the group identified that the communicator role learning outcomes had not been revised in their entirety since curriculum introduction in 2013. Consequently, the project group recommended to EDEC and EEMC (appendix 3.8) that the communicator learning outcomes were updated to reflect contemporary practice in this area (e.g. shared decision-making perioperatively). This revision is completed but not yet included in the curriculum, as there are consequent amendments required to other roles. This will be addressed when learning outcomes for all roles in practice are reviewed in 2023.

Standard 4

Teaching and learning

ANZCA
FPM

Standard 4: Teaching and learning

Overview

Key college teaching and learning resources include courses, the college library and museum, continuing medical education and other events, special interest groups, and eLearning resources in Networks, the college learning management system. Both anaesthesia and pain medicine training programs provide clear guidance for learning through defined outcomes matched to stage of training and, in the case of pain medicine, to the FPM roles in practice. Training involves mandatory training and skills courses, some convened at departmental and regional or national levels, and other centrally (FPM tutorial program) or externally (Effective Management of Anaesthetic Crises). There are no compulsory university courses. The ANZCA Educators Program (AEP) and workplace-based assessment (WBA) education is available to trainees, specialist international medical graduates (SIMGs) and fellows. Teaching and learning methods promote increasing responsibility as trainee skills, knowledge and experience grows, and promote self-assessment for learning, role modelling and interdisciplinary and interprofessional learning.

Anaesthesia training is supported by a comprehensive and progressively-improved training portfolio system, whereas pain medicine relies on paper-based portfolios and forms. This deficiency will be addressed in the lifelong learning project (standard 4). There are plans to implement a new exam management system, trainee portal system and learning management system to support all college training programs, as well as upgrade the existing continuing professional development (CPD) portfolio.

Key resources:

- College website:
    - *General:* Courses and resources overview, ANZCA educators program.
    - *Anaesthesia:* Introduction to anaesthesia training, ANZCA primary exam preparation courses and reading lists, ANZCA final exam preparation courses and reading lists.
    - *Pain medicine:* FPM centralised trainee tutorials, Clinical skills courses, Better Pain Management program.
- College library including links to external resources.
- Networks, college learning management system, which includes resources for all disciplines and ANZCA-, FPM- and Diving and Hyperbaric Medicine (DHM)-specific resources.

See also: standard 5 (for more detail on mixed purpose WBAs), and standard 7.4 (for resources on doctors health and wellbeing).

4.1 Teaching and learning approach

The AMC accreditation standards are as follows:	
4.1 Teaching and learning approach	
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.

Governance

Anaesthesia

The following committees oversee educational operations and strategy relating to teaching and learning activities for the anaesthesia training program: Education Executive Management Committee (EEMC) for educational oversight, Training Accreditation Committee (TAC) for accreditation, ANZCA Professional Affairs Executive Committee (PAEC) for professional development, Education Development and Evaluation Committee (EDEC) for educational projects, curriculum and evaluation, ASM and Events Planning Committee for conferences and events, Effective Management of Anaesthetic Crises (EMAC) Sub-committee, Scholar Role Sub-committee, ANZCA Educators Sub-committee for AEP and WBA training, and various project groups that are established as required. Each committee and working group includes ANZCA Trainee Committee representation and reporting.

Pain medicine

The following committees oversee educational operations and strategy relating to teaching and learning activities for the pain medicine training program: Training and Assessment Executive Committee (TAEC) for educational oversight, Learning and Development Committee for trainee and supervisor education, and curriculum evaluation, Training Unit Accreditation Committee (TUAC) for accreditation, FPM PAEC for professional development and the Scientific Meetings Committee.

Staff resourcing

Staff across the Education, FPM and Fellowship Affairs units coordinate and support development and delivery of college teaching and learning activities.

Staff resourcing includes a full time learning and development facilitator whose primary role is learning development leadership through facilitating, teaching and coaching college representatives (AEP), contribute to the development of learning content, tools and processes, supporting and fostering ANZCA and FPM learning culture, and participating in the ANZCA Education and Research unit committees and support activities.

College library staff provide teaching and learning services including literature search workshops and tutorials, library information sessions and introductory workshops, and the library guides which include support hubs and resource guides.

Teaching and learning approach

All learning is guided by the outcomes defined for domains and training levels within each training curriculum (anaesthesia, pain medicine, DHM). All curricula are expressed in terms of learning outcomes, organised under the seven roles in practice (see standards 2 and 3). These learning outcomes provide a comprehensive guide for trainee learning through each program.

Some assessment activities are dual purpose. WBAs are used for both assessment *for* learning and assessment *of* learning (see standard 5). College training programs place responsibility for learning upon trainees. This prepares them for ongoing learning for the whole of their professional lives. Trainees achieve learning outcomes via self-directed learning, workplace clinical experience and other educational experiences and activities. Over the past decade, the college has moved from primarily assessing and certifying learning, to also becoming an educational provider.

Anaesthesia

The principles of the anaesthesia training curriculum are outlined in standard 3.1. These guide the approach to experiential learning in the workplace and more formal teaching and learning resources. The ANZCA curriculum provides detailed learning outcomes for tasks required to achieve each of the ANZCA roles in practice.

Pain medicine

The pain medicine training program is based within multidisciplinary pain medicine units that are accredited by the faculty, under the supervision of a faculty-approved supervisor of training (SOT). As part of their clinical experience, FPM trainees are expected to participate in all aspects of pain medicine practice. Units may roster trainees to work in other areas within the institution where they can gain valuable experiences, for example in addiction medicine, palliative care, rehabilitation and consultation liaison psychiatry. Supervisors tailor these learning opportunities based on the needs of each individual trainee. As trainees grow in experience they will be given more complex patients to manage. Trainees are also encouraged to learn from the allied health members of the multidisciplinary pain medicine team, including physiotherapists, psychologists, occupational therapists and social workers.

Mapping of resources to ANZCA and FPM roles in practice

The following table shows examples of current teaching and learning resources mapped to the ANZCA and FPM roles in practice. This was undertaken for this reaccreditation submission, although there is not an ongoing systematic approach to such mapping for anaesthesia training (see '*Improvement opportunities and future plans'* at the end of this standard). The college has developed a roles in practice library guide which provides anaesthesia resources under each specialist role. With the 2015 pain medicine curriculum implementation, a suite of learning resources mapped to this curriculum was developed.

Table 4.1 Teaching and learning resources mapped to ANZCA and FPM roles in practice

	Anaesthesia training	**Pain medicine training**
Medical expert	EMAC course Advanced Life Support (ALS) course Can't Intubate Can't Oxygenate (CICO) course	NA
Clinician	NA	Essential topic area online study guides Basic and Advanced Clinical Skills Courses
Communicator	Communication essentials (Networks) Communicator role project – in progress under EDEC with Specialist Training Program (STP) funding, see standard 3.2 and 4 Communicator role library guide	Essential topic area online study guides Basic and Advanced Clinical Skills Courses
Collaborator	EMAC course	Essential topic area online study guides
Leader and manager	Management essentials (Networks) Professionals' essentials (Networks)	Essential topic area online study guides
Health advocate	See roles in practice library guide	Essential topic area online study guides Basic and Advanced Clinical Skills Courses
Scholar	Scholar role support resources Critical appraisal:10 e-learning modules and reference list Clinical audit exemplars (unsatisfactory, satisfactory, outstanding), clinical audit e-learning module and reference list	Scholar role support resources Critical appraisal:10 e-learning modules Essential topic area online study guides AEP (optional) Basic and Advanced Clinical Skills Courses

	Anaesthesia training	Pain medicine training
	Learning and teaching: 3 e-modules, references and learning plan templates AEP (optional) Research consultation service	Clinical case study support resource Research consultation service
Professional	Bulling, discrimination and sexual harassment (BDSH) resources Mentoring resources Critical incident debriefing toolkit	Essential topic area online study guides BDSH resources Mentoring resources Basic and Advanced Clinical Skills Courses

Pain medicine

In development and revision of the essential topic area online study guide resources (table 4.1), content is mapped to specific learning outcomes across the roles in practice and essential topic area sections of the curriculum. These study guides are not intended to be comprehensive but rather to provide introduction and direction for trainees on as broad a front as reasonable.

In 2018, the Learning and Development Committee undertook a mapping exercise of content covered in the Basic and Advanced Clinical Skills courses against the curriculum. These courses have been unable to be held in recent times due to COVID-19. It is likely that the content of both courses will be revised in coming years following the introduction of a centralised trainee tutorial program (see below). Introduced in 2021 to replace regionally-based activities, this new tutorial program covers the essential topic area section of the FPM curriculum.

4.2 Teaching and learning methods

The AMC accreditation standards are as follows:	
4.2 Teaching and learning methods	
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.

Practice-based training

A significant proportion of learning occurs in the clinical learning environment where trainees undertake a variety of roles as reflected in the ANZCA and FPM roles in practice. This work is supported by effective clinical supervisors and formal supervisory roles (standard 8.1), with supervision and supervisors evaluated at site accreditation. Standard 8.2 includes how accreditation ensures trainee exposure to the breadth of training opportunities and contexts, along with future plans to enhance accreditation.

Anaesthesia training

Clinical placements

Trainees undertake clinical placements that expose them to the full breadth of the discipline to achieve the graduate outcomes (standard 2). This includes experience towards the specialised study units (SSUs), which may be gained during a single clinical placement (e.g. in a specialised children's hospital) or over a number of years (e.g. paediatric experience in more general hospitals). On arrival at a new site, trainees are expected to develop a clinical placement plan with goals for that placement. This is reviewed by their SOT to ensure the goals are realistic for that placement.

Volumes of practice for cases and procedures (anaesthesia)

Volume of practice (VOP) refers to minimum time (standard 3.4), cases and procedures required of trainees during their first four years of training. These are considered core for every trainee, occurring frequently in practice, and, in some cases, are specific to particular training stages. Each assigned VOP is the minimum required to achieve curriculum learning outcomes. For some cases and procedures, it is expected that trainees will complete more than the minimum to achieve proficiency. Beyond these minimum numbers, trainees are strongly encouraged to enter all cases they encounter, as an important self-development tool through reflection and discussion.

Trainees log their clinical experiences in the training portfolio system (TPS), especially cases, procedures and sessions logged for required VOP where the trainee has gained meaningful experience. This is ideally entered on the day of the case or session. Any case may have aspects which can count towards VOP requirements. For example, anaesthesia for a craniotomy in a child may count towards:

- The neurosurgery and neuroradiology SSU requirements.
- Paediatric case requirements in the paediatric anaesthesia SSU.
- Arterial line insertion for the general anaesthesia and sedation clinical fundamental.

Trainees need to plan to maximise their opportunities to fulfil VOP requirements. All trainees should be able to access exposure without significant difficulty. A trainee may be unable to meet minimum required VOP, for example because of limitations on their clinical placement opportunities. In these circumstances, they may apply to the director of professional affairs (DPA) assessor for special consideration. SOT support for these applications is required. The DPA assessor decisions about exemptions or deferral to a subsequent training period

consider each trainee's particular circumstances and whether the balance of their training will provide them with sufficient clinical experience.

Pain medicine training

Trainees undertake clinical placements that expose them to the full breadth of the discipline to achieve graduate outcomes (standard 2). This includes specific clinical experiences supporting the essential topic areas. On arrival at a new unit and at the beginning of each in-training assessment (ITA) period, trainees are expected to develop learning goals which are recorded on the ITA and reviewed by the SOT or practice development stage supervisor (standard 8.1). Trainees work with their supervisor to identify the training opportunities that the unit can provide.

Adjuncts to learning in a clinical setting

College-wide

ANZCA Educators Program

The AEP aims to develop participant knowledge, skills and professional behaviours fundamental to facilitating learning effectively. The program is available to all fellows, basic and advanced trainees and SIMGs. Modules in this program are in figure 4.1.

Figure 4.1 Current AEP modules

Iterations of clinical teaching courses have been delivered for several decades. In the 2012 AMC submission ANZCA identified the implementation of an online version of the AEP. The two initial modules were expanded subsequently to a full eight-module course in 2013. This model was available for two years. It was discontinued as estimated ongoing maintenance and development costs outweighed the potential benefit and need. Launched in 2011 as the ANZCA Foundation Teachers Course, this was renamed the AEP and rebranded in 2015 with five new modules also added at that stage.

The college has a long history of engaging fellows to assist with the delivery of modules in a co-facilitation capacity. In 2015, the college established a formal facilitator role and educated a core group of fellows to deliver the AEP modules locally across Australia and Aotearoa New Zealand. The college currently has 27 active facilitators and is recruiting additional facilitators in 2022.

Since 2015, course availability has increased. The face-to-face format was offered a minimum of seven times per year in Australia and Aotearoa New Zealand, except in 2020 with COVID-19 interruptions leading to delivery of only two courses. As reported in the 2021 progress report, the college had adapted two modules for online delivery using Zoom. Evaluation of these modules confirmed positive participant experiences and achievement of learning outcomes, therefore a further five modules were adapted and are now available. In response to this feedback, the college will continue to deliver both online and face-to-face AEP courses.

The AEP was free from its introduction in 2010 until 2017, when a fee of $100 +GST per module was introduced. Participants were required to register for all of the modules in the course (which came in modules of eight or 11), until 2019 when single-module registration was introduced. Since 2020, trainees have received a 50 per cent fee reduction of the full fee. In 2022, the full block course registration requirement was resumed and an administration fee was added. 2022 fees are $50 +GST per module and a $25 admin fee for trainees, and $100+GST per module and a $50 admin fee for fellows.

College library and museum

The ANZCA Library supports the ANZCA and FPM curricula with access to over 13,000 medical e-books (including most of the primary examination texts) and over 900 anaesthesia, pain medicine, intensive care, perioperative medicine and medical education e-journals.

In 2014 and 2015, the college reviewed the library resulting in 24 recommendations (appendix 4.1), 22 of which are now implemented with significant improvements, particularly improving technology systems and enhancing the focus on training and research.

Since 2016, the library has developed a suite of library guides that collate relevant resources and services available for specialised anaesthesia, pain medicine, intensive care and perioperative care topic areas. Since 2020, the library has developed a series of support hubs for training and exams, SOTs, professional development, research support and safety and advocacy areas, as well as building numerous specific resource guides to support anaesthesia primary exams, the ANZCA roles in practice, pain medicine training, the DHM diploma, and the ANZCA educators program. Library guides are available for wellbeing (2019), gender equity (2019), environmental sustainability (2019), and critical incident debriefing (2021).

In line with the ANZCA and FPM 2018-2022 Strategic Plan, in 2020 the library worked with the Emerging Investigators Sub-committee and the Research Foundation to develop a research support toolkit. This provides resources supporting the whole research lifecycle, particularly for trainees, or those new to research. A broader research support hub collates all college research offerings. The ANZCA Library and research consultation service run information literacy and research workshops to support the scholar role activities through orientation sessions, exam courses, at events such as the Annual Scientific Meeting (ASM), as well as ad hoc sessions – scheduled and on-demand. In November 2021, the research

librarian and library manager presented on research support services at TRA2SHCON21, an anaesthesia trainee-led conference on environmental sustainability.

Since 2016, ANZCA library staff have presented literature search-related workshops as part of each ASM, with a particular focus on industry-standard databases such as Medline and PubMed. Since 2020, library staff have also provided one-on-one Zoom literature search tutorials, as requested. These workshops are supplemented by support-oriented library guides covering database use and searching, the literature search process and referencing. There are also regular information pieces in the *ANZCA Bulletin*, including an article on literature searching in September 2019.

Since the 2012 AMC accreditation, the library has presented information sessions at most Victorian regional courses (either in person or online), provided online information sessions for South Australian regional courses (since 2021) and provided online orientation guides for all other regional courses. Since 2016, the library has conducted introductory workshops at each ASM covering a wide range of library resources and services, as well as regular introductory sessions for new ANZCA staff conducted either in person or online (two to three times a year).

The Geoffrey Kaye Museum of Anaesthetic History

Founded in 1935, the Geoffrey Kaye Museum of Anaesthetic History is an internationally recognised and accredited collection of objects that also runs exhibitions (online and at the Melbourne office), develops resources and runs workshops and webinars. Establishment of the History and Heritage expert reference panel in 2014, and achievement of Victorian museum accreditation in February 2015 enhanced the museum's professionalisation. The museum created an online presence to build public programming and provide opportunities to use history and the collection for education, training, research and engagement. This included:

- Developing a blog in 2016, sharing articles on the history of anaesthesia and pain medicine, hosting online museum exhibitions and public programming from the museum, including papers and presentations.
- Developing the Lives of the Fellows platform recording the rich history of college and faculty fellows, launched in 2016 with regularly additions and updates.
- Expanding the oral history suite of interviews (on average about two new interviews each year) with significant fellows of the college, providing a record of historical events, people, and development, and a resource for future research.
- Museum-led history of medicine educational talks, events, workshops and symposia, such as the evidence-based history Medical History Masterclass in 2016 and the Women and Medicine symposium in 2019.
- A new immersive exhibition – *Djeembana Whakaora: First Nations medicine, health and healing*, which celebrates Aboriginal and Torres Strait Islander and Māori medicine and healing practices in both Australia and Aotearoa New Zealand.

CME and other events

The Fellowship Affairs unit, through its in-house events team and the Aotearoa New Zealand national and Australian regional offices, provides the mechanism by which continuing medical education (CME) and CPD activities are delivered to fellows, trainees and SIMGs. These activities are delivered through in-person, hybrid and virtual formats.

Annual Scientific Meeting

The signature college meeting is the five-day Annual Scientific Meeting (ASM) held each May with between 2000 and 2500 delegates in attendance. A regional or national organising committee is appointed for each ASM, working with the in-house events team to deliver the meeting. ASMs are held across Australia and Aotearoa New Zealand and, on occasion, in Asia and attract international speakers, facilitators and delegates. Each annual meeting incorporates the Faculty of Pain Medicine Symposium, the Emerging Leaders Conference, the college ceremony and, in most years, a satellite meeting of at least one special interest group (SIG). The program includes workshops, small group discussions, a scientific program, and social and networking activities.

Special interest groups

The SIGs are part of a tripartite collaboration between ANZCA, the Australian Society of Anaesthetists (ASA) and the New Zealand Society of Anaesthetists (NZSA). ANZCA manages and supports 14 of the 17 SIGs, delivering up to eight meetings annually. SIG membership is multidisciplinary and promotes collaboration between the specialities and opportunities for sharing ideas. SIGs also produce resource documents, library guides specific to each craft group, support professional document development and engage in international exchange.

Australian regional events

The Australian regions deliver state-based annual conferences as well as refresher courses, exam preparation courses, workshops and trainee orientation programs. Each year the Australian regions deliver 30 regional CME meetings, 45 trainee courses and support 115 committee meetings.

Other CME events

Meetings are also run for the ANZCA Clinical Trials Network, the Australian and New Zealand Anaesthetic Allergy Group and two meetings a year for the Peter MacCallum Cancer Centre. Every two years a hui is run in Aotearoa New Zealand to promote and raise awareness of cultural safety.

Further CME is provided through international collaborations of the International Academy of Colleges of Anaesthesiologists and the Tri-Nations Alliance. Due to COVID-19, the meeting of the Tri-Nations was cancelled in 2020 however work is recommencing in 2022 on webinars and a face-to-face meeting in 2023. Conferences and webinars are features of these two partnerships of which ANZCA is the secretariat (see standard 1).

Webinars focused on gender equity and environmental sustainability are also held annually, supported by the Fellowship Affairs unit and are open to all fellows, trainees and SIMGs.

Courses: Anaesthesia training

The following courses are *mandatory* during anaesthesia training. Each is linked to relevant learning outcomes in the curriculum:

1. Advanced Life Support (ALS) course

ALS or equivalent is required in each training stage, introductory training (IT) or during the 52 weeks prior to IT completion, basic training (BT), advanced training (AT) and provisional fellowship training (PFT), the latter requirement introduced in 2019. These courses can be provided at a department or hospital level, or at Australian regional or Aotearoa New Zealand national college conferences or by external organisations. The college publishes the minimum skills that trainees must demonstrate (ANZCA handbook for training section 2.15.3). Course centres set their own course attendance fees, although many departments run these in house. The ALS course provides learners with the skills and knowledge to manage the patient in the immediate period of crisis. It includes recognition, assessment and immediate management of the deteriorating patient. There are similar requirements for the ALS course in the ANZCA and FPM CPD program (standard 9).

2. Can't Intubate, Can't Oxygenate (CICO) course

A CICO course or equivalent must be completed in each training period. The college publishes requirements for the lead facilitator, recognised algorithms, recommended pre-reading, and learning objectives (ANZCA handbook for training section 2.15.4). ANZCA sets guidelines to assist course providers to develop CICO education sessions. CICO course fees vary between centres, although many departments run these in-house. The minimum learning objectives are that by the end of the education session, participants can:

- Apply criteria to recognise when a CICO situation has arisen.
- Communicate clearly to others that a CICO situation exists.
- Explain the steps and decision-making points in one of the recognised difficult airway algorithms that address CICO.
- Be fluent with equipment and procedures relevant to the preferred emergency algorithm.

3. Effective Management of Anaesthetic Crises (EMAC) course

EMAC provides techniques in the management of anaesthetic emergencies. ANZCA accredits EMAC simulation centres for the delivery of EMAC. The course is run over two and a half consecutive days and consists of five modules: airway management, human factors, cardiovascular emergencies, anaesthetic emergencies and trauma management. The college recommends EMAC is completed prior to the commencement of PFT, although it may be completed at any stage after IT. Course fees are $AU4255 including GST or $NZ4800 including GST. An overview of the EMAC course is in appendix 4.2 and the learning outcomes are in appendix 4.3.

4. Paediatric Life Support course

This must be completed once during training, preferably during the paediatric anaesthesia SSU or the obstetric anaesthesia and analgesia SSU. Guidance, including learning objectives, is in the ANZCA handbook for training (section 2.15.5) and the course can be run locally.

5. Neonatal Resuscitation course

This must be completed once during training, preferably during the obstetric anaesthesia and analgesia SSU. Guidance, including learning objectives, is in the ANZCA handbook for training (section 2.15.6) and the course can be run locally.

6. Early Management of Severe Trauma (EMST) course

The EMST course delivered by the Royal Australasian College of Surgeons (RACS) or equivalent (for example, Advanced Trauma Life Support) must be completed if the volumes of practice for the resuscitation, trauma and crisis management clinical fundamental has not been achieved. It is only required for the group of trainees who can't access the relevant clinical experience. Course fees are $AU3150 including GST or $NZ3525 including GST.

Other courses in anaesthesia training

- **Orientation courses**: The college offers an orientation course for new trainees, the introduction to anaesthesia training (previously part zero). Topics covered include an overview of the anaesthesia curriculum for introductory training, exam preparation with a focus on the primary exam, planning and work-life balance and introduction to the ASA. The course is currently under review and will include an online component in the next iteration.
- **Examination courses:** The college offers exam preparation courses for trainees for both primary and final exams across Australia and Aotearoa New Zealand. These are run by fellows. Appendix 4.4 overviews current exam preparation courses.

Networks (eLearning)

Introduced in 2015, Networks is the college learning management system (LMS), housing a variety of eLearning products (table 4.2).

Table 4.2 Examples of eLearning content in Networks

Anaesthesia	Professional learning (all specialties)	Pain medicine
• TPS support resources • WBA support resources • Exam support webinars • EMAC	• BDSH modules • Fundamentals of feedback • Fundamentals of mentoring • Communication, management and professionalism • AEP • Perioperative Anaphylaxis Response	• Better Pain Management • Examination of patients who present with pain • FPM Essential topic areas

Networks is also a central repository for committee and resource documents. There are two iterations of Networks, an internal platform for ANZCA and FPM members, and an external platform for non-members to access the FPM Better Pain Management modules. There have been no significant changes to the core system since its implementation. The college engages D2L Brightspace for the ongoing delivery and maintenance of the learning management system (LMS).

Multiple feedback avenues (e.g. fellows, the Trainee Wellbeing Working Group, the 2020 trainee survey) indicates the LMS is not user-friendly as it is difficult to navigate and serves multiple purposes. A review of the LMS is in-scope for the lifelong learning project (see '*Improvement opportunities and future plans*' at the end of this standard), with replacement planned for late 2022. Requirements for the new LMS are defined, focusing on the core function of eLearning delivery. Additional committee repository and central document resource functions will be removed from the LMS and addressed by different systems as part of the ICT strategy (standard 1).

In late 2021, eLearning templates were reviewed and new interactive templates produced for all college eLearning products. An example template is at appendix 4.5. These centralised templates aim to improve end-user experience and knowledge retention, standardising resources and ANZCA and FPM branding. This work was achieved through collaboration between the Education and Research unit, Communications team and FPM staff, with fellow, trainee and EEMC input. Evaluation will be via fellow and trainee satisfaction with eLearning products and functionality (see standard 6).

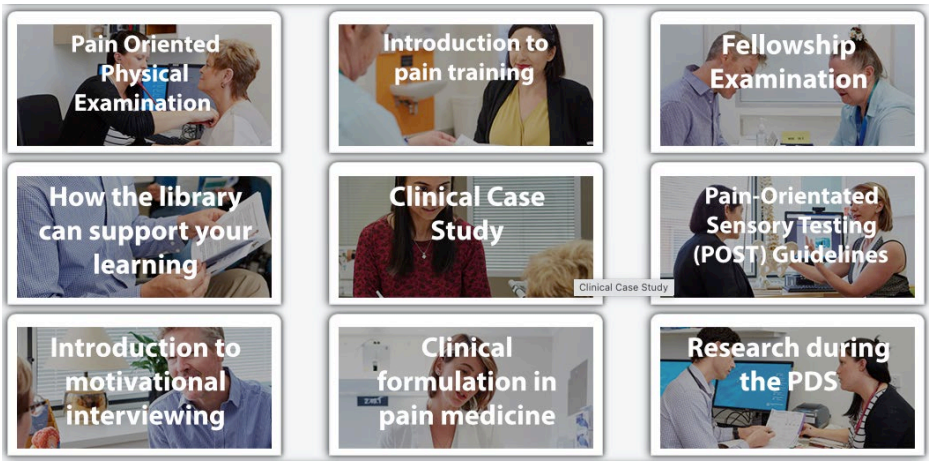
Anaesthesia teaching and learning cases

In the 2013 curriculum review, curriculum authors developed case vignettes which are available in Networks. They include facilitator versions (which includes guidance on what is expected for stage of training, resources and links) and question only versions (for trainees). Mapped to curriculum learning outcomes, they cover all ANZCA roles in practice and are adapted for each stage of training (IT, BT, AT). They spirally introduce greater complexity for more advanced trainees. They have not been updated since 2013.

Courses: Pain medicine

In hospital learning opportunities are supplemented by resources and courses provided by FPM. There are no compulsory courses for pain medicine trainees. Two clinical skills courses are delivered for trainees in their first year of training. Online study guides mapped to each section of the curriculum are available for trainees and the library provides collated collections specifically targeted to pain medicine trainees to facilitate self-directed learning (figure 4.2).

Figure 4.2 FPM trainee support resources landing page



Following pandemic disruption to in-person delivery of courses, FPM introduced an online weekly tutorial program in 2021, focused on trainees in the core training stage and centrally coordinated by a fellow. Each week a different topic linked to curriculum learning objectives is presented by an FPM fellow. Many fellows, including supervisors and examiners, offered to present sessions. Each session averages between 25 and 35 participants. The program was popular among trainees, with 27 new trainees joining the program in 2021.

The program is run weekly from March to October. Prior to implementation, each training unit was contacted to request protected time for trainees to attend. Recognising barriers to attendance, each presentation is recorded with the video uploaded to Networks in the week following. Trainees report that they re-watch recorded sessions while preparing for the examination. In 2021, supporting trainee real-time access to the online tutorials was added to accreditation criteria (standard 8.2). Each unit is expected to contribute at least one tutorial annually. The tutorial program convenor presented at a supervisor workshop in late 2021 to encourage protected time and participation from all units.

The tutorial program is evaluated by participant feedback after each session. In mid-2021, a trainee online survey had 22 respondents. The FPM Learning and Development Committee reviewed results (appendix 4.6). At the end of 2021, an evaluation discussion with trainees via Zoom identified improvements for 2022 (appendix 4.7).

University courses / external providers

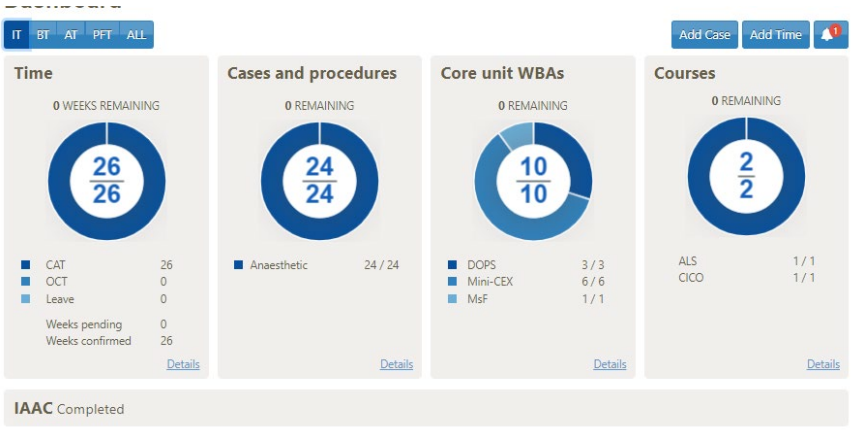
There is no current requirement nor future plan for ANZCA or FPM trainees to complete university or other formal award courses in their respective training programs.

Anaesthesia online training portfolio system

Specifically designed for the 2013 ANZCA training program and maintained by the college ICT team, the TPS allows trainees and ANZCA supervisors to record and track training progress. Trainees can access the TPS from the start of training and are responsible for keeping their record in it up-to date and accurate, as outlined in the ANZCA training agreement (appendix 7.1). They are required to log minimum training experiences and must enter time within four weeks and log cases within 13 weeks of accrual. Time not recorded within this timeframe may be changed to leave or interrupted training.

The TPS undergoes regular review and approximately two updates are released each year. In 2018, the TPS underwent significant enhancements which, following trainee and fellow consultation, included improved dashboards, additional target pages to assist progress tracking, and revised WBA and core unit review forms (standard 5). The current trainee dashboard shows outstanding requirement in clear pie charts (figure 4.3). Each widget is configured to show the current core unit requirements. The dashboard includes a notification feature for information and prompts for upcoming or outstanding requirements.

Figure 4.3 Training portfolio system - Example of a completed IT dashboard



ANZCA supervisors can access a TPS dashboard showing each trainee's progress in their current core unit. Access is tailored to each supervisory role, for example education officers (EOs) can see all trainees in their region and rotational supervisors (ROTs) can see all trainees in their rotation, standards 5.3.2 and 8.1.3. SOT, ROT and EO dashboards have two views. The default view is a snapshot of the trainee details and key information (figure 4.4). The dashboard can be expanded to show more detailed information (figure 4.5).

Figure 4.4 Training portfolio system- Example default view

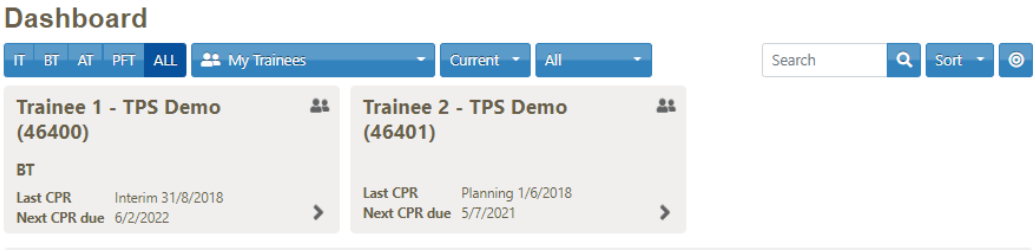
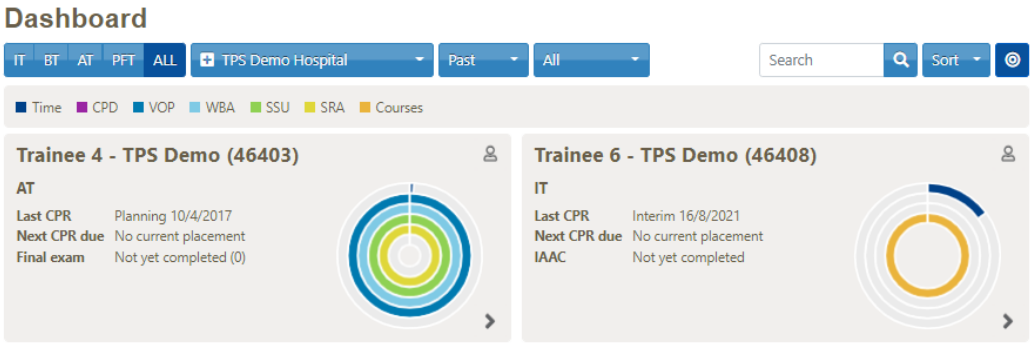


Figure 4.5 Training portfolio system - Expanded view



Each SOT dashboard also has a 'My Trainees' function which allows customisation of the dashboard so only relevant trainees appear each time the supervisor logs in. Supervisors can access trainee records up to 52 weeks after they have left that training site or start interrupted training and 13 weeks before starting at the training site. Prior to 2018 this was

only four weeks and was changed in response to user feedback. Notifications are generated when there is an activity requiring supervisor attention or action by a trainee.

Lifelong learning project (college-wide)

In late 2020, ANZCA commenced a multi-year project with the aim to review and upgrade the college's learning management portfolio to improve user experience and future proof the college's capability to deliver multiple training programs, online courses, continuing professional development, training site accreditation and other educational offerings. The project will be undertaken over three phases, with phase one – requirements project – completed in early 2022.

ANZCA's current learning management portfolio consists of a combination of systems: the training portfolio system, continuing professional development portfolio, training site accreditation, exam management system and learning management system. These systems are bespoke, inflexible and costly to maintain and upgrade. As changes to the ANZCA training program, FPM training program and CPD program are occurring, there is an opportunity for the college to find a scalable education solution that can be easily configurable to align with new policy, curriculum and process requirements. This also allows the college to refashion how education is delivered, and streamline workflows and processes to reduce the load on staff by removing lengthy steps of enrolment and payments, automating and simplifying educational workflows. The new learning management portfolio will also have the capability to deliver multiple training programs, online examinations, online courses, CPD, training site accreditation and other educational offerings.

As the IT systems associated with the lifelong learning project are delivered, it is anticipated that there will be benefits for supervisors who will have access to more trainee data which should help identify trainee learning needs. The systems will also allow FPM to monitor performance of supervisors and fellows undertaking workplace-based progressive feedback for trainees to enable targeted education.

Phase one of this project, which is still underway, set out to gather requirements, identify vendors and products, and cost out and make recommendations for an end-to-end education solution for the college. See also *'Improvement opportunities and future plans'* at the end of this standard.

Teaching and learning methods

Both anaesthesia and pain medicine training programs encourage self-directed learning and progressive increasing responsibility. The key methods by which this occurs are:

- Clinical placement planning for anaesthesia training.
- Self-assessment tools in TPS which require trainee responses to WBAs and core unit reviews (CURs) for anaesthesia and on the FPM in-training assessment form.
- Goal setting, learning needs analysis and career planning through the ANZCA provisional fellowship program and FPM practice development stage.
- Role modelling through the FPM mentoring program, fundamentals of mentoring resources (in Networks) and ANZCA and FPM scholar role activities which promote teaching of more junior staff.

- Peer-to-peer learning through ANZCA study groups and regional/national tutorial programs and the centralised FPM tutorial program.
- Interdisciplinary and interprofessional learning in anaesthesia through the EMAC course (human factors module) and multisource feedback (standard 5), and in pain medicine through the requirement for situated learning in multidisciplinary settings.
- Participation of anaesthesia provisional fellows in the ANZCA and FPM CPD program.

Facilitation of trainees' development of an increasing degree of independent responsibility as skills, knowledge and experience grow

Standards 2 and 3 describe the spiral nature of the anaesthesia curriculum and the two stages of the pain medicine training program. Each provides progressively increasing responsibility with each training stage building on prior stages and prior phases of medical education (standard 3.3.1).

Some of the learning methods which allow this to occur include:

- Use of WBAs requiring more direct observation early in anaesthesia training (mini-clinical evaluation exercise, direct observation of procedural skills), with those reflecting greater trainee responsibility (case-based discussion) later in the program (standard 5).
- Participation of ANZCA provisional fellows in the CPD program (standard 9).
- More independent, individualised and mature self-reflection and needs analysis required for planning ANZCA provisional fellowship training and the FPM practice development stage.
- Training requirements and tools encouraging senior trainees to provide teaching, assessment of and feedback to more junior trainees.

Training in cultural safety and reflection on unconscious bias for culturally safe patient care

The online courses run by the Health Quality and Safety Commission New Zealand are undertaken by fellows in FPM training units, with FPM trainees also encouraged to complete the courses by their units. The college has collated cultural competency resources that fellows and trainees can access in the library and the CPD resource section of the website.

While cultural safety training is not currently mandated in all college training programs, learning outcomes, resources and assessments are planned (see standard 3). As the Māori health initiatives discussed under standard 1 are implemented, there is an opportunity to incorporate such training. The college recognises the need for this training to be Māori led.

Impacts of COVID-19

- **Exam refresher courses:** Run by the Australian regions and Aotearoa New Zealand office staff, fellows and senior trainees, were delivered online. Some regions (e.g. WA) continued primarily face-to-face delivery.
- **EMAC**: During 2020 and 2021, many EMAC courses were cancelled due to lockdowns and other restrictions. Due to the requirement for high fidelity simulation and hands-on experience, EMAC courses could not be moved online. The EMAC

Sub-committee and EEMC gained ANZCA Council approval for an EMAC deferral pathway for 2020 and 2021 PFTs. Due to continued COVID-19 disruptions in 2021, the EMAC deferral pathway was recently extended to the end of hospital employment year (HEY) 2022.

- In 2020, communication was sent to all PFTs who had not completed EMAC requesting they contact their regional simulation centre to register and request prioritisation. Simulation centres prioritised PFT registrations. As lockdowns ended, many simulation centres added additional courses to their events calendars. Consequently, by the end of 2021, 98.4 per cent of PFTs and SIMGs were able to complete EMAC prior to their transition to fellowship. Of 432 trainees and SIMGs admitted to fellowship between March 2020 and December 2021, only seven were admitted without EMAC. These fellows made a written undertaking to complete EMAC in their first 52 weeks of specialist practice, with non-compliance subject to the provisions of regulation 26.
- **COVID-19 library guide:** A COVID-19 library guide was developed in conjunction with the COVID-19 expert working group to highlight and disseminate approved COVID-19-related clinical resources. Following its launch in mid-March 2020, the guide saw tremendous use with over 38,000 page views. At its peak, it was attracting 500-1000 hits per day. The guide is regularly updated with new evidence and guidance.
- **WBA workshops:** The pandemic impacted 2020 delivery of WBA workshops due to restricted access to training sites, travel restrictions and competing clinical priorities. See standard 8.1.
- **FPM Basic and Advanced Clinical Skills Course:** From March 2020 these courses could not be delivered in their usual face-to-face format. Some of the content was integrated into the centralised trainee tutorial program in 2021 and several Zoom trainee workshops in 2020.
- **FPM centralised trainee tutorial program:** Following the introduction of Zoom technology, FPM expanded the NSW-run trainee tutorials into a centralised trainee tutorial program and include presenters from across Australia and Aotearoa New Zealand. The Learning and Development Committee oversees this program which is a positive outcome of the pandemic disruptions.
- **Virtual educational meetings:** In 2021, the college delivered its first virtual ASM, virtual SIG and CME meetings, and a series of webinars to provide CPD opportunities for fellows and trainees while usual educational and training opportunities were impacted by COVID-19. More than 2600 delegates attended the virtual ASM. Registration systems for events are aligned allowing eligible credits for events to be automated and loaded into the online CPD portfolio system (standard 9).

FPM Procedures Endorsement Program

The Procedures Endorsement Program has a by-law which defines the requirements of the program, a curriculum which includes the learning outcomes and a program handbook that covers processes and policies.

All the forms utilised in the program are available on the website. Targeted library guides have been developed to support endorsees completing the program and as references in support of the Procedures in Pain Medicine Clinical Care Standard. A number of

presentations for endorsees and accredited procedural supervisors have been recorded and collated on the Networks platform. There are no mandated courses within the Procedures Endorsement Program.

Other training programs

Joint Consultative Committee on Anaesthesia (JCCA)

To complete JCCA training, trainees must complete one emergency medicine course within the last four years or have a confirmed position on a future course. Approved courses are Anaesthetic Crisis Resource Management (ACRM), Emergency Life Support Course (ELS), Rural Emergency Skills Training (ACRRM REST), Clinical Emergency Management Program (CEMP) Advanced (course now discontinued but credit given is completed between 2017 to 2019), and the EMAC course.

The JCCA does not directly provide courses. Other resources available to trainees and graduates include rural SIG conferences, the rural SIG session at the ANZCA Annual Scientific Meeting, the Society for Paediatric Anaesthesia in New Zealand and Australia (SPANZA) events, and regional meetings (e.g. annual SA weekend, trainee orientation weekend).

Diploma of Rural Generalist Anaesthesia (DRGA)

Training will occur primarily in the clinical environment, with entrustable professional activities (EPAs) promoting progressive independence and responsibility. Key resources will include the curriculum document, training handbook and regulation. Training will be recorded using an e-portfolio, in development as part of the lifelong learning project (standard 4).

The mandatory courses for the DRGA are:

- Can't Intubate, Can't Oxygenate (CICO) (or equivalent).
- Cardiac arrest (or equivalent).
- Neonatal resuscitation (or equivalent).
- Perioperative Anaphylaxis Response online course (provided through Networks).
- Paediatric life support (or equivalent).

These courses can be run locally at the training site, with the required course content modelled on the ANZCA CPD course requirements. Alternatively, trainees can access the required leaning objectives by attending an appropriate externally-run course.

Diploma of Advanced Diving and Hyperbaric Medicine (DHM)

The DHM trainee toolkit includes all forms, courses and fee information. Key resources for the DHM diploma include ANZCA Advanced DHM Curriculum, Handbook for Advanced DHM Training, Handbook for Advanced DHM Accreditation, regulation 36 - ANZCA Diploma of Advanced DHM and the DHM training agreement (appendix 4.8). DHM trainees have access to the college library which includes a DHM library guide.

Recording of DHM training is paper-based currently, including an excel workbook file for logging cases, WBA forms and CPR forms, with staff transcribing data into iMIS and saving copies of emails and assessment. Trainees are expected to collate their training record as actual or scanned copies of all documents. They are responsible for submitting relevant

material to the college. The lifelong learning project will move DHM training to an online portfolio in 2023 (standard 4).

Trainees must complete the following mandatory courses and qualifications which are externally run and incur an additional cost to them.

1. The South Pacific Underwater Medicine Society (SPUMS) Diploma. While this is delivered and certified by an external organisation, many DHM specialists are involved in both organisations and thus the college is kept well informed about changes to the SPUMS diploma.
2. Two short (two-week) courses, one in diving medicine and the other in hyperbaric medicine. A list of pre-approved courses is on the college website. Providers apply to the DHM Sub-committee (DHMSC) for approval. Alternatively, trainees can apply for prospective approval of a course that is not on the pre-approved list using this form, which is considered by the DPA assessor in consultation with the DHMSC chair.

An Advanced Life Support course, or equivalent, must have been completed within the 52 calendar weeks prior to date of completion of other DHM training requirements. A valid ALS 1 or ALS 2 course within the previous 208 weeks or EMAC course within the previous 104 weeks will also meet this requirement.

Progressive independence and responsibility is promoted through supervision frameworks (standard 8) and the DHM roles in practice. The process of gaining progressive independence is managed at local facilities. Trainees in DHM are very senior, working alongside supervisors of training and other specialists in the clinical setting and on call for emergencies. They are supervised at all times. The judgment of progressive independence (and more remote supervision) is managed locally by the facility specialist staff, based on the casemix exposure, the performance of the candidate under supervision and WBAs (standard 5).

Diploma of Perioperative Medicine (POM)

The DipPOM will provide learners with the opportunity to undertake WBA for progressive feedback. Details are being finalised as part of the curriculum outline document (refer standard 3). The DipPOM project is dependent on the lifelong learning project (standard 4). The diploma program is most likely to be built and managed within the college's new LMS, due for implementation in late 2022. To date, no mandatory courses have been identified; however recommended courses will be included for participants to achieve the learning outcomes of the program.

Dual FANZCA-FCICM pathway

Consideration will be given to how the various policies documents and processes for each college articulate to form a unified pathway. While yet to be developed, key resources for the dual training pathway may include a combined pathway handbook and regulation. Recording of training will be in the training portal system that is planned with the lifelong learning project (standard 4).

Strengths

Mapping of pain medicine resources to curriculum content (standard 4.1)

FPM has strong governance of teaching and learning resources. In the 2015 curriculum redesign, mapping of resources to key content areas was introduced. This supports all graduate outcomes and FPM roles in practice.

ANZCA training portfolio system (standard 4.2)

The dedicated anaesthesia trainee portal provides trainees and supervisors with a reliable platform to track and monitor training requirements and performance. Feedback from trainees and supervisors confirm that past investment in enhancements meet their needs. It is also a rich data source for program monitoring (standard 6) and accreditation (standard 8.2).

Clear guidance through curriculum documents and handbooks for all programs (standard 4.2)

Trainees benefit from accessing annually updated curriculum documents and handbooks that clearly articulate teaching and learning requirements and opportunities.

FPM centralised tutorial program (standard 4.2)

FPM has successfully converted to a centralised tutorial delivery program. It has revised online resources and is developing new ones. This promotes equity of access to high-quality resources for standardisation of teaching and learning bi-nationally.

ANZCA Educators Program (standard 4.2)

The AEP continues to undergo regular review with facilitator upskilling so the program reflects best practice and is valuable to fellows, SIMGs and trainees. Evaluation shows it is rated highly for relevance and skills acquisition.

College-wide: The learning and development facilitator (standard 4.2)

Having a dedicated staff member facilitating AEP and training incoming AEP facilitators (fellows) adds significant value through the consistent delivery of medical education training for fellows and trainees. It also strengthens the outcomes of various education projects and activities that this role contributes to, by linking back the experiences of trainees and their supervisors in the clinical learning environment.

College-wide library services (standard 4.2)

Feedback from fellows and trainees consistently demonstrates that college library services are well regarded as one of the key college offerings. The library team provides a high quality service through the provision of formal and informal information literacy training at the ASM, in orientation sessions, courses, at other events, both scheduled and on request.

Improvement opportunities and future plans

College-wide resource sharing between training, SIMG assessment and CPD (standards 4.1, 9 and 10)

There are opportunities for greater sharing across the continuum of medical practice (e.g. between training and CPD), and among training programs. While there are notable collaborative examples such as the ANZCA and FPM CPD program, SIMG assessment

process and some projects (e.g. the accreditation and learning environment project standard 8.2, Indigenous health learning outcomes project standard 3), there is a tendency for many developments in the two disciplines to occur somewhat in isolation. Benefits include support for interdisciplinary learning and resource efficiencies creating opportunities. Discipline-specific resources and guidance are of course still required.

Resource sharing would be facilitated by college-wide mapping of existing and planned resources to the ANZCA and FPM roles in practice. The non-clinician, non-medical expert roles are sufficiently generic that cross-discipline sharing could occur. This would also better promote resources developed for trainees to fellows and SIMGs for use during their CPD. Examples include cultural competency and safety modules, and resources for communication, scholar role and leadership. This requires both a commitment and a shift in current ways of working to embed consideration of all training programs, all stakeholders and all phases of the medical continuum.

College-wide: eLearning Management System (standard 4.1)

Repeated trainee and fellow feedback (trainee and fellow surveys) shows that the current college learning management system is not fit for purpose, as users find it difficult to find the resources they need. As part of the college's lifelong learning project, the college plans to replace the current LMS with an upgraded system with improved functionality and user experience. This is flagged for implementation in late 2022 and early 2023.

Continuous quality improvement (standard 4.1)

The existing suite of online learning products (in Networks) undergoes ad hoc review. The college would benefit from introducing a quality improvement process to ensure all learning products (including eLearning) undergo more systematic review. This is addressed in the Education Quality Framework (in development) which incorporates continuous quality improvement (refer standard 1.7 for more information).

Mapping anaesthesia resources (standard 4.1)

The anaesthesia training and CPD programs would benefit from a more systematic (regular) process for mapping teaching and learning resources to the ANZCA roles in practice. Some roles have a specific group responsible for their oversight (e.g. the ANZCA Scholar Role Sub-committee), but many roles do not. Some specific role resources are in development (e.g. for the communicator role), whereas other roles (e.g. leader and manager, health advocate) have limited teaching and learning resources.

From paper-based to electronic systems for pain medicine training (standards 1.5 and 4.2)

FPM looks forward to the lifelong learning project delivering a system that allows pain medicine trainees and supervisors to record training experiences and assessments online, and to allow online access to full trainee records. This will provide a clearer picture of trainee progress through the program. Trainees can then better plan their training experiences. Electronic data will also facilitate more targeted resource development (standard 4), systematic monitoring and evaluation (standard 6) and training accreditation (standard 8.2). While FPM trainees are not required to record and submit a log of cases, this requirement will be reconsidered once there is technology in place to produce such a record (standard 3).

College-wide Aboriginal and Torres Strait Islander and Māori health modules (standard 4.2)

There are opportunities to strengthen college educational offerings for Aboriginal and Torres Strait Islander and Māori health and cultural safety training. The college is liaising with RACS to procure the recently developed Indigenous health modules to include in the suite of resources available to ANZCA and FPM trainees, fellows and SIMGs.

Centralised online ANZCA exam preparation program (standard 4.2)

The college recognises that there is an opportunity to streamline and centralise anaesthesia trainee exam preparation courses and resources, as FPM already does. With a new stream of funding available to specialty colleges from 2022, the DHS STP FATES fund, the college submitted a proposal for an exam preparation resource development project. Unfortunately, this grant application was not successful and EEMC is exploring alternative pathways for resourcing the project. The project aims for equitable access to exam preparation resources for all trainees, addressing existing wide variation in preparation training and resources. The project stages are:

- Stage 1: Assess the need and identify best practice.
- Stage 2: Resource development and pilot.
- Stage 3: Evaluation and implementation.

Key committees, councillors, and staff have provided input to project design.

Learning resources to support the communicator role in practice (standard 4.2)

A 2015 SOT survey identified that many non-medical expert ANZCA roles in practice were not formally taught. The communicator role was identified as the most pressing area for resource development (Bunbury and Castanelli, appendix 4.9). Reporting to EDEC, the ANZCA Communicator Role Project Group was established to review existing teaching and learning resources for the communicator role in anaesthesia training, and to develop additional resources where gaps were identified. It also revised relevant learning outcomes (see *'Improvement opportunities and future plans'* standard 3).

Project objectives were developing a framework of learning support for trainees and their supervisors addressing the communicator role, and activities for observation, feedback, and reflection to support related learning. Project outcomes include a new ANZCA library guide providing ready access to research publications and other reference materials, instructional videos (demonstrating good communication practices), online learning activities and coaching resources. All project outcomes reflect contemporary practice.

Standard 5

Assessment of learning

Standard 5: Assessment of learning

Overview

All training programs include a portfolio of assessments that sample across the relevant roles in practice to ensure graduate outcomes are achieved. These include workplace-based performance assessment and examinations, along with other requirements such as scholarly activities, all blueprinted to the relevant curriculum. Valid methods of standard setting are used for all examinations, assisted since 2017 by the Australian Council for Education Research (ACER). Assessment quality is regularly reviewed, for example through the extensive peer-reviewed research by fellows on workplace-based assessments (WBAs) in anaesthesia training and pain medicine assessments review for the 2015 curriculum. Quality of pain medicine training is supported by the involvement of a large proportion of FPM fellows in assessment, also facilitating feedback and change management.

Regular and timely feedback on trainee performance is provided via multiple mechanisms including ANZCA WBAs and FPM workplace based progressive feedback (WBPF), in-training meetings with supervisors, exam reports and individual feedback mechanisms and interviews. Supervisors are informed of trainee performance (including when high-stakes results are released) and are supported for early identification, intervention and escalation where trainees are not meeting outcomes. Formal remediation is through the ANZCA and FPM trainee support and trainee performance review processes, which include escalation to employers and regulators where patient or trainee safety is of concern (fortunately rare).

Areas for improvement include:

- Evolving pain medicine training from the current reliance on paper-based processes to efficient and secure online systems (in the lifelong learning project, standard 4) to support trainees, their supervisors and the faculty for more efficient and effective decision-making, monitoring and evaluation (including accreditation).
- Improving feedback to successful trainees on examination performance (regularly highlighted in college trainee surveys and the Australian Medical Training Survey as a trainee concern).
- Improved governance of anaesthesia assessments to ensure integration of all assessment modalities, review of the risks and educational and wellbeing impacts of current high-stakes, centralised assessments, and evolution towards a more programmatic approach.
- Review of specific anaesthesia assessment components and processes through the training program evolution project. This includes WBA and portfolio review under the lifelong learning project, greater standardisation of assessment in introductory training, and introduction of problem-focused group decision-making.
- For improved consistency and procedural fairness, a planned college-wide approach to special consideration in assessments.

Key resources to support the assessment of learning in the anaesthesia and pain medicine training programs are:

- ANZCA curriculum.
- FPM curriculum.

- ANZCA handbook for training.
- FPM training handbook.
- The ANZCA training portfolio system.
- The ANZCA exams management system.

See also: standard 1.3 (reconsideration, review and appeals), standard 2 (program and graduate outcomes), standard 3 (curriculum framework and content), standard 4 (training portfolio system, lifelong learning project), and standard 8.1 (assessor selection, training and performance evaluation).

5.1 Assessment approach

The AMC accreditation standards are as follows:	
5.1 Assessment approach	
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.

Governance and staffing of assessments

Anaesthesia training

The following committees are responsible for assessment governance, development and implementation:

- The Education Executive Management Committee (EEMC), responsible for guiding the Education Development and Evaluation Committee (EDEC), Training Accreditation Committee (TAC) and Specialist International Medical Graduate (SIMG) committee to ensure implementation of education initiatives of the college strategic plan and annual business plans.
- EDEC, responsible for responsible ongoing quality improvement of ANZCA education activities and input to the development of new education and training initiatives (for anaesthesia training, SIMG assessment, diploma of rural generalist anaesthesia, perioperative medicine and the joint FANZCA-FCICM pathway)
- The Primary Exam Sub-committee (PESC), responsible for conducting the ANZCA primary exam.
- The Final Exam Sub-committee (FESC), responsible for conducting the ANZCA final exam.
- The Scholar Role Sub-committee (SRSC), responsible for support to departmental scholar role tutors and educational resources and publications relating to the ANZCA scholar role.

- The Examination Advancement Advisory Committee, which discusses the evolution and development of anaesthesia, pain medicine and diving and hyperbaric medicine (DHM) exams. In 2022, this has evolved into the Assessments Advisory Group which will focus on all anaesthesia training program assessments in the first instance in order to set a direction post COVID-19. In late 2022 this will be expanded to include FPM and other college program assessment (see *'Improvement opportunities and future plans'* at the end of this standard).
- The Trainee Performance Review (TPR) Sub-committee, responsible for delivery of the TPR process. In 2022, it is planned that the terms of reference are expanded to formalise responsibility for the trainee support process (TSP) and associated trainee watchlist.
- The Primary Exam Candidate Support Project Group, formed to support unsuccessful primary examination candidates, particularly those who have failed on three or more occasions.

Assessment development is supported by the Learning and Innovation team, and implementation by the Training and Assessments team, both within the Education and Research unit.

Pain medicine training

The following committees are responsible for assessment governance, development and implementation:

- The FPM Training and Assessment Executive Committee (TAEC), responsible for the oversight, alignment and coordination of the FPM training program.
- The FPM Examination Committee, responsible for the development and implementation of coordinated, accountable and auditable processes in the conduct of FPM examinations. This includes the conduct of the FPM fellowship examination and long case assessments and the clinical case study processes.
- The Learning and Development Committee, responsible for developing the assessment framework as part of the development, support and evaluation of the training program, curriculum and other educational initiatives.

Staffing for assessments is through the FPM unit with advice from the Education and Research department.

Program of assessments aligned to outcomes for progressive judgements

The college adopts a programmatic approach to assessment without being fully and completely programmatic. Using a combination of progressive formative assessments and summative core unit reviews (for anaesthesia) and in-training assessments (for pain medicine), trainees, supported by their supervisors of training (SOTs), plan their training to meet all assessment requirements for progression to the next stage. The program of assessment includes multiple methods that assist in developing a picture of each trainee, including through workplace-based performance assessments, formal examinations and other assessments such as ANZCA scholar role activities and the FPM clinical case study.

Anaesthesia training

The assessment requirements for anaesthesia training are regular WBA, training reviews (see 5.2), the initial assessment of anaesthetic competence (IAAC) for introductory training,

primary exam (basic training), final exam (advanced training), and scholar role activities (SRAs). Figure 3.1 *Anaesthesia training program structure* (standard 3) illustrates the timing of these assessments by core unit.

Pain medicine training

In 2015 FPM revised its assessment structure to reflect contemporary medical education expectations and to ensure that the breadth of the curriculum was covered over multiple touch points over the training journey. Assessments are aligned to learning outcomes and the assessment strategy includes assessments 'for' learning supported with assessments 'of' learning. The program includes a mix of low-, mid- and high-stakes assessments. The assessment requirements for pain medicine are regular WBPF, the general physical examination assessment, training stage reviews, long case assessments, the fellowship examination and the clinical case study.

Outcomes of reviews of assessment approach since 2012 accreditation

Anaesthesia training

Since 2013, there has been progressive refinement of the assessment components (see standard 5.2) without significant alteration of the overall assessment approach. The CBME arm of the training program evolution project, undertaken from 2019 to 2021, has identified further steps and initiatives to evolve anaesthesia training to a more programmatic approach, supported by enhanced technology (see *'Improvement opportunities and future plans'* at the end of this standard).

Pain medicine training

With the implementation of the 2015 pain medicine curriculum, significant changes were made to the assessment structure. Formative assessment was enhanced and given greater priority with WBPFs introduced and the quarterly in-training assessment (ITA) process revised. The 2015 program introduced two distinct training stage reviews to be completed by the supervisor at the completion of each. Such reviews confirm that the trainee had met the requirements for the stage and is operating at the required level to progress. The FPM fellowship examination was revised with the written component held before the oral component and objective structured clinical examination (OSCE) stations added to the oral component, replacing short cases. The long case assessment was separated out from the fellowship examination. The number of clinical case studies was reduced to one and the structure further defined. See standard 5.2 for details.

Clear accessible documentation of assessment requirements

Anaesthesia training

Assessment requirements and their mapping to learning outcomes are in the ANZCA curriculum with practical details on implementation in the ANZCA handbook for training.

Pain medicine training

Assessment requirements are outlined in the FPM Training Handbook which is publicly available on the college website and readily accessible to trainees, supervisors and staff.

Special consideration in assessment

All decisions made by college role holders and education and training committees are open to reconsideration, review and appeal (ANZCA regulations 30 and 31). This is clearly

documented in training handbooks and in communication with trainees about decisions on their training. See standard 1.3.

Anaesthesia training

Policies on special consideration for ANZCA examinations are in the ANZCA handbook for training, section 2.14.5. This includes consideration for chronic illness or disability, which requires an application at least 18 weeks prior to the exam closing date. There is also consideration for inability to present for an exam for medical or compassion reasons, or for illness during an examination.

Pain medicine training

Special consideration policies for FPM examinations are in By-law 4, FPM Training Program and the FPM Training Handbook.

MCNZ requirement: Specialist advice on the assessment of trainees' cultural safety and delivery of culturally safe care

When seeking specialist advice regarding the assessment of trainees' cultural safety and ability to deliver culturally safe care, the college will look to the Māori Anaesthetists' Network of Aoteaora (MANA) and FPM's Māori fellows for advice in the first instance, and SOTs often seek advice from their hospital's Māori health unit.

5.2 Assessment methods

The AMC accreditation standards are as follows:	
5.2 Assessment methods	
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.

Range of assessment methods fit for purpose and including workplace performance

Anaesthesia training

The assessment requirements for the anaesthesia training program are detailed in figure 5.1.

Figure 5.1 Anaesthesia training program assessment requirements

Introductory training (IT)	Basic training (BT)	Advanced training (AT)	Provisional fellowship training
▪ The IAAC, which includes: o 3 satisfactory DOPS assessments o 6 satisfactory mini-CEX assessments o 1 CICO course o IAAC questions ▪ 1 MSF ▪ At least 1 planning and 1 feedback clinical placement review for each clinical placement ▪ 1 ALS course ▪ 1 satisfactory CUR – at the end of introductory training	▪ 12 DOPS assessments ▪ 12 mini-CEX assessments ▪ 6 CBD assessments. ▪ 1 MSF ▪ 1 ALS course ▪ 1 CICO and use of the intubating LMA course ▪ At least 2 of the 5 core scholar role activities# ▪ The primary examination ▪ At least 1 planning and 1 feedback clinical placement review for each clinical placement ▪ 1 satisfactory CUR – at the end of basic training	▪ 8 DOPS assessments ▪ 16 mini-CEX assessments ▪ 8 CBD assessments ▪ 1 MSF ▪ 1 ALS course ▪ 1 CICO and use of jet ventilation course. ▪ Completion of all 5 core scholar role activities# – by the end of advanced training ▪ Completion of all 12 specialised study unit reviews^ ▪ The final examination ▪ At least one planning and one feedback clinical placement review for each clinical placement – minimum 4 during advanced training ▪ 1 satisfactory CUR – at the end of advanced training	▪ Neg* DOPS assessments. ▪ Neg* mini-CEX assessments At least 2 CBD assessments ▪ 1 MSF ▪ 1 ALS course ▪ At least 1 planning and 1 feedback clinical placement review for each clinical placement – minimum two during provisional fellowship training ▪ 1 satisfactory provisional fellowship review – at the end of provisional fellowship training

Over the duration of basic and advanced training:

- ^At least 12 specialised study unit reviews – by the end of advanced training
- One Neonatal Resuscitation course
- One Paediatric life support course

Over the duration of introductory, basic and advanced training:

- #Completion of the five core scholar role activities – by the end of advanced training:
  - Teach 1 skill (with evaluation, feedback and reflection)
  - Facilitate 1 small group discussion or run a tutorial (with evaluation, feedback and reflection)
  - 1 critical appraisal of a paper published in a peer-reviewed indexed journal for internal assessment
  - 1 critical appraisal of a topic for internal evaluation and present it to the department
  - Complete 1 audit and provide a written report for internal evaluation

Over the duration of training:

- Attend 2 regional or greater conferences/meetings
- Participate in 20 existing quality assurance programs
- One Effective Management of Anaesthetic Crises (EMAC) course – completing the EMAC course exempts the trainee from completing an advanced life support course in the core unit the EMAC is completed

Key:
DOPS: Direct observation of procedural skills
Mini-CEX: Mini clinical evaluation exercise
CICO: Can't Intubate, Can't Oxygenate
IAAC: Initial assessment of anaesthetic competence
ALS: Advanced life support
MSF: Multi-source feedback
CUR: Core unit review
CBD: Case-based discussion

Workplace-based assessments

An important component of the assessment suite is assessment of trainee performance in the workplace. WBAs were introduced into the anaesthesia training program in 2013, following orientation and training of trainees and assessors throughout 2012, and are now an integral component of training. WBAs are initiated by trainees and completed by WBA assessors in the training portfolio system (TPS) (standards 4 and 8.1).

The four WBA tools, with the relevant section of the ANZCA handbook for training in brackets, are:

1. Direct observation of procedural skills (DOPS) (section 2.12.5).
2. Mini clinical evaluation exercise (mini-CEX, referred to as CEX in the curriculum) (section 2.12.6).
3. Case-based discussion (CBD) (section 2.12.7).
4. Multi-source feedback (MSF), required at least once per training stage (section 2.12.4).

Since 2013, anaesthesia WBAs have been completed online, and entered into the TPS. This has greatly facilitated uptake, documentation, tracking progress and evaluation. The TPS dashboard allows trainees, their supervisors and the college to monitor progress against requirements. There are minimum numbers of each WBA type in every training stage with both mandatory and optional WBAs. Total numbers are in the order of 15 WBAs of different types in each training stage, representing approximately one WBA per month.

WBAs are formative assessment tools, facilitating feedback from supervisors on a range of areas, depending on the WBA type. WBAs are completed using an entrustment scale, where the supervisor is asked to make a judgement on the trainee based on the extent to which they trust the trainee to do a similar case in the future with distant supervision. There is space for written comments on topics discussed, things done well or needing improvement, and an action plan to address perceived gaps.

The initial assessment of anaesthetic competence (IAAC)

Introductory training (IT) includes specified WBAs (mini-CEX, DOPS and MSF) mapped against IT learning outcomes. The initial assessment of anaesthetic competence (IAAC) is an assessment of trainee competence to work with more distant supervision and join the after-hours roster. The process for making this determination is developed at a hospital or regional level, with guidance in the ANZCA handbook for training. Frequent components include a locally devised multiple choice question (MCQ) test, a range of mini-vivas on critical situations such as anaphylaxis, difficult airway management, and shock, or simulated scenarios. In some sites, the IAAC includes an assessment of competence to undertake obstetric analgesia and anaesthesia with distant supervision. See training program evolution project in '*Improvement opportunities and future plans'* at the end of this standard .

Examinations

Anaesthesia training program assessments includes two centralised examinations (table 5.1).

Table 5.1 ANZCA primary and final examination components, timing and number of attempts permitted

	Primary examination	Final examination
Components	MCQ Short answer questions (SAQ) Viva voce examination (viva)	MCQ SAQ Medical viva voce Anaesthetic viva voce (viva)
Timing	Required for progression from basic training (BT) to advanced training (AT)	Required for progression from AT to provisional fellowship training (PFT)
Maximum number of attempts permitted	Five	Five

Primary exam components are:

- **MCQ paper (pass-fail component):** 150 Type A questions in 150 minutes with a single best answer of 4 options, 150 marks. There is a mixture of repeat and new questions (approximately 50% of each). All new questions undergo a multi-stage review process prior to being selected for an exam paper. All questions must have the answer referenced in at least one of the textbooks on the recommended examination reading list.
- **SAQ paper (50% of overall mark):** 15 questions with ten minutes to answer each question with 15 minutes reading time, 75 marks total.
- **Viva Voce (50% of overall mark)**: 3 vivas each of 20 minutes duration, 12 questions in total (4 per viva), 120 marks total. Each viva station is assessed by two examiners who mark the candidate independently of each other.

Final exam components are:

- **MCQ paper (20% of overall mark):** 150 Type A questions in 150 minutes, 150 marks total.
- **SAQ paper (20% of overall mark):** 15 questions (150 minutes), 150 marks total . .
- **Medical vivas (12% of overall mark):** 2 vivas each 15 minutes with a different single examiner.
- **Anaesthetic vivas (48% of overall mark):** 8 vivas each 15 minutes with a different single examiner, 80 marks total.

Changes since 2012 accreditation and impact

Australian Council for Education Research

The ACER was first commissioned by the college in 2016 to review and enhance college-wide examination quality. ACER continues to be involved in the psychometric equating methodologies and comparing differences in exam difficulty and cohort ability across

different anaesthesia exams. These equating methodologies are done at every exam to enable validation of the Ebel standard setting method that allows for the standard to be maintained and monitored in the primary exam. For the ANZCA final examination, due to the impacts of the COVID-19 pandemic, ACER work has been placed on hold and will recommence in 2022, specifically for the MCQ component where standardisation exercises will be continued. ACER has also worked with FPM on its fellowship examination with details provided below.

ANZCA workplace-based assessments

Progressive improvements have occurred, largely in response to extensive high-quality quantitative and qualitative research on workplace assessment and supervision in ANZCA training by academic anaesthetists Professor Jennifer Weller, Dr Damian Castanelli and others (table 5.2). This has been facilitated by the college providing access to the college membership for distribution of surveys via the college Fellowship Affairs unit. There has also been ongoing investment in training WBA assessors to increase quality of feedback provided to trainees (standard 8.1).

Qualitative studies consistently demonstrate the value of WBAs in enhancing observation and feedback, though there is room for improvement. Supervisors and trainees report lack of understanding of the entrustment scale, and confusion about the formative and summative purposes of WBAs. Choice of lenient assessors and easy cases can limit learning from a case. Review of submitted WBA forms reveals limited documentation of actionable feedback.

Table 5.2 Studies of WBA and supervision in ANZCA training

Study	Finding	Application in the anaesthesia training program
Weller et al Br J Anaesth 2022 (in press)	Explored reasons SOT use shadow systems *[qualitative]*	Proposed design principles for future WBA
Weller et al Br J Anaesth 202;127:703	Scoping review on innovations in WBA tools	Will inform final options for competency-based medical education (CBME, see '*Improvement opportunities and future plans'*)
Castanelli et al Adv Health Sci Educ Theory Pract 2020;25:131	Performance decisions often made using 'shadow systems' rather than the formal assessment portfolio *[qualitative]*	Portfolio improvements under the lifelong learning project (standard 4) and the training program evolution project (standard 5)

Study	Finding	Application in the anaesthesia training program
Castanelli et al Anaesth Intens Care 2019 0310057X19853593	Conflicting roles of SOT in coaching and assessing leading to dilemmas *[qualitative]*	Support through group decision-making and more standardised e-portfolio (see *'Improvement opportunities and future plans'*)
Castanelli et al Can J Anaesth 2019;66:193	Acceptable reliability for interim with 9 WBAs and for final decisions with 15 WBAs *[67,405 WBAs analysed]*	Supports current approach
Weller et al Br J Anaesth 2017;118:207	Mini-CEX has reliability G>0.8 with only nine assessments	Supports current approach
Castanelli et al Can J Anaesth 2016;63:1345	Trainees and SOTs viewed mini-CEX potential for quality feedback, finding time for feedback challenging, contrasting goals in case selection *[qualitative]*	Training program evolution project will deliver guidance on case complexity for learning and portfolio review for progression
Weller et al Br J Anaesth 2014;112:1083	Seminal work, established reliability of entrustment scale for WBAs	Entrustment scale asks assessors to make a judgement about entrustment on a similar case in the future
Weller et al Br J Anaesth 2009;103:524	Assessors unwilling to critically evaluate trainees, withholding negative scores and feedback	Informs entrustment scale development, training program evolution project scoring and feedback template
Weller et al Br J Anaesth 2009;102:633 (ANZCA funded)	Generalisability analysis to guide numbers needed for mini-CEX reliability	High numbers needed for traditional scale, fewer for subsequently developed entrustment scale

This body of evaluative work has contributed to the deliberations of the training program evolution project (see standard 6.1). In addition, there are regular trainee surveys and consultation with SOTs and education officers (EOs) in each region or nation over the last two years. There has been consultation with other specialist training colleges, and systematic reviews of the relevant literature on CBME and group decision making (GDM). The GDM short report is at appendix 5.1.

Other changes to WBAs include:

- 2015 implementation of an online MSF in TPS, facilitating SOT collation, with trainees able to view summary results.
- In 2017, a project group reporting to EDEC investigated entrustable professional activities (EPAs) within the anaesthesia training program. Subsequently, a decision was made by EEMC to not pursue this at that time.
- In 2018, the college launched WBA support resources (see standard 4) and in 2019 the WBAs were relaunched (see standard 8.1).
- In 2018, WBA support resources were launched. These resources were developed to help SOTs, WBA assessors and trainees understand the philosophy of WBAs and their uses to enhance learning. The Networks repository is a key source of information relating to WBAs, including practical tips, checklists and a comprehensive list of frequently asked questions.

ANZCA primary examination

In the 2013 curriculum, the primary vivas were changed to integrate physiology, pharmacology, equipment and safety, with anatomy introduced. Previously, physiology and pharmacology were discrete components that could be sat separately, limiting topic integration. Examining time increased from two 20-minute vivas to three 20-minute integrated stations. Currently, candidates are examined by six examiners (previously four), with questions from at least 12 different curriculum areas. A template for viva selection ensures all candidates receive a similar experience in terms of difficulty and content relevance. The outcome of these changes is that candidates focus on clinical application of basic sciences to an initial anaesthesia plan or treatment. This has strengthened overall exam quality.

In 2016, the MCQ component became a pass/fail barrier. This change was in response to a highly sophisticated online repository of remembered exam questions that compromised exam integrity, which had relied on post hoc analysis. The benchmark for achieving the standard is now set pre-emptively using the Ebel method. Since 2016, ACER undertakes post hoc analysis of the MCQ examination paper to ensure that primary exam standard setting produces a fair, reliable and valid exam.

In 2021, following consultation with ACER, the MCQ questions were changed from single best answer with five options to single best answer with four options. The relevant ACER analysis showed the fifth distractor was rarely chosen and did not affect question difficulty. Removal of the fifth distractor reduced candidate cognitive load and made question writing easier. ACER communicated that there was a successful transition, providing a more valid exam, less open to cheating by reduced reliance on using repeated questions.

In recent years, the SAQ paper has moved to a hybrid-marking scheme incorporating a holistic element to reward understanding of the material rather than just a list of facts. Examiner training has taken place on producing these rubrics. All SAQ papers are marked against a pre-prepared rubric (see appendix 5.2 for primary exam rubric and appendix 5.3 for final exam rubric). Shadow marking for the SAQ paper has also been introduced to achieve consistency and greater calibration amongst markers. Further work on strengthening wording of questions to reduce misinterpretation is underway.

In 2020, the PESC with EEMC approval and council endorsement determined that candidates who are invited to the viva component but were unsuccessful overall can carry an MCQ component pass to the next exam sitting. This was introduced in 2021 and backdated for 2020 candidates. Data are being collected to evaluate, but it is too early to determine the impact of this change.

ANZCA final examination

In 2017 ACER were engaged for the final exam leadership group to provide technical advice and assistance on elements of examination design and quality. Subsequently, ACER has analysed marks for each exam sitting for greater insight into exam validity. This has assisted in understanding exam processes and provided a platform for future developments. The FESC regularly discusses future plans, partly based on the ACER reports.

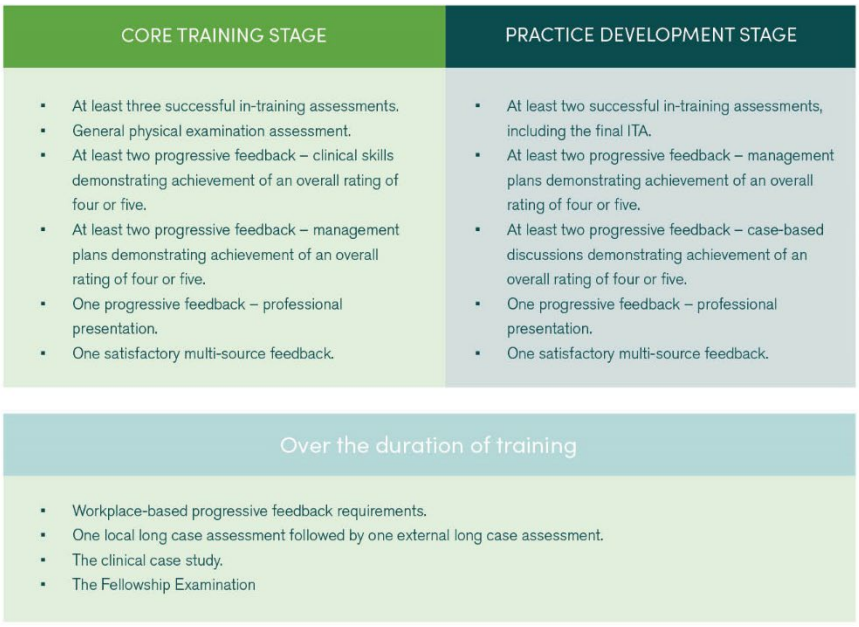
At the end of 2020, the FESC reviewed the examination and agreed to permit trainees who had achieved a greater than 50% score in both the MCQ and SAQ but were unsuccessful in the viva to carry their written scores over to the next exam sitting. This assists candidates with preparation and facilitates progression.

In 2021, the FESC endorsed moving from five to four MCQ distractors. This decision was driven by ACER data analysis in line with the primary exam rationale above. Also in 2021, to decrease the relevance of an unofficial online remembered questions repository, the MCQ stems for the past five years were released. It is firmly believed that releasing the stems will lessen the unknown aspects of the examination and remove the propensity to remember and share the stems and answer options.

Pain medicine training program

The pain medicine training program assessment requirements are detailed in figure 5.2.

Figure 5.2 Pain medicine training program assessment requirements



FPM workplace-based progressive feedback

Regular WBA was introduced in the 2015 FPM training program. In 2018 WBA was renamed workplace-based progressive feedback to emphasise its formative rather than summative purpose. The WBPF tools which cover the key skills of specialist pain medicine physicians are:

1. General physical examination.
2. Clinical skills assessment.
3. Management plans.
4. Case-based discussions.
5. Professional presentations.
6. Multi-source feedback.

The tools are linked to specific learning outcomes from the curriculum and are not limited to specific types of pain. These tools will be reviewed in the 2022 assessment strategy review.

FPM examinations

In 2015, the FPM fellowship examination was changed as part of the curriculum review project. It was redeveloped with a written component of 10 short answer questions and an oral component of four structured viva voce examination stations and four OSCE stations. Each written question and oral station is linked to curriculum learning outcomes.

The FPM fellowship examination is held once a year. Trainees can sit it in either stage of training and must pass both the written and oral components in the same sitting. In 2015, the number of allowed attempts was changed from 10 to five, mirroring the maximum duration that each trainee can spend in the program. Trainees who commenced training prior to the 2015 program are still allowed 10 attempts.

The fellowship examination assesses learning outcomes across the breadth of the curriculum. Developing a blueprint of assessments is an identified outcome of the current assessment strategy review by the Learning and Development Committee (see *'Improvement opportunities and future plans'* at the end of this standard).

For sustainability, a pool of experienced examiners has been built by recruiting five to seven examiners per year. FPM currently has over 50 examiners, representing more than 10% of practising fellows.

FPM - other assessments

The **clinical case study** is the key scholar role activity within the pain medicine training program. A document to guide trainees' progress with this piece of work is available on the website along with the password-protected marking criteria (appendix 5.4). The goals of the clinical case study are to develop:

- Trainee knowledge, skill and judgment in identifying, acquiring, selecting and prioritising, positive and negative patient information that is relevant to a particular case presentation . .

- Trainee knowledge, skill and judgment in identifying, acquiring, selecting and prioritising scientific literature that is relevant to particular patient information in a particular case presentation.
- Trainee knowledge and skill in integrating relevant patient information and relevant scientific literature to understand the patient's presentation and condition(s) and how these may be best managed.
- Trainee knowledge and skill in clinical reasoning with clinical data and such relevant literature as may be available, in order to make professional judgments and form professional opinions, and, develop a comprehensive, sociopsychobiomedical formulation encompassing a diagnostic impression and case formulation from which an individually tailored, multidisciplinary management plan is presented.
- Trainee knowledge and skill in implementing and evaluating a patient-centred management plan and adjusting that plan based on outcome assessment.

The **long case assessment** was separated from the fellowship examination in 2015. Trainees completed two formal long case assessments, marked by examiners. The sustainability of this assessment was a challenge and the faculty received consistent feedback from trainees, supervisors and examiners seeking change. The changes made since 2015 are:

- A long case assessor role was introduced to increase the pool of fellows who had experience in this assessment. FPM specifically targeted supervisors of training who were not examiners to be part of this process.
- Whilst initially trainees were required to complete one long case per training stage, this changed to at least one of the two being undertaken during the practice development stage.
- In 2020, the first long case became a formative assessment undertaken in the training unit with just the second long case being a summative assessment undertaken by examiners and long case assessors.

It is anticipated that this assessment will become formative and be undertaken within the training unit as part of a programmatic assessment approach.

Blueprinting

Anaesthesia training

The curriculum clearly outlines the requirements for each training stage (core units and provisional fellowship training). Assessment of trainees comprises a range of different approaches blueprinted against the learning outcomes described in the curriculum. The assessment tools for each learning outcome are tabulated as shown in the figure below. Sampling occurs throughout training and through blueprinted exams.

*Figure 5.3 Anaesthesia curriculum example with mapping of assessments to learning outcomes**

1.1 Medical expert

By the end of training, a trainee will be able to:

Code	Learning outcome	Role	Assessment
1. Practice medicine within their defined scope of practice and expertise			
AR_ME 1.1	Demonstrate a commitment to high-quality patient care	ME	CEX, FEx
AR_ME 1.2	Integrate the roles of collaborator, communicator, health advocate, leader and manager, medical expert, professional, and scholar into practice as an anaesthetist	ME	CEX, FEx
AR_ME 1.3	Apply knowledge of the clinical and biomedical sciences relevant to anaesthesia	ME	PEx, FEx
AR_ME 1.4	Perform appropriately timed clinical assessments with management plans and recommendations that are presented in an organised manner	ME	CEX
AR_ME 1.5	Carry out professional duties in the face of multiple, competing demands	ME	CbD, CEX, FEx
AR_ME 1.6	Recognise and respond to the complexity, uncertainty, and ambiguity inherent in medical practice	ME	CbD, CEX

** CEX mini-CEX, FEx final exam, PEx primary exam, CbD case-based discussion*

The primary exam MCQ paper is developed according to a template which ensures questions are picked across all of the learning outcomes mapped to the primary examination curriculum. The SAQ paper is also selected according to a template to ensure that a consistent range of core and non-core topics are picked in each examination. Topics selected for the viva examination are chosen in conjunction with each SAQ paper to prevent overlap of material examined and ensure that a wide range of learning outcomes are examined at each sitting.

There is no current examination blueprint for either examination.

Pain medicine training

The FPM Training Handbook advises trainees and their supervisors that competencies related to the knowledge, behaviours and clinical skills pertinent to a specialist medical practitioner in the discipline of pain medicine will be tested at the examination. These competencies are found in sections one, two and three of the curriculum. The content in section four, optional topic areas is not assessed in the fellowship exam. Following the 2019-2021 curriculum review, the FPM is now commencing a review of the assessment philosophy and strategy which will include blueprinting the assessments to specific learning outcomes (see *'Improvement opportunities and future plans'* at the end of this standard).

Valid methods of standard setting

Anaesthesia training

Current standard setting methods - Primary exam

- **MCQ paper:** Ebel commenced in 2016. A group of approximately 15 examiners sit the paper blindly and set the relevance and difficulty for each question. The scores are aggregated and applied to an Ebel matrix to develop the final cut score for the

examination. ACER contribute by checking the assessment and validity of exam questions after each exam.

- **SAQ paper:** Criterion method. All questions have a peer-reviewed marking rubric developed prior to the examination. The rubric identifies the expected standard for a borderline candidate and passing candidate and provides guidance for marking questions well below the standard and of a high standard (0-5 scale). Reference material is provided with each marking rubric using material obtained from the core references suggested for primary examination candidates. Each question is marked by single examiner with shadow marking by a senior examiner of a random sample of the questions to ensure consistency.
- **Viva:** Standard setting via the criterion method. Question authors provide a marking rubric indicating the minimum expected standard for a passing candidate and also guidance for candidates across the full range of the performance scale (0-5). At the conclusion of each day of examining, all examiners involved review all scores to ensure that they have been entered correctly and that there are no inconsistencies detected (at the court meeting).

Current standard setting methods - Final exam

- **MCQ paper:** Norm referenced (mean +/- 1SD), standardised. Under guidance of ACER, the Modified Anghoff method was trialled in 2018 and compared with the norm-referenced method. Bookmarking method to be trialled in 2022 with the assistance of ACER. This bookmarking process will be undertaken in conjunction with the regular process and the results compared to analyse whether changes should be made.
- **SAQ paper:** the criterion method is utilised in the development of the SAQ paper. A panel of 12 to 15 expert examiners determine requirements for a minimum pass for each question and outline these requirements for a single marker. Each SAQ is then double marked by a second marker. All markers are given the marking guide that is developed by the examiner panel, which outlines minimum requirements as well as background knowledge, appropriate references and suggested answers. A marking rubric is also provided as a guide to marking.
- **Medical viva:** The criterion method is used to score the medical viva, with requirements for a minimum pass for each question determined by panel of experts (eight to 10 final examiners). These requirements are then reviewed by the entire examiner panel (80 examiners) and adjusted as necessary. A marking rubric is also provided as a guide to examiners for this process.
- **Anaesthesia vivas:** The criterion method is also used for marking this component of the final exam. The requirements for a minimum pass for each question are determined by a panel of experts (15 to 20 final examiners). Answers which lead to a fail are also determined prior to the viva to assist examiners and provide greater consistency in marking and as part of the calibration process. A marking rubric is provided to examiners to assist with consistency in marking based on the response provided by a candidate and to remove subjectivity.

Changes since 2012 accreditation and impact – Primary examination

Since 2017, ACER has been involved in the psychometric equating methodologies and comparing differences in exam difficulty and cohort ability across different exams. They

attend the examiner workshops, providing assistance and teaching of the current assessment standards.

In December 2017, a PESC standard-setting workshop considered the minimum knowledge a competent candidate would need to demonstrate at the examination. The workshop considered passing standards, marking rubrics, question data bank and the impacts of the black bank and viva practice, an evaluation of current and future examiner skills, competencies and training of current and new examiners. An action plan is under development to advance this work. Similar workshops were to be conducted in 2020 and 2021, but were cancelled due to the implications of COVID-19.

Changes that were introduced in 2018 include:

- Increased SAQ paper reading time to 15 minutes, with candidates now allowed to make notes on the question paper.
- Five point global rating scale for SAQs along with double marking for all SAQ questions.
- A workshop for current examiners to upskill and educate on the standard-setting process.
- The PESC undertook a study to better understand the relationship of basic demographic factors to examination success or failure.

Changes since 2012 accreditation and impact – Final examination

Since 2012, changes to standard setting in the final exam have included:

- The key investigation was the 'ANZCA Advancing Exams Initiative. Summary Report I to ANZCA: Final Examination', August 2017 (appendix 5.5). This identified standard setting across the exam as an area for development.
- In 2018, the FESC worked with ACER to trial modified Angoff and Bookmark Methods, using data from the 2017.2 exam. Further work was undertaken using the MCQ 2018.2 MCQ exam. Based on a statistical review, candidates must now achieve at least 40% in the SAQ and MCQ and pass at least one out of MCQ, SAQ and medical exam, in order to progress to the anaesthesia vivas.

Pain medicine training

Current standard setting methods FPM fellowship exam

- **Written component:** The FPM Examination Committee identifies the learning outcomes and content areas to be assessed in each written question and oral station. A nominated examiner authors the question and accompanying marking guide. Questions are then tested on examiners to ensure that the meaning is clear and the expectations around how much can be written in the timeframe is appropriate and that the marking guides allows for differences in practice across different regions. Questions and marking guides are revised based on the feedback, before being reviewed by ACER.
- **Oral component:** The Examination Committee identifies the learning outcomes and content areas to be assessed in each written question and oral station. An examiner then authors the station and accompanying marking guide. The content is then reviewed, practised and calibrated by the group of examiners assessing the station.

Once the content is finalised by the examiners it is reviewed by the oral examination lead and Examination Committee chair.

Changes since 2012 accreditation and impact

- In 2017, ACER reviewed several years of FPM examination material and attended the 2017 oral examination, interviewing examiners ahead of making recommendations (appendix 5.6). In recent years, ACER has supported the examination process by reviewing written marking guides as part of the quality assurance process. ACER has also reviewed written examination marks and provided analysis of a range of metrics summarising the quality and difficulty of the questions and the examination overall from a statistical standpoint. These metrics are used by the FPM Examination Committee when reviewing examination scores and determining pass marks. ACER also attends Examination Committee meetings where the marks from the written examination are discussed, to provide clarification on their analysis as required.

5.3 Performance feedback

The AMC accreditation standards are as follows:	
5.3 Performance feedback	
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.

Regular and timely performance feedback

Anaesthesia training

In-training feedback and reviews

WBAs include written fields to document feedback to the trainee on their performance, including a field for trainee reflection and planned actions. All written comments on the mini-CEX, WBA and CBD forms are visible to trainees. The TPS provides reminders to trainees when the run rates for WBAs are falling behind.

Regular reviews between trainees and their supervisors provide feedback, confirm training requirement completion and, in some cases, involve progression decisions:

- Clinical placement reviews (CPRs): these are undertaken at the beginning (planning CPR) and end of each placement (feedback CPR). They must occur at least every six months and more frequently if required. An interim CPR is undertaken if a trainee remains at the same site for longer than six months.

- Specialised study unit reviews (SSURs): these provide feedback and signoff that requirements for each specialised study unit (SSU) are met.
- Core unit reviews (CURs): occur at the end of IT, BT and AT, for SOT feedback to trainees and decision on progression to next training stage, on basis of demonstrating expected level of performance.
- Provisional fellowship reviews (PFRs): occur at the completion of PFT, confirming performance at expected level and eligibility to apply for fellowship.

Improving feedback conversations

Changes to the scholar role activities in 2020 provide a pathway for trainees to participate in five specific AEP modules (see standard 3). These changes include “Feedback to enhance learning” as an alternative pathway for trainees to demonstrate they have achieved relevant teaching learning outcomes in the scholar role. The feedback module explores feedback literacy including features of the feedback literate learner, a) appreciation of the purpose of feedback, b) capacity to make sound judgments, c) maintain emotional equilibrium and d) take action based on the feedback. The module exposes participants to feedback frameworks for engaging in feedback conversations.

Feedback on examinations

Both examination sub-committees publish detailed information on the exams at the end of each examination. These are available in Networks. Reports from the most recent primary examination sitting are in appendix 5.7 and final examination sitting in appendix 5.8.

Primary examination

All unsuccessful trainees are provided with detailed written feedback on all components of the examination. As of 2017, the raw score of the MCQ component (out of 150 total marks) is provided as a bracket, with performance in the core areas in the MCQ paper as a percentage. As of 2018, the raw score of each SAQ (0-5) is provided to unsuccessful candidates. Additionally for any questions in the SAQ exam or viva exam where the candidate has scored less than 40%, they receive individual written feedback detailing specific shortcomings and errors.

Trainees may request a feedback interview within four weeks of failing the examination. This is based on the results for their most recent examination sitting only. It is held with a senior examiner either face-to-face or by videoconference and includes:

- Detailed consideration of the score breakdown, highlighting problems and suggesting remedies.
- Consideration of any supporting information such as examiner feedback sheets which are completed for candidates who score below 1 out of 5 in any SAQ or viva question.
- Exploration of the candidate’s departmental support and exam preparation.

The interview is an interactive supportive session aimed to improve the trainee’s chance of success in their next attempt at the examination, with a focus on trainees engaging their SOT throughout the process for appropriate support.

In 2019, two **fundamentals of success** workshops were held by a group of senior examiners for candidates who had multiple failed exam attempts to address the psychological aspects of failure and to teach skills to improve exam performance in a collegial way. There was also an opportunity for these often-marginalised candidates to form peer networks. Although COVID-19 meant these workshops were not held in 2020 and 2021, the PESC aims to recommence them in 2022. Initial feedback was excellent both subjectively and in terms of pass rates; however, data points are still limited and it is intended that further analysis of the impact of the intervention occur.

Final examination

Trainees can request a **feedback interview** within four weeks of failing the examination. This is held with a senior examiner either face-to-face or by videoconference and includes:

- Detailed consideration of the score breakdown, highlighting problems and suggesting remedies.
- Consideration of any supporting information such as examiner feedback sheets which are completed for candidates who score below 3 out of 10 in any SAQ or viva question.
- Exploration of the candidate's departmental support and exam preparation.

Both anaesthesia examinations

Any candidate who has had three or four unsuccessful exam attempts must attend a remediation interview (RI), a process instigated by the college. These interviews are framed as positive, supportive sessions for trainee to establish a structured approach to preparation for their next exam attempt, using the GROW coaching conversation model. It is expected that trainees who require an RI have already had a feedback interview with an examiner at previous unsuccessful attempts at the exam and have attended or will attend an examination support workshop.

The three-stage process encourages active participation, critical thinking, planning and preparation by the trainee. Key areas of the RI are:

1. Identifying factors relating to examination difficulty, reviewing trainee preparation and facilitating positive study habits. Formulating an action plan to improve capacity to pass the examination at the next attempt.
2. Focusing on candidate study habits. Trainees are strongly advised to reflect on their examination preparation with their SOT prior to attending the session. A checklist aids reflection and analysis of past exam effort.
3. An action plan is formulated having evaluated trainee training, work and social context. Timing of future examination attempts is addressed and forms part of the RI recommendations. Optimal timing of the next attempt balances readiness to sit versus time limits on training and employment opportunities.
4. For the primary examination, it is expected that the trainees will have attended a fundamentals of success workshop addressing expectations of the examination and providing guidance on MCQ, SAQ and viva performance.

An example of a redacted remediation interview form and workplan is in appendix 5.9. A comparison of the remediation and feedback interviews is in table 5.3. The number of remediation interviews from 2017 to 2021 is in table 5.4.

Table 5.3 Comparison of feedback and remediation interviews

Remediation Interview	**Feedback request / interview**
Regulation 37.14.5.1.3 Handbook 2.14.7	Handbook 2.14.7
Compulsory after three unsuccessful attempts	Optional at any unsuccessful attempt
Initiated by the college	Initiated by SOT
Conducted by the EO	Conducted by an exam representative
Attended by trainee, EO, SOT and mentor	Attended by SOT and candidate
Face-to-face or videoconferencing	Teleconference or videoconference
Exam performance at past three or four attempts discussed	Current unsuccessful attempt discussed
Meeting to documented with RI form submitted to college	Informal meeting
Action plan required	Action plan not required

Table 5.4 Number of remediation interviews for the ANZCA exams from 2017 to 2021

Exam sitting	**ANZCA primary exam**	**ANZCA final exam**
2017.1	10	7
2017.2	24	5
2018.1	23	6
2018.2	15	6
2019.1	5	4
2019.2	15	4
2020.1	11	4
2020.2	7	2
2021.1	12	1

Pain medicine training

In-training feedback and reviews

Multiple opportunities for formative assessment occur in the workplace. Formative assessments require trainees to identify clinical opportunities for development of competence across a variety of skills articulated in the curriculum. Feedback is provided to assist further learning and if, performance is unsatisfactory, to assist remediation. Formal summative assessment is progressive throughout the program.

ITA is undertaken every 11 weeks, providing trainees with opportunities for regular formal review and feedback against the requirements of the training program with their nominated supervisor. The ITA cycle involves goal setting at the commencement of each 11-week period and review of progress at the conclusion. The assessment covers the trainee's progress against:

- WBPF.
- The trainee's areas of strength and areas requiring further improvement.
- Progress against proficiency in the FPM roles in practice from the level of a new trainee to that of a junior specialist pain medicine physician.

At the completion of the core training stage and the practice development stage the trainee meets with their nominated supervisor to undertake a training stage review. In this review the supervisor confirms that the trainee has met the requirements for that stage of training and confirms that the performance of the trainee is at the required level to progress.

Feedback on examinations

After each FPM fellowship examination an **examination report** (appendix 5.10) is prepared and made available to trainees. These reports are accessed via the learning management system along with a podcast that provides suggestions for trainees around structuring their study.

Trainees who are unsuccessful in the FPM fellowship examination are offered, and usually participate in a **feedback interview** with an experienced examiner. Trainees must bring a supervisor or mentor to the feedback interview to support them developing an individualised and structured plan for exam preparation over the following year. Prior to these interviews, trainees are asked to reflect on their examination experience and preparation and identify any barriers to success (appendix 5.11). The number of remediation interviews held over the last few years for Australian and Aotearoa New Zealand candidates is in table 5.5.

Table 5.5 Number of FPM fellowship examination remediation interviews for trainees in Australia and Aotearoa New Zealand

	2017	2018	2019	2020	2021
Number of unsuccessful candidates	3	8	11	13	16
% pass rate	88%	72%	70%	59%	57%
Number of remediation interviews	3	8	10	10	11

One of the challenges for pain medicine trainees who are unsuccessful at the fellowship examination on multiple occasions is that they have usually finished the clinical experience component of their training and may decide to work in their primary speciality area rather than in another pain medicine role which makes it more difficult to pass the examination. These trainees in particular are encouraged to participate in the mentoring program offered by FPM to ensure they stay connected and supported.

Long case assessments

All candidates receive individual feedback following FPM long case assessments. Examiners identify areas where each candidate performed strongly and areas which they might like to focus on (see examples in appendix 5.12).

Supervisors informed about assessment performance of trainees for whom they are responsible

Anaesthesia training

Each SOT has access to the TPS of all trainees for whom they are responsible. Rotational supervisors (ROTs) have access to those on the relevant rotation and the EOs have access to all in their region. This includes WBAs to inform progression decisions, and examination outcomes. In line with the recommendations of the Trainee Wellbeing Working Group (standard 7.4), SOTs are notified of trainee examination failure by being copied into the letter that trainees receive notifying them of this outcome.

Pain medicine training

Ahead of written examination results being sent to candidates, all pain medicine SOTs are emailed to advise that they are being released. The list of successful fellowship examination candidates is published in the *ANZCA Bulletin*. FPM trainees who attend a feedback interview after an unsuccessful attempt at the fellowship examination must bring their SOT . If they have completed their training time and no longer have a nominated supervisor they may bring along a mentor. Following a long case assessment trainees are encouraged to share the feedback with their supervisors. The future delivery of a training portfolio system will allow enable SOTs access to real-time training data on their trainees (see *"Improvement opportunities and future plans'* standard 4).

Early identification of trainees not meeting outcomes and response

Anaesthesia training

Anaesthesia trainee support process (TSP)

The TSP assists trainees who require more support. It is a staged process to guide learning and provide structured feedback. It is not a disciplinary measure but a way of exploring pathways to support trainees in difficulty.

Concerns about trainee performance should be discussed with the SOT and/or head of department. Concerns may be identified at any time including during WBAs, at the time of reviews (CPR or CUR). Trainees may also self-report difficulties. If concerns about a trainee are expressed, the SOT should act on them. Early detection and local intervention increase the likelihood of improved performance and may prevent future problems. Effective completion of this process is often rewarding.

Early indicator checklists (appendix 5.13) assist SOTs by outlining presentation, risk assessment, planning for and meeting with the trainee, action plan and options, when to consider the trainee support process, documentation and resources for:

1. Exam failure or failure to present for an exam.
2. Clinical performance issues.
3. Professionalism and/or insight deficiencies.
4. Illness.
5. Global assessment concerns.

This may lead to initiation of the TSP. When a TSP has been initiated, the SOT must advise the EO for their region or country, relevant ROT and the college as soon as practicable.

The TSP steps are:

1. The SOT contacts the trainee and schedules a meeting in advance, with some context to the meeting given.
2. The meeting takes place and could include the SOT discussing issues and the trainee providing a self-assessment. They work together to come up with an action plan which should be documented using the TSP guidelines and meeting template.
3. Completed forms are sent to ANZCA and the trainee should acknowledge the action plan.
4. The final stage is monitoring progress with a set of review dates. Once trainee performance is at an acceptable level the SOT should contact ANZCA.
5. If trainee performance does not progress, then the EO could be contacted and the ANZCA training department and DPA assessors will work with the SOT to negotiate the next steps.

Data on TSP numbers and outcomes for the past five years are in table 5.6.

Table 5.6 Anaesthesia training program TSP outcomes 2017-2021

Year	Number of trainees	Outcomes
2017	20	16 successfully completed 1 voluntarily withdrew from training program 2 withdrawn from training program 0 escalated to TPR process 1 in progress
2018	19	12 successfully completed 3 voluntarily withdrew from training program 4 withdrawn from training program 0 escalated to TPR process

Year	Number of trainees	Outcomes
2019	12	6 successfully completed 1 voluntarily withdrew from training program 3 withdrawn from training program 0 escalated to TPR process 2 in progress
2020	18	13 successfully completed 0 voluntarily withdrew from training program 2 withdrawn from training program 0 escalated to TPR process 3 in progress
2021	22	8 successfully completed 1 voluntarily withdrew from training program 0 withdrawn from training program 0 escalated to TPR process 13 in progress

Trainee performance review (TPR)

The TPR process is publicly available in regulation 37.31 and section 3.5 of the ANZCA handbook for training. The TPR process is governed by the Trainee Performance Review Sub-committee, which reports to the EEMC.

The TPR process is initiated when any of the following apply:

- Local measures (e.g. TSP) have failed to resolve a trainee's problems.
- The trainee has been suspended or has conditions or undertakings on registration by the relevant regulatory body.
- A trainee can initiate a TPR if they feel their workplace relationships are preventing a fair and valid assessment of their progress.
- The TPR Sub-committee has concerns about a trainee's progress.

The TPR steps are:

- The TPR Sub-committee selects a review team of at least three members.
- The trainee, SOT(s) and other interviewees are given notice of the process.
- The review team interviews the trainee and other relevant individuals such as past and present supervisors, colleagues, hospital staff and other trainees.

- The review team create a report which includes a recommendation for the TPR outcome, which is one of the following: 1) The trainee continues training without conditions; 2) The trainee continues training subject to meeting certain conditions or requirements; or 3) The trainee is removed from the ANZCA vocational training program.
- The TPR Sub-committee reviews and endorses the report, making a decision on actions to be taken.
- The trainee, their employing department and other relevant bodies are informed of the TPR outcome.

For the trainees who are permitted to continue in the training program with conditions, the process is:

- The TPR Sub-committee monitors the trainee, with the relevant EO submitting progress reports to the subcommittee every three months.
- The EO submits a final report to the TPR Sub-committee, indicating whether the trainee has achieved the desired level of performance within the required timeline. Trainees who have satisfactorily completed the recommendations may resume training without conditions, while the TPR Sub-committee may recommend trainees who are unable to meet conditions be removed from the training program. The final decision is sent to EEMC for approval.

Data on TPR numbers and outcomes for the past five years are in table 5.7.

Table 5.7 Anaesthesia training program TPR outcomes 2017-2021

Year	Number of trainees	Outcomes
2017	6	1 successfully completed 3 withdrew from training program 1 removed from training program 1 deceased
2018	0	Not applicable
2019	0	Not applicable
2020	0	Not applicable
2021	0	Not applicable

Pain medicine training

Every 11 weeks, supervisors will assess each ITA term as satisfactory, borderline or unsatisfactory. When a trainee received one borderline assessment through an ITA the unit will identify specific areas of development for the trainee and consider additional support necessary (see table 5.8 below).

Table 5.8 Pain medicine trainees in Australia and Aotearoa New Zealand provided additional support from 2019 to 2021 but who did not progress to a trainee experiencing difficulty process.

Trainees provided additional support			
Year	Number	% supported	Summary of outcomes
2019	1	100%	Completed by receiving a satisfactory ITA in the following quarter
2020	5	100%	Completed by receiving a satisfactory ITA in the following quarter
2021	3	66%	Two completed by receiving a satisfactory ITA in the following quarter One in progress

When a trainee receives a second borderline assessment or an unsatisfactory assessment, the trainee must enter the **trainee support process**. This process was called the trainee experiencing difficulty process (TEDP) until 2022. Requirements for this process are outlined in the FPM training handbook and are similar to that used in the anaesthesia training program. Supporting trainees though remediation processes and having difficult conversations is a recurring theme of FPM supervisor workshops.

The FPM trainee performance review process which is aligned with the anaesthesia training program process that is initiated when a trainee does not satisfactory complete a TSP, if conditions are placed on a trainee's registration or when it is determined that there are reasonable grounds for believing the trainee's performance raises a risk to patient safety, or that there are other reasonable concerns about performance. FPM has had one trainee who has entered the trainee performance review process which at the time of preparing the submission is still in progress.

Table 5.9 Pain medicine trainees undergoing remediation via TEDP from 2019 to 2021

Trainees remediated			
Year	**Number**	**% remediated**	**Summary of outcomes**
2019	1	Still in progress	Trainee interrupted training following initiation of TEDP, due to return to training in 2022
2020	2	50%	1 trainee satisfactorily completed the TEDP 1 trainee was unsuccessful in the TEDP and has commenced a TPR
2021	0	Not applicable	Not applicable

Procedures to inform employers and regulators about patient safety concerns in assessment

Anaesthesia training

The anaesthesia training program has processes to manage trainee and patient safety concerns (regulation 37.29.7). The early indicator checklists include to contact the head of department as soon as possible in the case of professional misconduct or issues that threaten the safety of patients or the trainee. Early identification of patient safety concerns is addressed in the TSP checklist. Processes for dealing with trainees under medical board or council conditions, suspension or removal from a medical register are outlined in regulation 37.30.

Pain medicine training

The pain medicine training program has processes to manage trainee and patient safety concerns. By-law 4 identifies to trainees and training units that the FPM will become involved where there are concerns around patient safety as outlined below.

- 4.15.4 Maintenance of confidentiality and the protection of the trainee's privacy must be ensured. The exceptions are the mandatory reporting requirements to external regulatory authorities, and where immediate patient safety is at risk.
- 4.15.5 Trainees should notify the faculty of any illness or disability that would preclude the safe practice of pain medicine. In cases where patient safety may be affected, the faculty reserves the right to notify medical regulatory bodies or other appropriate authorities.

Processes for dealing with trainees under medical board or council conditions, suspension or removal from a medical register are consistent with those for the anaesthesia training program and are outlined in by-law 4.16.

MCNZ requirement: Supporting mandatory reporting to MZNZ for doctors with concerns about another doctors' performance

All ANZCA processes that cover concerns about another doctor's performance, such as the complaints and notifications policy, trainee support process or trainee performance review have a mandatory first step of asking if the doctor in question may pose of risk of harm to the public. If the answer is yes, then the next step is reporting to the MCNZ or AHPRA. The college is not aware of any such notifications occurring.

FPM training by-laws reinforce the expectations around mandatory reporting requirements. Specialist pain medicine physicians have a role in treating colleagues who may be using opioids inappropriately with the potential impairment of their competency. FPM strongly backs cultural support mechanisms for the steps that occur prior to mandatory reporting . .

5.4 Assessment quality

The AMC accreditation standards are as follows:	
5.4 Assessment quality	
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.

Regular reviews of assessment quality and new methods when required

Anaesthesia training

Regular review of quality, consistency, fairness, impact and feasibility

Since 2017, the ACER forms part of the review process of the college-wide examinations for quality, consistency, in the psychometric equating methodologies and comparing differences in exam difficulty and cohort ability across different anaesthesia exams. These equating methodologies are done at every exam to enable validation of the Ebel (modified Angoff, Bookmarking) standard setting method that allow for the standard to be maintained and monitored in the ANZCA primary examination. From 2022, the ANZCA final examination will use the Ebel method of standard setting.

All new questions in both the ANZCA MCQ and the SAQ undergo a multi-stage review process by examiners prior to being selected in an exam paper. SAQ questions are set by a by a panel of experts in the area who are examiners, rubrics are set to standard, and double marking of questions to ensure fairness and quality of marking. This process is consistent across both the ANZCA primary and final examinations.

ANZCA viva questions are determined by a panel. Working groups formulate the viva questions workshopping them together to assist in developing the marking rubrics. This is also undertaken in the ANZCA final examination in the medical viva component. Each clinical and viva exam component has an appointed lead to oversee the question formation process. The rubrics/marking rubrics guide the examiner in consistent and fair marking of candidate responses and assists in calibration of examiners.

At the conclusion of every exam, the PESC and FESC meet to discuss the performance of the overall examination, discussing any changes needed.

Review and changes since 2012 accreditation

Changes implemented to the anaesthesia assessment process include the involvement of ACER in the statistical analysis of the examinations. The ANZCA primary examination introduced standard setting based on expert judgment to the MCQ. The Ebel standard setting method was adopted and the final examination introduced a modified Angoff until the 2022.1 examination. In 2022, the final examination will also be adopting the Ebel method, which increases the number of competency-based questions in the MCQ component.

As of 2017, the MCQ component of the primary examination became pass/fail. An MCQ sub-committee was established to set subsequent papers and assess every question in terms of

difficulty and importance according to a matrix (as described by Ebel). In 2018, the primary examination SAQ marking was moved to be a total per question of 5 rather than 25 marks.

In 2021, in response to the COVID-19 pandemic, a decision was made to permit the carry-over of the written score to the next sitting of the final examination. This can occur if a candidate received greater than 50% in both the MCQ and the SAQ, but failed the exam overall due to a fail in the viva component.

Since 2012, both ANZCA examination sub-committees have developed working groups that focus on the development of SAQ questions and the rubrics associated with each question to assist examiners undertaking the marking process. In addition, in 2019, reading time for the SAQ component of the written examination was increased from 10 minutes to 15 minutes. Candidates are now allowed to write during this time.

Further structured rubrics for each viva question have also been developed since the last AMC visit. The purpose of these is to increase calibration of examiners, decreasing the disparity in marking of candidates. This is analysed in the ACER analysis of results.

In 2021, both the primary and final examinations moved the MCQ to 4 instead of 5 options decreasing the number of distractors. This was based on the advice from ACER that this would not impact the quality of this examination component and would assist in the creation of high quality MCQs.

Regular review of assessment items

Each of the primary and final exam subcommittees monitor curriculum learning outcomes (LOs) and consider the validity and currency of these outcomes to each exam . .Recommendations are made to EDEC for inclusion or amendments of the LOs to be relevant and current, and mapped against the assessments scope and sequence. There has also been improved examiner familiarity with all parts of the curriculum by rotating examiner membership on exam working groups annually. As a result of this examiners have a greater understanding of the breadth of the curriculum which assists in standard setting measures for each exam.

As part of the ongoing quality improvement associated with the exams, both examinations have a process by which the SAQ questions have a peer-reviewed and the marking rubric is developed. In line with this process is the development of the rubric for the primary and final exam vivas. This rubric is designed and validated by a panel of examiners that are subject matter experts.

At the completion of each day of viva examining, each court of examiners meets to review all scoring to monitor for inconsistencies in marking and discuss performance of the candidates. This further checks that the vivas are meeting the purpose for which they were written, and is viewed as a quality assurance process.

Pass rates for summative assessments by attempt

The ANZCA Primary Examination Sub-committee and Final Examination Sub-committee, together with the examination staff, review the pass rates and drill down to analyse these by attempts. The data demonstrate decreasing likelihood of passing each exam with increasing number of attempts, with optimal pass rates at first and second sittings. These data are being further analysed to look at trends in pass rates and attempt numbers by jurisdiction.

In response to the known issue of decreased likelihood of passing with increasing exam attempts, the college is investigating equity in access to examination preparation. In addition to remedial interviews, the college has introduced the Fundamentals of Success for primary examination candidates and is investigating the development of an online exam preparation resource which can assist in knowledge acquisition and testing (standard 4) . This would provide real time feedback on preparation for candidates in specific knowledge areas, tracking their progress and mastery of each subject area. The objective is to assist candidates in preparing differently, not repeating the same errors that led to previous failed attempts.

Table 5.10 Pass rates for the ANZCA primary exam 2017.1 – 2021.2

Summative assessment name:	**Primary exam**																	
Year:	**Aggregated data – from 2017.1 – 2021.2 (5 years)**																	
	1st attempt			**2nd attempt**			**3rd attempt**			**4th attempt**			**5th attempt**			**6th attempt**		
	No. passed	**No. sitting**	**% passed**	**No. passed**	**No. sitting**	**% passed**	**No. passed**	**No. sitting**	**% passed**	**No. passed**	**No. sitting**	**% passed**	**No. passed**	**No. sitting**	**% passed**	**No. passed**	**No. sitting**	**% passed**
Total	913	1340	68.1%	188	393	47.8%	77	182	42.3%	38	92	41.3%	12	37	32.4%	5	8	62.5%
Male	585	806	72.6%	95	203	46.8%	38	98	38.8%	23	52	44.2%	7	18	38.9%	4	6	66.7%
Female	328	534	61.4%	93	190	48.9%	39	84	46.4%	15	40	37.5%	5	19	26.3%	1	2	50.0%
ACT	18	37	48.6%	6	18	33.3%	4	10	40.0%	2	4	50.0%	0	2	0.0%			
NSW	219	350	62.6%	51	114	44.7%	27	64	42.2%	10	36	27.8%	8	16	50.0%	1	1	100.0%
QLD	185	294	62.9%	55	110	50.0%	19	49	38.8%	16	26	61.5%	0	9	0.0%	2	4	50.0%
SA/NT	45	79	57.0%	18	27	66.7%	2	6	33.3%	1	3	33.3%						
TAS	23	29	79.3%	4	6	66.7%	1	2	50.0%	0	1	0.0%		1	0.0%			
VIC	196	249	78.7%	24	50	48.0%	13	27	48.1%	6	10	60.0%	2	4	50.0%	2	2	100.0%
WA	63	84	75.0%	9	22	40.9%	3	7	42.9%		1	0.0%	0	1	0.0%			
NZ	164	216	75.9%	21	46	45.7%	8	17	47.1%	3	11	27.3%	2	4	50.0%	0	1	0.0%
ATR*		2	0.0%															
Independent#	119	212	56.1%	25	59	42.4%	7	34	20.6%	10	31	32.3%	4	13	30.8%	4	5	80.0%
Rotational@	794	1128	70.4%	163	334	48.8%	70	148	47.3%	28	61	45.9%	8	24	33.3%	1	3	33.3%

*Affiliated Training Regions included Singapore, Malaysia and Hong Kong.

Independent: Trainee is in an independent position for this exam sitting

@ Rotational: Trainee is in a rotational position for this exam sitting

ANZCA
FPM

Summative assessment name:	Primary exam *Affiliated Training Regions included Singapore, Malaysia and Hong Kong.

	1st attempt			2nd attempt			3rd attempt			4th attempt			5th attempt			6th attempt		
	No. passed	No. sitting	% passed	No. passed	No. sitting	% passed	No. passed	No. sitting	% passed	No. passed	No. sitting	% passed	No. passed	No. sitting	% passed	No. passed	No. sitting	% passed
2017.1	78	115	67.8%	6	34	17.6%	4	11	36.4%	4	8	50.0%						
Male	56	77	72.7%	4	22	18.2%	1	7	14.3%	2	6	33.3%						
Female	22	38	57.9%	2	12	16.7%	3	4	75.0%	2	2	100.0%						
ACT	2	4	50.0%	0	4	0.0%												
NSW	16	27	59.3%	3	12	25.0%	4	6	66.7%	1	2	50.0%						
QLD	26	40	65.0%	2	7	28.6%	0	2	0.0%	1	2	50.0%						
SA/NT	5	5	100.0%	0	1	0.0%					1	0.0%						
TAS				0	1	0.0%												
VIC	7	11	63.6%	0	4	0.0%	0	3	0.0%	1	2	50.0%						
WA	9	9	100.0%	1	2	50.0%												
NZ	13	17	76.5%	0	3	0.0%				1	1	100.0%						
ATR*	0	2	0.0%															
Independent	5	13	38.5%	2	7	28.6%	1	1	100.0%	1	1	100.0%						
Rotational	73	102	71.6%	4	27	14.8%	3	10	30.0%	3	7	42.9%						
2017.2	**89**	**129**	**69.0%**	**20**	**41**	**48.8%**	**10**	**29**	**34.5%**	**3**	**8**	**37.5%**	**0**	**3**	**0.0%**			
Male	61	78	78.2%	12	22	54.5%	8	18	44.4%	3	6	50.0%	0	2	0.0%			
Female	28	51	54.9%	8	19	42.1%	2	11	18.2%	0	2	0.0%	0	1	0.0%			
ACT	1	4	25.0%	1	1	100.0%	1	4	25.0%									
NSW	20	29	69.0%	6	10	60.0%	4	10	40.0%	1	5	20.0%	0	1	0.0%			
QLD	12	20	60.0%	9	16	56.3%	1	4	25.0%	1	1	100.0%	0	1	0.0%			

Summative assessment name:	Primary exam *Affiliated Training Regions included Singapore, Malaysia and Hong Kong.																	
SA/NT	6	11	54.5%	0	1	0.0%												
TAS	3	3	100.0%	0	1	0.0%	0	1	0.0%									
VIC	34	42	81.0%	3	5	60.0%	2	6	33.3%	1	2	50.0%						
WA	5	8	62.5%															
NZ	8	12	66.7%	1	7	14.3%	2	4	50.0%				0	1	0.0%			
Independent	15	22	68.2%	1	6	16.7%	0	5	0.0%	0	1	0.0%						
Rotational	74	107	69.2%	19	35	54.3%	10	24	41.7%	3	7	42.9%	0	3	0.0%			
2018.1	69	109	63.3%	16	38	42.1%	6	20	30.0%	3	12	25.0%		2	0.0%			
Male	40	58	69.0%	8	17	47.1%	4	13	30.8%	2	8	25.0%						
Female	29	51	56.9%	8	21	38.1%	2	7	28.6%	1	4	25.0%	0	2	0.0%			
ACT	2	6	33.3%	0	1	0.0%				0	1	0.0%						
NSW	20	33	60.6%	4	9	44.4%	1	6	16.7%	1	6	16.7%						
QLD	18	31	58.1%	7	13	53.8%	3	7	42.9%	2	3	66.7%	0	2	0.0%			
SA/NT	2	5	40.0%	2	3	66.7%	1	1	100.0%									
TAS	0	1	0.0%				1	1	100.0%	0	1	0.0%						
VIC	7	9	77.8%	0	7	0.0%	0	1	0.0%	0	1	0.0%						
WA	7	9	77.8%	1	3	33.3%												
NZ	13	15	86.7%	2	2	100.0%	0	4	0.0%									
Independent	9	13	69.2%	2	6	33.3%	1	8	12.5%	1	4	25.0%						
Rotational	60	96	62.5%	14	32	43.8%	5	12	41.7%	2	8	25.0%		2	0.0%			
2018.2	106	145	73.1%	25	40	62.5%	12	21	57.1%	7	17	41.2%	2	6	33.3%	1	1	100.0%
Male	68	88	77.3%	9	18	50.0%	3	6	50.0%	3	7	42.9%	2	5	40.0%	1	1	100.0%
Female	38	57	66.7%	16	22	72.7%	9	15	60.0%	4	10	40.0%	0	1	0.0%			

ANZCA
FPM

Summative assessment name:	Primary exam *Affiliated Training Regions included Singapore, Malaysia and Hong Kong.																	
ACT	1	1	100.0%	2	5	40.0%	0	1	0.0%	0	1	0.0%						
NSW	22	38	57.9%	4	12	33.3%	4	5	80.0%	2	5	40.0%	1	3	33.3%	1	1	100.0%
QLD	15	22	68.2%	8	11	72.7%	2	6	33.3%	3	4	75.0%	0	1	0.0%			
SA/NT	4	7	57.1%	3	3	100.0%	0	1	0.0%									
TAS	4	4	100.0%	1	1	100.0%												
VIC	33	37	89.2%	2	2	100.0%	4	5	80.0%	1	2	50.0%	1	2	50.0%			
WA	6	7	85.7%	2	2	100.0%	1	2	50.0%									
NZ	21	29	72.4%	3	4	75.0%	1	1	100.0%	1	5	20.0%						
Independent	11	19	57.9%	1	3	33.3%	3	6	50.0%	3	10	30.0%	1	3	33.3%			
Rotational	95	126	75.4%	24	37	64.9%	9	15	60.0%	4	7	57.1%	1	3	33.3%	1	1	100.0%
2019.1	80	117	68.4%	20	37	54.1%	3	12	25.0%	2	5	40.0%	6	11	54.5%			
Male	45	66	68.2%	10	19	52.6%	1	9	11.1%	2	2	100.0%	2	4	50.0%			
Female	35	51	68.6%	10	18	55.6%	2	3	66.7%	0	3	0.0%	4	7	57.1%			
ACT	4	5	80.0%				0	2	0.0%	1	1	100.0%	0	1	0.0%			
NSW	22	31	71.0%	5	14	35.7%	1	5	20.0%				4	7	57.1%			
QLD	22	33	66.7%	2	4	50.0%	0	3	0.0%	1	3	33.3%						
SA/NT	6	12	50.0%	3	4	75.0%												
TAS	2	4	50.0%										0	1	0.0%			
VIC	7	11	63.6%	4	6	66.7%	1	1	100.0%				1	1	100.0%			
WA	5	7	71.4%	0	1	0.0%												
NZ	12	14	85.7%	6	8	75.0%	1	1	100.0%	0	1	0.0%	1	1	100.0%			
Independent	9	15	60.0%	1	2	50.0%	0	2	0.0%	1	2	50.0%	2	4	50.0%			
Rotational	71	102	69.6%	19	35	54.3%	3	10	30.0%	1	3	33.3%	4	7	57.1%			

ANZCA
FPM

Summative assessment name:	Primary exam *Affiliated Training Regions included Singapore, Malaysia and Hong Kong.																	
2019.2	120	177	67.8%	16	36	44.4%	10	20	50.0%	4	11	36.4%	1	3	33.3%			
Male	77	112	68.8%	10	21	47.6%	5	10	50.0%	2	7	28.6%						
Female	43	65	66.2%	6	15	40.0%	5	10	50.0%	2	4	50.0%	1	3	33.3%			
ACT	1	3	33.3%	1	1	100.0%				1	1	100.0%	0	1	0.0%			
NSW	27	44	61.4%	6	10	60.0%	5	9	55.6%	1	6	16.7%						
QLD	24	40	60.0%	5	13	38.5%	2	4	50.0%	1	2	50.0%	0	1	0.0%			
SA/NT	4	6	66.7%	2	4	50.0%	0	1	0.0%									
TAS	4	6	66.7%	1	1	100.0%												
VIC	31	42	73.8%	0	4	0.0%	2	3	66.7%	1	1	100.0%						
WA	5	7	71.4%	1	2	50.0%	0	1	0.0%									
NZ	24	29	82.8%	0	1	0.0%	1	2	50.0%	0	1	0.0%	1	1	100.0%			
Independent	20	36	55.6%	1	4	25.0%	0	1	0.0%	1	4	25.0%	0	1	0.0%			
Rotational	100	141	70.9%	15	32	46.9%	10	19	52.6%	3	7	42.9%	1	2	50.0%			
2020.1	88	126	69.8%	24	46	52.2%	5	12	41.7%	2	7	28.6%	2	3	66.7%	1	1	100.0%
Male	63	80	78.8%	14	25	56.0%	3	6	50.0%	2	5	40.0%	2	2	100.0%	1	1	100.0%
Female	25	46	54.3%	10	21	47.6%	2	6	33.3%	0	2	0.0%	0	1	0.0%			
ACT	1	3	33.3%		1	0.0%												
NSW	24	34	70.6%	6	12	50.0%	1	3	33.3%	1	3	33.3%	2	3	66.7%			
QLD	20	29	69.0%	7	17	41.2%	2	3	66.7%	1	3	33.3%						
SA/NT	7	11	63.6%	2	3	66.7%	1	2	50.0%	0	1	0.0%						
TAS	3	3	100.0%															
VIC	7	11	63.6%	7	8	87.5%	1	2	50.0%							1	1	100.0%
WA	10	15	66.7%	0	2	0.0%	0	1	0.0%									

ANZCA
FPM

Summative assessment name:	**Primary exam** *Affiliated Training Regions included Singapore, Malaysia and Hong Kong.																	
NZ	16	20	80.0%	2	3	66.7%	0	1	0.0%									
Independent	10	17	58.8%	5	8	62.5%	1	1	100.0%	0	3	0.0%	1	1	100.0%	1	1	100.0%
Rotational	78	109	71.6%	19	38	50.0%	4	11	36.4%	2	4	50.0%	1	2	50.0%			
2020.2	52	91	57.1%	11	24	45.8%	5	14	35.7%	2	5	40.0%	1	2	50.0%			
Male	30	50	60.0%	5	12	41.7%	3	8	37.5%	0	1	0.0%	1	2	50.0%			
Female	22	41	53.7%	6	12	50.0%	2	6	33.3%	2	4	50.0%						
ACT	0	2	0.0%	0	1	0.0%												
NSW	13	25	52.0%	3	8	37.5%	2	6	33.3%				1	1	100.0%			
QLD	7	17	41.2%	1	6	16.7%	2	5	40.0%	1	2	50.0%	0	1	0.0%			
SA/NT	0	2	0.0%	2	2	100.0%												
TAS	3	3	100.0%	2	2	100.0%												
VIC	18	24	75.0%				1	2	50.0%									
WA	1	3	33.3%	1	2	50.0%				0	1	0.0%						
NZ	10	15	66.7%	2	3	66.7%	0	1	0.0%	1	2	50.0%						
Independent	11	21	52.4%	4	6	66.7%	0	2	0.0%	0	1	0.0%	0	1	0.0%			
Rotational	41	70	58.6%	7	18	38.9%	5	12	41.7%	2	4	50.0%	1	1	100.0%			
2021.1	126	165	76.4%	26	47	55.3%	13	24	54.2%	6	9	66.7%	0	5	0.0%	1	1	100.0%
Male	76	96	79.2%	12	24	50.0%	8	12	66.7%	4	5	80.0%	0	3	0.0%	1	1	100.0%
Female	50	69	72.5%	14	23	60.9%	5	12	41.7%	2	4	50.0%	0	2	0.0%			
ACT	4	6	66.7%	1	2	50.0%	2	2	100.0%									
NSW	35	48	72.9%	6	15	40.0%	2	5	40.0%	1	3	33.3%						
QLD	21	28	75.0%	10	14	71.4%	6	11	54.5%	2	2	100.0%	0	3	0.0%	1	1	100.0%
SA/NT	8	11	72.7%	1	2	50.0%	0	1	0.0%	1	1	100.0%						

Summative assessment name:	Primary exam *Affiliated Training Regions included Singapore, Malaysia and Hong Kong.																
TAS	2	2	100.0%														
VIC	21	24	87.5%	4	7	57.1%	0	1	0.0%	2	2	100.0%	0	1	0.0%			
WA	12	16	75.0%	2	2	100.0%	2	3	66.7%									
NZ	23	30	76.7%	2	5	40.0%	1	1	100.0%	0	1	0.0%	0	1	0.0%			
Independent	9	17	52.9%	5	9	55.6%	0	4	0.0%	0	1	0.0%	0	3	0.0%	1	1	100.0%
Rotational	117	148	79.1%	21	38	55.3%	13	20	65.0%	6	8	75.0%	0	2	0.0%			
2021.2	106	167	63.5%	24	50	48.0%	9	19	47.4%	5	10	50.0%	0	2	0.0%	2	5	40.0%
Male	70	102	68.6%	11	23	47.8%	2	9	22.2%	3	5	60.0%				1	3	33.3%
Female	36	65	55.4%	13	27	48.1%	7	10	70.0%	2	5	40.0%	0	2	0.0%	1	2	50.0%
ACT	2	3	66.7%	1	2	50.0%	1	1	100.0%									
NSW	21	42	50.0%	8	12	66.7%	3	9	33.3%	2	6	33.3%	0	1	0.0%			
QLD	20	34	58.8%	4	9	44.4%	1	4	25.0%	3	4	75.0%				1	3	33.3%
SA/NT	3	9	33.3%	3	4	75.0%												
TAS	2	3	66.7%															
VIC	31	38	81.6%	4	7	57.1%	2	3	66.7%							1	1	100.0%
WA	3	3	100.0%	1	6	16.7%							0	1	0.0%			
NZ	24	35	68.6%	3	10	30.0%	2	2	100.0%							0	1	0.0%
Independent	21	40	52.5%	3	8	37.5%	1	4	25.0%	3	4	75.0%				2	3	66.7%
Rotational	85	127	66.9%	21	42	50.0%	8	15	53.3%	2	6	33.3%	0	2	0.0%	0	2	0.0%

Table 5.11 Pass rates for the ANZCA final exam 2017.1 – 2021.2

Summative assessment name:	**Final exam**																									
Year:	**Aggregated Data – from 2017.1 – 2021.2 (5 years)**																									
	1st attempt			**2nd attempt**			**3rd attempt**			**4th attempt**			**5th attempt**			**6th attempt**			**7th attempt**			**8th attempt**			**9th attempt**		
	No. passed	**No. sitting**	**% passed**	**No. passed**	**No. sitting**	**% passed**	**No. passed**	**No. sitting**	**% passed**	**No. passed**	**No. sitting**	**% passed**	**No. passed**	**No. sitting**	**% passed**	**No. passed**	**No. sitting**	**% passed**	**No. passed**	**No. sitting**	**% passed**	**No. passed**	**No. sitting**	**% passed**	**No. passed**	**No. sitting**	**% passed**
Total	**1030**	**1323**	**77.9%**	**185**	**280**	**66.1%**	**39**	**100**	**39.0%**	**18**	**56**	**32.1%**	**12**	**39**	**30.8%**	**6**	**22**	**27.3%**	**3**	**14**	**21.4%**	**1**	**5**	**20.0%**	**0**	**1**	**0.0%**
Male	421	541	77.8%	82	115	71.3%	12	35	34.3%	9	23	39.1%	4	13	30.8%	0	5	0.0%	1	6	16.7%	1	4	25.0%	0	1	0.0%
Female	609	782	77.9%	103	165	62.4%	27	65	41.5%	9	33	27.3%	8	26	30.8%	6	17	35.3%	2	8	25.0%	0	1	0.0%			
ACT	22	30	73.3%	5	7	71.4%	0	2	0.0%	0	2	0.0%	0	2	0.0%											
NSW	258	339	76.1%	45	74	60.8%	10	31	32.3%	5	19	26.3%	2	12	16.7%	2	8	25.0%	0	4	0.0%	1	3	33.3%			
QLD	217	277	78.3%	46	60	76.7%	10	16	62.5%	2	7	28.6%	5	9	55.6%	1	3	33.3%	1	4	25.0%						
SA/NT	58	77	75.3%	11	17	64.7%	1	6	16.7%	4	6	66.7%	1	4	25.0%	1	2	50.0%									
TAS	18	23	78.3%	3	6	50.0%	0	2	0.0%	0	2	0.0%	1	2	50.0%	1	1	100.0 %									
VIC	217	271	80.1%	36	55	65.5%	7	18	38.9%	2	9	22.2%	3	7	42.9%	1	4	25.0%	0	2	0.0%	0	1	0.0%	0	1	0.0%
WA	74	97	76.3%	16	24	66.7%	4	9	44.4%	1	3	33.3%	0	2	0.0%	0	3	0.0%	2	3	66.7%						
NZ	164	202	81.2%	23	33	69.7%	6	11	54.5%	2	4	50.0%	0	1	0.0%											
ATR*	2	7	28.6%		4	0.0%	1	5	20.0%	2	4	50.0%				0	1	0.0%	0	1	0.0%	0	1	0.0%			
Independent#	54	80	67.5%	16	26	61.5%	8	13	61.5%	2	7	28.6%	4	9	44.4%	1	6	16.7%	2	8	25.0%	0	2	0.0%	0	1	0.0%
Rotational @	953	1166	81.7%	148	200	74.0%	26	54	48.1%	10	25	40.0%	3	14	21.4%	1	5	20.0%	0	1	0.0%	1	1	100.0 %			
ATR*	2	7	28.6%	0	4	0.0%	1	5	20.0%	2	4	50.0%				0	1	0.0%	0	1	0.0%	0	1	0.0%			
SIMG	21	70	30.0%	21	50	42.0%	4	28	14.3%	4	20	20.0%	5	16	31.3%	4	10	40.0%	1	4	25.0%	0	1	0.0%			

*Affiliated Training Regions included Singapore, Malaysia and Hong Kong.

Independent: Trainee is in an independent position for this exam sitting

@ Rotational: Trainee is in a rotational position for this exam sitting

ANZCA
FPM

Summative assessment name:	Final exam																								
	1st attempt			2nd attempt			3rd attempt			4th attempt			5th attempt			6th attempt			7th attempt			8th attempt			9th attempt		
	No. passed	No. sitting	% passed	No. passed	No. sitting	% passed	No. passed	No. sitting	% passed	No. passed	No. sitting	% passed	No. passed	No. sitting	% passed	No. passed	No. sitting	% passed	No. passed	No. sitting	% passed	No. passed	No. sitting	% passed	No. passed	No. sitting	% passed
2017.1	**123**	**154**	**79.9%**	**12**	**21**	**57.1%**	**5**	**14**	**35.7%**				**2**	**3**	**66.7%**	**0**	**1**	**0.0%**									
Male	69	89	77.5%	9	15	60.0%	2	7	28.6%				2	3	66.7%	0	1	0.0%									
Female	54	65	83.1%	3	6	50.0%	3	7	42.9%																		
ACT	1	3	33.3%				0	1	0.0%																		
NSW	32	45	71.1%	3	5	60.0%	1	2	50.0%																		
QLD	24	27	88.9%	6	8	75.0%	1	1	100.0 %				2	2	100.0 %												
SA/NT	6	8	75.0%	1	2	50.0%	0	1	0.0%				0	1	0.0%												
TAS	3	4	75.0%	1	1	100.0 %																					
VIC	41	44	93.2%	0	1	0.0%	0	4	0.0%																		
WA	6	9	66.7%				1	1	100.0 %																		
NZ	10	13	76.9%	1	3	33.3%	2	3	66.7%																		
ATR*	0	1	0.0%	0	1	0.0%	0	1	0.0%							0	1	0.0%									
Independent	0	1	0.0%	0	1	0.0%	0	1	0.0%							0	1	0.0%									
Rotational	4	5	80.0%	1	2	50.0%	1	2	50.0%				1	1	100.0 %												
ATR*	117	137	85.4%	9	14	64.3%	3	8	37.5%				1	1	100.0 %												
SIMG	2	11	18.2%	2	4	50.0%	1	3	33.3%				0	1	0.0%												
2017.2	**77**	**119**	**64.7%**	**15**	**27**	**55.6%**	**6**	**11**	**54.5%**	**2**	**6**	**33.3%**	**0**	**2**	**0.0%**	**1**	**2**	**50.0%**	**0**	**1**	**0.0%**						
Male	44	64	68.8%	10	16	62.5%	4	8	50.0%	1	3	33.3%	0	1	0.0%	1	2	50.0%									
Female	33	55	60.0%	5	11	45.5%	2	3	66.7%	1	3	33.3%	0	1	0.0%				0	1	0.0%						
ACT	1	2	50.0%	1	2	50.0%																					

ANZCA
FPM

Summative assessment name:							Final exam																				
NSW	15	21	71.4%	3	10	30.0%	1	3	33.3%							0	1	0.0%									
QLD	17	31	54.8%	3	3	100.0 %	2	3	66.7%	0	1	0.0%							0	1	0.0%						
SA/NT	6	8	75.0%	2	2	100.0 %	0	1	0.0%	1	2	50.0%	0	1	0.0%	1	1	100.0 %									
TAS	1	2	50.0%	1	1	100.0 %																					
VIC	10	14	71.4%	2	3	66.7%	1	2	50.0%	1	3	33.3%															
WA	3	5	60.0%	2	3	66.7%							0	1	0.0%												
NZ	24	33	72.7%	1	3	33.3%	1	1	100.0 %																		
ATR*	0	3	0.0%				1	1	100.0 %																		
Independent	3	3	100.0 %	1	1	100.0 %	1	1	100.0 %				0	1	0.0%	0	1	0.0%	0	1	0.0%						
Rotational	74	104	71.2%	12	19	63.2%	4	8	50.0%	1	4	25.0%	0	1	0.0%												
ATR*	0	3	0.0%				1	1	100.0 %																		
SIMG	0	9	0.0%	2	7	28.6%	0	1	0.0%	1	2	50.0%				1	1	100.0 %									
2018.1	**130**	**158**	**82.3%**	**26**	**39**	**66.7%**	**3**	**14**	**21.4%**	**3**	**8**	**37.5%**							**1**	**1**	**100.0 %**	**0**	**1**	**0.0%**			
Male	75	88	85.2%	11	19	57.9%	2	8	25.0%	2	4	50.0%							1	1	100.0 %						
Female	55	70	78.6%	15	20	75.0%	1	6	16.7%	1	4	25.0%										0	1	0.0%			
ACT	3	4	75.0%	1	1	100.0 %				0	1	0.0%															
NSW	31	39	79.5%	4	6	66.7%	1	8	12.5%	0	2	0.0%															
QLD	24	28	85.7%	9	14	64.3%				1	1	100.0 %							1	1	100.0 %						
SA/NT	4	5	80.0%	2	2	100.0 %																					
TAS	3	4	75.0%																								
VIC	32	40	80.0%	2	4	50.0%	1	1	100.0 %	0	1	0.0%															

ANZCA
FPM

Summative assessment name:	Final exam																										
WA	16	18	88.9%	2	2	100.0%	0	1	0.0%																		
NZ	16	19	84.2%	6	8	75.0%	1	3	33.3%	0	1	0.0%															
ATR*	1	1	100.0%	0	2	0.0%	0	1	0.0%	2	2	100.0%										0	1	0.0%			
Independent	4	5	80.0%	1	1	100.0%				1	2	50.0%							1	1	100.0%						
Rotational	123	145	84.8%	22	29	75.9%	2	7	28.6%	0	3	0.0%															
ATR*	1	1	100.0%	0	2	0.0%	0	1	0.0%	2	2	100.0%										0	1	0.0%			
SIMG	2	7	28.6%	3	7	42.9%	1	6	16.7%	0	1	0.0%															
2018.2	**72**	**91**	**79.1%**	**17**	**25**	**68.0%**	**4**	**11**	**36.4%**	**5**	**11**	**45.5%**	**3**	**7**	**42.9%**	**0**	**1**	**0.0%**	**0**	**1**	**0.0%**						
Male	41	48	85.4%	6	11	54.5%	4	7	57.1%	3	6	50.0%	2	4	50.0%				0	1	0.0%						
Female	31	43	72.1%	11	14	78.6%		4	0.0%	2	5	40.0%	1	3	33.3%	0	1	0.0%									
ACT	2	2	100.0%																								
NSW	25	29	86.2%	6	8	75.0%	1	2	50.0%	3	8	37.5%	1	2	50.0%												
QLD	19	23	82.6%	4	4	100.0%	1	4	25.0%				1	1	100.0%				0	1	0.0%						
SA/NT	3	6	50.0%	0	1	0.0%				1	1	100.0%	1	1	100.0%												
TAS	2	2	100.0%	0	1	0.0%																					
VIC	5	7	71.4%	4	7	57.1%	1	1	100.0%	0	1	0.0%	0	3	0.0%												
WA	5	8	62.5%	1	2	50.0%										0	1	0.0%									
NZ	11	14	78.6%	2	2	100.0%	1	2	50.0%	1	1	100.0%															
ATR*								2	0.0%																		
Independent	4	5	80.0%							0	2	0.0%	1	2	50.0%				0	1	0.0%						
Rotational	66	76	86.8%	15	19	78.9%	3	7	42.9%	5	6	83.3%	2	3	66.7%	0	1	0.0%									

ANZCA
FPM

Summative assessment name:	Final exam																										
ATR*							0	2	0.0%																		
SIMG	2	10	20.0%	2	6	33.3%	1	2	50.0%	0	3	0.0%	0	2	0.0%												
2019.1	**152**	**192**	**79.2%**	**10**	**23**	**43.5%**	**3**	**10**	**30.0%**	**2**	**8**	**25.0%**	**2**	**4**	**50.0%**	**1**	**5**	**20.0%**	**0**	**1**	**0.0%**						
Male	107	134	79.9%	3	10	30.0%	1	6	16.7%	1	4	25.0%	1	2	50.0%	1	3	33.3%	0	1	0.0%						
Female	45	58	77.6%	7	13	53.8%	2	4	50.0%	1	4	25.0%	1	2	50.0%		2	0.0%									
ACT	5	6	83.3%		1	0.0%																					
NSW	36	49	73.5%	1	6	16.7%	1	2	50.0%	0	1	0.0%	1	3	33.3%	0	1	0.0%									
QLD	28	35	80.0%	3	4	75.0%	0	1	0.0%	1	3	33.3%															
SA/NT	12	14	85.7%	1	3	33.3%	0	1	0.0%																		
TAS	3	3	100.0 %	0	1	0.0%	0	1	0.0%																		
VIC	30	41	73.2%	0	1	0.0%	1	4	25.0%				1	1	100.0 %	1	3	33.3%									
WA	12	14	85.7%	2	3	66.7%	1	1	100.0 %	0	1	0.0%					1	0.0%									
NZ	25	28	89.3%	3	3	100.0 %				1	1	100.0 %															
ATR*	1	2	50.0%		1	0.0%				0	2	0.0%							0	1	0.0%						
Independent	6	8	75.0%	0	1	0.0%	1	1	100.0 %	1	1	100.0 %	1	1	100.0 %	0	3	0.0%									
Rotational	140	170	82.4%	5	11	45.5%	2	3	66.7%	1	3	33.3%															
ATR*	1	2	50.0%	0	1	0.0%				0	2	0.0%							0	1	0.0%						
SIMG	5	12	41.7%	5	10	50.0%	0	6	0.0%	0	2	0.0%	1	3	33.3%	1	2	50.0%									
2019.2	**55**	**85**	**64.7%**	**25**	**40**	**62.5%**	**2**	**10**	**20.0%**	**2**	**7**	**28.6%**	**0**	**8**	**0.0%**	**0**	**1**	**0.0%**	**1**	**2**	**50.0%**						
Male	27	49	55.1%	15	25	60.0%	0	5	0.0%	1	5	20.0%	0	4	0.0%	0	1	0.0%	0	1	0.0%						
Female	28	36	77.8%	10	15	66.7%	2	5	40.0%	1	2	50.0%	0	4	0.0%				1	1	100.0 %						
ACT				1	1	100.0 %	0	1	0.0%				0	1	0.0%												

ANZCA
FPM

Summative assessment name:	Final exam																										
NSW	15	19	78.9%	6	12	50.0%	2	5	40.0%		1	0.0%	0	2	0.0%	0	1	0.0%									
QLD	13	23	56.5%	7	7	100.0 %	0	1	0.0%		1	0.0%	0	4	0.0%												
SA/NT	4	6	66.7%	2	3	66.7%	0	2	0.0%	1	1	100.0 %															
TAS							0	1	0.0%		1	0.0%															
VIC	7	9	77.8%	6	12	50.0%				1	3	33.3%							0	1	0.0%						
WA	5	10	50.0%	2	3	66.7%							0	1	0.0%				1	1	100.0 %						
NZ	11	18	61.1%	1	2	50.0%																					
Independent	3	9	33.3%	3	3	100.0 %	0	2	0.0%					2	0.0%				1	1	100.0 %						
Rotational	51	73	69.9%	19	32	59.4%	2	4	50.0%	1	1	100.0 %	0	4	0.0%												
SIMG	1	3	33.3%	3	5	60.0%	0	4	0.0%	1	6	16.7%	0	2	0.0%	0	1	0.0%	0	1	0.0%						
2020.1	**116**	**148**	**78.4%**	**23**	**29**	**79.3%**	**7**	**12**	**58.3%**	**1**	**4**	**25.0%**	**2**	**4**	**50.0%**	**0**	**4**	**0.0%**	**0**	**3**	**0.0%**						
Male	69	90	76.7%	16	22	72.7%	6	8	75.0%	0	2	0.0%	1	3	33.3%	0	2	0.0%	0	2	0.0%						
Female	47	58	81.0%	7	7	100.0 %	1	4	25.0%	1	2	50.0%	1	1	100.0 %	0	2	0.0%	0	1	0.0%						
ACT	3	4	75.0%																								
NSW	30	39	76.9%	3	4	75.0%	3	6	50.0%	1	2	50.0%		1	0.0%	0	2	0.0%	0	2	0.0%						
QLD	24	30	80.0%	6	9	66.7%	1	1	100.0 %	0	1	0.0%	1	1	100.0 %	0	1	0.0%									
SA/NT	3	5	60.0%	1	1	100.0 %																					
TAS	3	5	60.0%							0	1	0.0%		1	0.0%												
VIC	37	45	82.2%	2	2	100.0 %	2	3	66.7%				1	1	100.0 %												
WA	8	12	66.7%	4	5	80.0%	1	2	50.0%							0	1	0.0%	0	1	0.0%						
NZ	8	8	100.0 %	7	8	87.5%																					

Summative assessment name:	Final exam																									
Independent	11	16	68.8%	7	9	77.8%	2	2	100.0%	0	1	0.0%							0	2	0.0%					
Rotational	102	125	81.6%	14	17	82.4%	5	9	55.6%							0	2	0.0%								
SIMG	3	7	42.9%	2	3	66.7%	0	1	0.0%	1	3	33.3%	2	4	50.0%	0	2	0.0%	0	1	0.0%					
2020.2	**61**	**77**	**79.2%**	**12**	**14**	**85.7%**	**3**	**6**	**50.0%**	**2**	**6**	**33.3%**	**0**	**1**	**0.0%**				**0**	**2**	**0.0%**					
Male	33	39	84.6%	7	9	77.8%	3	6	50.0%	1	4	25.0%	0	1	0.0%											
Female	28	38	73.7%	5	5	100.0%				1	2	50.0%							0	2	0.0%					
ACT	2	2	100.0%	1	1	100.0%					1	0.0%														
NSW	12	15	80.0%	4	5	80.0%		1	0.0%		2	0.0%							0	1	0.0%					
QLD	13	15	86.7%	5	6	83.3%	2	2	100.0%																	
SA/NT	5	6	83.3%				1	1	100.0%	1	2	50.0%														
TAS																										
VIC	7	13	53.8%	1	1	100.0%		1	0.0%				0	1	0.0%				0	1	0.0%					
WA	4	4	100.0%	1	1	100.0%				1	1	100.0%														
NZ	18	22	81.8%					1	0.0%																	
Independent	2	4	50.0%	1	3	33.3%	1	2	50.0%										0	1	0.0%					
Rotational	58	69	84.1%	11	11	100.0%	2	3	66.7%	1	5	20.0%							0	1	0.0%					
SIMG	1	4	25.0%					1	0.0%	1	1	100.0%	0	1	0.0%											
2021.1	**143**	**169**	**84.6%**	**16**	**24**	**66.7%**	**2**	**4**	**50.0%**	**1**	**4**	**25.0%**	**2**	**5**	**40.0%**	**2**	**3**	**66.7%**	**1**	**2**	**50.0%**	**0**	**1**	**0.0%**		
Male	81	99	81.8%	8	14	57.1%	1	3	33.3%	0	3	0.0%	1	4	25.0%	2	3	66.7%	1	1	100.0%					
Female	62	70	88.6%	8	10	80.0%	1	1	100.0%	1	1	100.0%	1	1	100.0%				0	1	0.0%	0	1	0.0%		
ACT	2	3	66.7%																							

ANZCA
FPM

Summative assessment name:	Final exam																									
NSW	33	43	76.7%	4	5	80.0%	0	1	0.0%	1	2	50.0%	0	2	0.0%	0	1	0.0%	0	1	0.0%						
QLD	26	30	86.7%	0	1	0.0%	1	1	100.0 %				1	1	100.0 %	1	1	100.0 %									
SA/NT	8	8	100.0 %	2	3	66.7%							0	1	0.0%												
TAS	3	3	100.0 %	1	2	50.0%							1	1	100.0 %	1	1	100.0 %									
VIC	39	48	81.3%	8	10	80.0%				0	1	0.0%										0	1	0.0%			
WA	6	7	85.7%	1	3	33.3%	0	1	0.0%										1	1	100.0 %						
NZ	26	27	96.3%				1	1	100.0 %	0	1	0.0%															
Independent	11	12	91.7%	1	4	25.0%	1	1	100.0 %	0	1	0.0%	1	1	100.0 %	1	1	100.0 %				0	1	0.0%			
Rotational	129	154	83.8%	14	16	87.5%	1	2	50.0%	1	2	50.0%	0	2	0.0%												
SIMG	3	3	100.0 %	1	4	25.0%	0	1	0.0%	0	1	0.0%	1	2	50.0%	1	2	50.0%	1	2	50.0%						
2021.2	**101**	**129**	**78.3%**	**29**	**38**	**76.3%**	**4**	**8**	**50.0%**	**0**	**2**	**0.0%**	**1**	**5**	**20.0%**	**2**	**5**	**40.0%**	**0**	**1**	**0.0%**	**1**	**3**	**33.3%**	**0**	**1**	**0.0%**
Male	63	82	76.8%	18	24	75.0%	4	7	57.1%	0	2	0.0%	1	4	25.0%	2	5	40.0%	0	1	0.0%	0	1	0.0%			
Female	38	47	80.9%	11	14	78.6%	0	1	0.0%				0	1	0.0%							1	2	50.0%	0	1	0.0%
ACT	3	4	75.0%	1	1	100.0 %							0	1	0.0%												
NSW	29	39	74.4%	11	13	84.6%	0	1	0.0%	0	1	0.0%	0	2	0.0%	2	2	100.0 %				1	3	33.3%			
QLD	29	35	82.9%	3	4	75.0%	2	2	100.0 %							0	1	0.0%	0	1	0.0%						
SA/NT	7	11	63.6%													0	1	0.0%									
TAS																											
VIC	9	10	90.0%	11	14	78.6%	1	2	50.0%				1	1	100.0 %	0	1	0.0%							0	1	0.0%
WA	9	10	90.0%	1	2	50.0%	1	3	33.3%	0	1	0.0%															
NZ	15	20	75.0%	2	4	50.0%							0	1	0.0%												

ANZCA

FPM

Summative assessment name:							Final exam																				
Independent	6	13	46.2%	1	2	50.0%	1	2	50.0%				0	1	0.0%	0	1	0.0%	0	1	0.0%	0	1	0.0%	0	1	0.0%
Rotational	93	112	83.0%	27	32	84.4%	2	3	66.7%	0	1	0.0%	0	3	0.0%	1	2	50.0%				1	1	100.0 %			
SIMG	2	4	50.0%	1	4	25.0%	1	3	33.3%	0	1	0.0%	1	1	100.0 %	1	2	50.0%				0	1	0.0%			

Monitoring pass rates and responding to unacceptable rates

The ANZCA examination sub-committees review the interim and exam-end reports of each primary and final examination sitting. Discussions occur either by the sub-committees or court of examiners (at the end of the exam). Assessment of poorly performing questions, difficulty of questions compared with previous exams, changes to scoring affecting the performance, changes to exemptions affecting success and failure, conditions around the examination, such as COVID-19 impacts to trainee preparation, performance and wellbeing are discussed and considered as to how they may have impacted each exam.

When unfavourable results are identified, they are noted and addressed by each exam subcommittee. Steps are taken to address these concerns with the relevant committees, DPAs and SOTs. One of the outcomes of the identified issues is the fundamentals of success workshop, which is conducted to support trainees with multiple failures. Feedback interviews were amended to be more structured and focused. Wellbeing support was provided via the college trainee wellbeing program (standard 7.4).

Pass rates in 2021 progress report

Pass rates reported in the 2021 progress report have been used to further inform development of the anaesthesia training program and the consistency of the assessment process in each exam. Primary exam results from 2019 to 2020 indicated consistent pass rates until the 2020.2 sitting. Upon further analysis, it was concluded that the lower than average pass rate for this sitting was partly due to a number of candidates taking a lower than normal written score into the viva component of the examination. This may have been due to the initial impacts of COVID-19 on that cohort's preparation. Additionally, this cohort was informed that the college would add an additional sitting opportunity to that cohort (who had been impacted by COVID-19) hence potentially encouraging some to sit the exam when under-prepared. Subsequent pass results in the primary examination have been more consistent with prior years.

The final examination pass rates presented in the 2021 progress report demonstrate a lower than average pass rate in the 2019.2 sitting. Upon analysis of the results, this was accounted for by a greater amount of calibration activities undertaken by the court of examiners prior to the viva component. Significant time was allocated prior to the vivas on critical events in a viva that would endanger patients and how this might contribute to a fail for that viva station. As a result, it is believed that the examiner cohort became more aware of this and as a group marked accordingly, contributing to an overall lower pass rate. As a consequence, the college has undertaken bias training with the final examination court and is looking at scoring and failure rates when critical clinical events occur in a candidate's viva answer.

Comparison of different trainee cohort and SIMGs examination performance

Comparison of pass rates for independent and rotational trainees is in standard 7.1. Comparison of pass rates for trainees and SIMGs is in standard 10.

Risks in assessment

There are inherent risks in any program of assessment. Within the anaesthesia program risks associated with the volunteer examiner workforce and potential disruption due to the COVID-19 pandemic have been added to the college risk register.

The COVID-19 pandemic has highlighted risks in the assessment process specifically with the exam component. As a result, the college has been flexible in its approach to delivering exams which included increasing the number of sites for the written component and moving to a dispersed/distributed viva examination program that included online hybrid vivas. ANZCA examination sub-committees have made changes to allow candidates to carry written scores to a subsequent sitting of the exam, when the candidate meets predefined criteria.

Specific COVID-19 related risks over the last two years were identified and mitigation methods considered and enacted if needed, with guidance from the exam sub-committees and the ANZCA Council. The Assessment Advisory Committee is taking a more holistic approach to reviewing assessment in light of the college's programmatic approach and forecasted changes to introductory training. This committee, together with college education staff, identify risks and work to consider mitigation strategies as required.

Recent changes with a distributed approach to examinations have highlighted a number of positive and negative aspects to examining in this manner. The potential for bias has been a significant finding of a process in which local candidates are examined by local examiners who may have been directly associated with their training. This created potential for both positive and negative bias in marking. Should a candidate be unsuccessful in their exam attempt the pool of available local examiners to examine at the next sitting may be small and there is a higher likelihood of being re-examined by the same examiner. Feedback from candidates is positive in relation to reduced expense due to decreased travel and less time away, but the potential issues seem to outweigh the benefits. In addition, examiner feedback on this method tells the narrative of a significant impact on collegiality experienced by the examiners and increased difficulty in developing future examinations questions.

The management of identified risk is an ongoing process in assessment that will become part of the Assessment Advancement Group's remit. See also standards 1 and 6.3.

Pain medicine training

Regular review of quality, consistency, fairness, impact and feasibility

Following the implementation of the 2015 training program FPM has completed one review of the summative assessment strategy in 2018 and is in the process of commencing a broad review in 2022. The 2018 review was partly based on findings from the evaluation strategy and partly due to concerns around the sustainability of assessments. In 2022, the philosophy and assessment strategy will be reviewed, with the expected outcome a move towards a more programmatic approach.

Review and changes since 2012 accreditation

The foundations in pain medicine examination was introduced in 2015 as a barrier examination for prospective trainees, prior to commencing training. This examination consisted of 50 multiple choice questions. As it was held only twice a year, the unsatisfactory situation emerged of trainees in accredited training units who were not accruing clinical experience as they had not had the opportunity to sit or had been unsuccessful at this examination. In the 2018 assessment sustainability review, it was decided to retire this examination and instead require trainees to complete the existing online Better Pain Management modules to ensure they started training with some foundational knowledge in pain medicine.

Regular review of assessment items

Once the learning outcomes to be assessed have been identified for the examination, specific examiners are asked to draft question and marking rubrics which undergo several rounds of peer review and testing before being finalised.

At the completion of each examination, the FPM Examination Committee prepares an examination report that discusses the performance of each question and provides advice to trainees and their supervisors to support learning in that topic area. The report is discussed at the Training and Assessment Executive Committee which allows learnings from the examination to be picked up and actioned by the Learning and Development Committee who oversee the curriculum.

Pass rates for summative assessments by attempt

Data on FPM fellowship pass rates for the past five years are shown in table 5.12 to 5.16 below. This is for trainees in Australia and Aotearoa New Zealand only, with results for trainees in Hong Kong and Singapore excluded. The small numbers make subgroup comparisons challenging. In general, overall pass rates are acceptable for a post-specialist qualification.

Table 5.12 FPM fellowship exam pass rates by number of attempts in 2017

2017 FPM fellowship exam	**1st attempt**			**2nd attempt**			**3rd attempt**		
	No. sitting	**No. passed**	**% passed**	**No. sitting**	**No. passed**	**% passed**	**No. sitting**	**No. passed**	**% passed**
Total	18	16	89%	4	3	75%	2	2	100%
Male	8	6	75%	3	2	67%	-	-	-
Female	10	10	100%	1	1	100%	2	2	100%
NSW/ACT	2	2	100%	1	1	100%	-	-	-
NT	-	-	-	-	-	-	-	-	-
QLD	4	3	75%	1	1	100%	1	1	100%
SA	1	1	100%	1	0	0%	-	-	-
TAS	1	1	100%	-	-	-	-	-	-
VIC	5	5	100%	1	1	100%	1	1	100%
WA	4	3	75%	-	-	-	-	-	-
NZ	1	1	100%	-	-	-	-	-	-

Table 5.13 FPM fellowship exam pass rates by number of attempts in 2018

2018 FPM fellowship exam	1st attempt			2nd attempt			3rd attempt (or more)		
	No. sitting	No. passed	% passed	No. sitting	No. passed	% passed	No. sitting	No. passed	% passed
Total	25	19	76%	2	2	100%	2	0	0%
Male	14	10	71%	2	2	100%	2	0	0%
Female	11	9	82%	-	-	-	-	-	-
NSW/ACT	5	5	100%	-	-	-	-	-	-
NT	-	-	-	-	-	-	-	-	-
QLD	6	4	67%	1	1	100%	1	0	0%
SA	2	2	100%	-	-	-	1	0	0%
TAS	-	-	-	-	-	-	-	-	-
VIC	5	3	60%	-	-	-	-	-	-
WA	4	2	50%	1	1	100%	-	-	-
NZ	3	3	100%	-	-	-	-	-	-

Note, this includes 2 SIMG candidates who passed at their first attempt in 2018

Table 5.14 FPM fellowship exam pass rates by number of attempts in 2019

2019 FPM fellowship exam	1st attempt			2nd attempt			3rd attempt (or more)		
	No. sitting	No. passed	% passed	No. sitting	No. passed	% passed	No. sitting	No. passed	% passed
Total	29	22	76%	6	4	67%	2	0	0%
Male	16	11	69%	4	3	75%	2	0	0%
Female	13	11	85%	2	1	50%	-	-	-
NSW/ACT	8	7	88%	-	-	-	-	-	-
NT	-	-	-	-	-	-	-	-	-
QLD	5	3	60%	2	2	100%	1	0	0%
SA	-	-	-	-	-	-	1	0	05
TAS	2	1	50%	-	-	-	-	-	-
VIC	8	6	75%	2	1	50%	-	-	-
WA	3	3	100%	2	1	50%	-	-	-
NZ	3	2	67%	-	-	-	-	-	-

Table 5.15 FPM fellowship exam pass rates by number of attempts in 2020

2020 FPM fellowship exam	1st attempt			2nd attempt			3rd attempt (or more)		
	No. sitting	No. passed	% passed	No. sitting	No. passed	% passed	No. sitting	No. passed	% passed
Total	24	17	71%	5	1	20%	3	1	33%
Male	13	9	69%	4	0	0%	2	1	50%
Female	11	8	73%	1	1	100%	1	0	0%
NSW/ACT	6	3	50%	1	0	0%	-	-	-
NT	-	-	-	-	-	-	-	-	-
QLD	6	6	100%	2	0	0%	1	0	0%
SA	2	0	0%	-	-	-	-	-	-
TAS	1	1	100%	-	-	-	-	-	-
VIC	6	4	67%	2	1	50%	1	0	0%
WA	2	2	100%	-	-	-	1	1	100%
NZ	1	1	100%	-	-	-	-	-	-

Table 5.16 FPM fellowship exam pass rates by number of attempts in 2021

2021 FPM fellowship exam	1st attempt			2nd attempt			3rd attempt (or more)		
	No. sitting	No. passed	% passed	No. sitting	No. passed	% passed	No. sitting	No. passed	% passed
Total	25	18	69%	7	1	14%	5	3	60%
Male	13	9	69%	4	1	25%	4	3	75%
Female	12	9	75%	3	0	0%	1	0	0%
NSW/ACT	8	6	75%	3	1	33%	1	1	100%
NT	-	-	-	-	-	-	-	-	-
QLD	8	6	75%	-	-	-	2	1	50%
SA	2	1	50%	2	0	0%	-	-	-
TAS	1	0	0%	-	-	-	-	-	-
VIC	2	2	100%	1	0	0%	2	0	0%
WA	3	2	67%	-	-	-	-	-	-
NZ	1	1	100%	1	0	0%	-	-	-

Monitoring pass rates and responding to unacceptable rates

The FPM Examination Committee, TAEC and the FPM Board have been concerned around the declining pass rate at the fellowship examination for several years now, in particular the declining pass rate for repeat candidates. Several steps have been taken to address this, including revision of the feedback interview template and process, the introduction of a weekly tutorial program that can be accessed by all trainees and encouraging trainees to

access FPM resources including the mentoring program. Work with ACER has also been beneficial in strengthening the validity and consistency of the examination process.

The declining pass rate is one of the catalysts for commencing review of the assessment philosophy and strategy. FPM has also identified that it would like to consider resources to assist in the selection of trainees for units and resources for potential trainees to understand the skills and attributes needed to progress through the training program.

Risks in assessment

The summative assessment structure introduced in 2015 was labour intensive for a small faculty and resulted in challenges in delivering these assessments. In February 2017, FPM engaged with the ACER to provide support around standard setting, developing consistent marking guides and building confidence within the pool of examiners. The sustainability of the FPM fellowship examination was added to the ANZCA Strategic Risk Register in early 2018 and a review of summative assessment components undertaken. The included risk is in table 5.17.

Table 5.17 Sustainability of FPM fellowship examination as included in ANZCA Strategic Risk Register

Risk description	**If the FPM examinations model places stress on the limited fellow and staff resources to execute**
Risk impact	Then the examination load on a small number of fellows and staff creates the following impact: 1. Too few fellows and staff with capacity to manage the volume of work within the timeframe 2. Lack of adherence to processes and risk mitigation 3. Errors and near misses occurring in examination processes 4. Potential damage to our reputation

Maintaining assessment comparability across training sites

Anaesthesia training

Triangulation confirms variable requirements for the IAAC at different training sites and trainee perceptions that this is unfair. Most recently, this variability was confirmed through consultation with introductory training tutors from around Australia and Aotearoa New Zealand, during the training program evolution project. This will be addressed as part of a redesigned assessment process in introductory training (see '*Improvement opportunities and future plans*').

Pain medicine training

Supervisor workshops regularly include WBPF calibration sessions. However, it has been difficult with a paper-based system to analyse how consistently these are being performed across training sites. Trainees are not currently required to provide FPM with all the WBPF they complete but instead summarise them as part of the ITA process. It is expected that moving to an online system as part of the lifelong learning project (standard 4) will provide clarity on how WBPF are performed and identify additional education needs of supervisors.

Impacts of COVID-19

Anaesthesia training

Regionally convened exams

The ANZCA regional and Aotearoa New Zealand offices have become more important during COVID-19 as they were needed for viva exams that previously were held at a single central venue. Regional staff worked closely with the Melbourne ANZCA exams team to ensure a consistent approach to exams across all venues. Each venue had a process document to follow to ensure consistency implementation of all exam components.

Hybrid exam delivery

COVID-19 related travel restrictions meant that not all trainees were examined face-to-face by examiners. Viva questions were workshopped and developed via Zoom in a manner similar to prior to the pandemic. Zoom workshops for each viva question were conducted prior to the start of each exam sessions. A hybrid approach also ensured that trainees were not examined exclusively by examiners from the same region as the trainee.

College and exam staff attending AMC assessment workshop series

Senior college staff and members of the court of examiners attended the AMC online workshop series on assessment. This was a useful forum to hear from the AMC, other medical colleges, and medical education organisations on assessment scenarios and potential future directions for assessment.

Final examination medical viva redesign

Prior to COVID-19, the medical viva component of the final examination required direct observation of candidate interaction with real patients. In 2020, the community risks of this approach were considered unacceptable. Assessment of the relevant areas was incorporated into both the SAQ and anaesthesia vivas. A new format was developed by FESC, approved by council and implemented from the 2021.1 examination onwards. This includes two vivas on assessment and management of medical conditions.

In late 2020, the ANZCA Medical Viva Examination Redesign Working Group, chaired by the EEMC chair and including final examiners, a co-chair of the ANZCA Trainee Committee, an education officer, fellows with educational expertise and college education staff, explored assessment of candidate-patient interactions in the workplace. Formal guidelines for assessor section, training and processes were developed. Future work will enhance existing WBAs.

COVID-19-related progression decisions (exams and other training requirements)

In March 2020, the ANZCA Council, on recommendation from EEMC, delegated decision-making for individual anaesthesia training exemption requests to an ANZCA COVID-19 Training Progression Group. This group included the ANZCA DPA assessors, executive DPA, DPA education and the executive director, education and research. The aim was to ensure timely decisions that minimised the negative impacts of COVID-19 on training progression. This delegation lasted from March 2020 to May 2021, and was reinstated from September 2021 until May 2022 for the omicron outbreak.

The delegation allowed backdated training unit progression (basic to advanced, advanced to provisional fellowship) for those who passed a delayed ANZCA primary or fellowship examination. Backdating was to the originally scheduled examination date, provided all other requirements of that training period had also been met at that date. The delegation was also for other applications for deferral of requirements from one to training unit to the next. This included volumes of practice and mandatory courses (e.g. ALS). All exemption applications required evidence of the impact of COVID-19 on that training requirement, including support of the SOT.

Pain medicine training

Long case assessments

Long case assessment requirements changed for the beginning of the 2020 hospital employment year, with one performed within the training unit and the other summative and external. This change reduced disruptions due to COVID-19. As part of the transition arrangements, trainees who had already achieved a pass in one externally organised long case assessment in 2019 could complete the training unit-organised long case assessment to achieve this requirement. During 2020 and 2021, a number of externally organised long case assessments were postponed as shown in table 5.18. On some occasions, the second examiner participated via Zoom to ensure at least one assessor did not work with the candidate.

Table 5.18 COVID-19 related postponement of FPM long case assessments 2020-2021

Region	**Candidates**			
	2020 first sitting	**2020 – second sitting**	**2021 – first sitting**	**2021 – second sitting**
Aotearoa New Zealand	Postponed	No registrations	1	Postponed
Queensland	Postponed	4	4	1
New South Wales	No registrations	5	2	8 (delayed to Dec 2021)
Victoria	No registrations	Postponed	3	Postponed
South Australia	No registrations	No registrations	No registrations	3
Western Australia	3	1	1	3 (delayed to Dec 2021)

Some trainees applied for special consideration to sit a long case without meeting eligibility requirements. Usually these must be met by the examination closing date to ensure enough time to confirm patient availability. In consideration of the circumstances, trainees were allowed to meet eligibility as little as one week before the assessment.

From September 2021, trainees nearing the end of their training time were allowed to arrange an external long case assessment within their unit. This option will be in place until regularly scheduled external long cases can resume.

Pre-exam orientation sessions

The pre-exam orientation sessions introduced due to the change to a video conference based exam will be integrated into the standard exam.

FPM Procedures Endorsement Program

The supervised clinical experience pathway of the Procedures Endorsement Program is entirely workplace-based, where learning is facilitated by multiple observational assessments and ongoing formative feedback from the accredited supervisor. The accredited procedural supervisor declares the endorsee as eligible for endorsement when they are satisfied that the endorsee can competently and independently perform the learned procedure within the sociopsychobiomedical framework.

The assessment tools developed for the program range from low to high stakes assessments, with an emphasis on regular feedback from supervisors. The assessment tools utilised in the program are:

- Low-stake assessments: recording each procedure on the Zwisch app and receiving feedback from the supervisor.
- Mid-stake assessments: Direct observation of procedural skills assessment is used to progress the endorsee to the next level of supervision.
- High-stakes assessment: Confirmation of competence form is used by the procedural supervisor when they are satisfied that the endorsee can competently and independently perform a particular procedure within the context of the sociopsychobiomedical framework, and that they are suitable for faculty endorsement in the nominated procedure. Each procedure is signed off separately and endorsees are not required to seek endorsement in all procedures.

Accredited procedural supervisors are invited to workshops that have a particular focus on standardisation of assessment.

Other training programs

Joint Consultative Committee on Anaesthesia (JCCA)

Trainees complete a logbook which is reviewed by their supervisor at 3-, 6- and 12-month reviews, providing them with regular feedback opportunities. Trainees must achieve a satisfactory end-of-training report and three satisfactory case study presentations to their local supervisor before they present for the examination. There are no formal WBAs. Trainees who require remediation are managed at the local level with local processes. Training forms are available on the JCCA website.

The examination is run locally and, in some regions, regionally. There are two examiners, ideally one FANZCA and one general practice anaesthetist (GPA), but on occasion two FANZCAs. One can be the trainee's supervisor. The duration is 60 minutes and there is emphasis on risk assessment and management of anaesthesia complications and problems. Questions are in seven areas –obstetric anaesthesia and analgesia; epidural anaesthesia; airway assessment, difficult and failed intubation; preoperative assessment and case

selection; management of anaesthetic crises; emergency anaesthesia; and paediatric anaesthesia. The examination form, submitted to the JCCA following the assessment, is publicly available. The outcome includes endorsement of the graduate's minimum age for administering paediatric anaesthesia (three, five or ten years, with three being unusual). There is no assessment blueprinting, no standard setting process and no procedure for ensuring comparability across training sites.

The JCCA committee deals with special considerations in assessment on an individual basis. Identification and remediation of trainee underperformance is managed at a local level. Processes to inform employers and, where relevant regulatory bodies, are also in accordance with local processes.

Diploma of Rural Generalist Anaesthesia (DRGA)

Assessment requirements for award of the DRGA will include regular WBAs and two centralised examinations (see below). The draft curriculum document maps assessment methods against each learning outcome. These are clearly documented in the curriculum and handbook which will be publicly available and thus accessible to all staff, supervisors and trainees.

The WBAs, described in more detail in the curriculum document and handbook, include:

- Patient consultation observation (PCO) for structured preoperative assessment.
- Mini-CEX.
- Direct observation of procedural skills.
- Case-based discussion.
- Multisource feedback.

These will provide regular formative feedback to trainees who will be expected to reflect on comments and develop action plans to improve performance. Facilitation of feedback will occur through progress review and planning meetings every three months. This will include an initial training plan, logbook review and EPA review.

The examinations, in development, are anticipated to be:

- An MCQ examination of 50 questions randomly selected from an MCQ bank, in development for FANZCA introductory training (part of the training program evolution project). This assessment will occur in the first six months of training.
- A centrally-run Structured Assessment Using Multiple Patient Scenarios (StAMPS) examination focused on practical integration and application of knowledge in clinical practice.

Policies on special consideration in assessment are yet to be developed and will conform to the planned ANZCA-wide policy, in development. The process for early identification of trainees not meeting outcomes, including remediation action pathways and procedures to inform employers and, where appropriate, regulators, where patient safety concerns arise in assessment, are in development. A DRGA trainee support process will be implemented to support trainees experiencing difficulties. The assessments will be regularly reviewed in line with the draft education quality framework. Comparability in assessment practices and standards across training sites will be maintained by regular monitoring.

Diploma of Advanced Diving and Hyperbaric Medicine (DHM)

The assessment requirements for award of DHM diploma include WBAs and the DHM examination. These are clearly documented in the curriculum and handbook, which are publicly available and thus accessible to all staff, supervisors and trainees.

Required WBA are:

- Clinical skills assessment (3).
- Management plan assessment (2).
- Case-based discussion (2).
- Multisource feedback (1).

These ensure trainees are provided with regular formative feedback as they progress through training.

The first diploma examination was held in 2017. It is a test of knowledge, behaviours and clinical skills and is held annually. The components are:

1. **Written exam (50 marks, 50% of overall mark):** 10 short answer questions in 100 minutes, with 10 minutes of reading time prior. Candidates must score at least 50% to progress to the viva. Standard setting uses **the criterion method** with four or five DHM examiners determining the marking guide and minimum pass requirements for each question. Each question is marked by a single examiner using a marking guide and rubric with minimum requirements, background knowledge, references and suggested answers. A second marker is not used in the DHM exam due to the small pool of DHM experts in the field.
2. **Viva voce (50 marks, 50% of overall mark):** single 30-minute assessment with two examiners. Four questions with examiners marking independently (each out of 25 marks).

The viva covers a broad range of topics within the curriculum, linked to the roles in practice:

- Medical expertise, including clinical judgement, prioritisation, interpretation of complex clinical situations and anticipation of clinical actions and their sequelae.
- Collaboration, including the role and responsibilities of a DHM physician and other professionals in the healthcare team.
- Leadership, including the safe practice of DHM and improvement systems.
- Professionalism, including the trainee's approach to commonly encountered ethical issues in DHM.

Table 5.19 DHM examination pass rates 2017-2021

Year	Number sat written	Number sat vivas	Successful	Overall pass rate	Notes
2017	Revised program commenced with no candidates eligible to sit				
2018	1	1	1	100	Written and viva exam in Melbourne
2019	5	4	4	80	Written exam in regions and viva exam face to face Melbourne
2020	No candidates applied for the exam				
2021	2	3*	3	100	Written exam in regions viva - hybrid - virtual vivas

** Candidate was assessed and awarded an exception during transition (pathway 3) to only sit the viva exam, which the trainee delayed sitting until 2021. Any other transition trainees who have an exemption will need to sit the full exam as of 2022 as the deadline to carry the exemption has closed.*

Due to COVID-19 -related travel restrictions in 2021, the written and viva exams were delivered in the candidates' home states. The written exam was conducted in Tasmania for the two candidates. The vivas were conducted virtually, with the trainees and examiners attending from their home state college offices. The examiners were located in Western Australia and the trainees were in Tasmania and Queensland.

To date, only one candidate has failed the written exam. Unsuccessful candidates receive a feedback letter with raw scores and marker feedback (for written only or both written and viva components, as relevant). Those who fail are also provided with information about seeking a feedback interview with an examiner. There is no DHM remediation interview process.

Policies on special consideration in assessment are analogous to those used in anaesthesia training (handbook section 5.3). DHM assessments will be addressed in the planned college-wide review.

The DHM program recruits very senior registrars who have already been through specialist training programs or are in later stages of primary training. The requirement for continuous supervision by hyperbaric specialists also serves to limit potential safety concerns for patients. It is expected that any patient safety concerns would be raised firstly through local hospital processes (where the immediate safety issue has impact), followed by local remedy. If the issue or concern remains active, then supervisors can bring it to the attention of the DHM Sub-committee and TSP or TPR would be initiated, as relevant.

Whilst not formally monitored, documented guidance is provided for all supervisors to assist consistency of approach to WBA implementation.

Diploma of Perioperative Medicine (POM)

Assessment for the DipPOM will be through a combination of case reports, case-based discussions and observation of clinical practice. Assessment models, activities and forms aligned to the learning outcomes are yet to be finalised. All requirements will be clearly documented and publicly available.

Dual FANZCA-FCICM pathway

An array of assessment tools will be developed; each chosen for its ability to best assess achievement of learning outcomes and facilitate regular feedback to trainees on their progress. These include workplace-based assessments, clinical placement reviews, examinations, and others such as scholar role activities. Where there is common content, completion of one college's requirements may lead to recognition of prior learning for the requirements of the other. This may be applicable for some volumes of practice, mandatory courses (e.g. Advanced Life Support course) and scholar role activities. The removal of duplication will promote feasibility of the assessment load for dual trainees, their training supervisors and units.

Streamlining of curriculum content, teaching and learning resources, and assessments will be facilitated by mapping of the current outcomes of each program to the various components of the other. All requirements will be clearly documented and made publicly available.

The pathway will also clearly define how existing processes of the two colleges are tailored to meet the demands of specific circumstances such as requests for special consideration in assessment, identifying and managing underperforming trainees, and responsibility for notifying employers and, where appropriate, regulators when patient safety concerns are raised. Considerations of comparability in assessment practices and standards across training sites will also be addressed.

Strengths

College-wide workplace performance assessment (standard 5.2)

The college has established programs of assessment for all training programs with embedded WBA/WBPF tools and practices at accredited training sites.

ACER input to college-wide assessment methods (standards 5.2 and 5.4)

The college has engaged ACER for continuous improvement of high stakes assessments. Examples of outcomes include improved standard setting for ANZCA, FPM and DHM examinations.

ANZCA WBA research and quality improvement (standards 5.4 and 6)

There is a strong empirical basis for evolution of anaesthesia WBAs through internationally-cited quantitative and qualitative research. This body of work has been used to improve progressively the design of WBA in anaesthesia training.

Pain medicine assessments and continuous improvement (standard 5.4)

There is a continual focus on review and improvement of processes. Involvement by a significant proportion of the fellowship in the assessment and training of pain medicine trainees allows for broad engagement with change processes.

Improvement opportunities and future plans

FPM assessment review (standard 5.1)

Work commenced in 2021 to review the assessment philosophy and structure within pain medicine training. This work will be progressed over the next two to three years. It is anticipated that a more programmatic approach to assessment and blueprinting of assessments to specific learning outcomes will be introduced.

College-wide policy on special consideration in exams (standard 5.1)

In 2022, development of a college-wide special consideration in exams policy is planned, to be led by the Executive Director of Professional Affairs. This aims to improve consistency, transparency and ensure equitable consideration of requests. Additionally, the current policy has a narrow scope, focusing on special consideration due to events during the examination process. The review will broaden to other issues that may occur prior to the examination process. Originally scheduled for 2021, this was delayed by COVID-19.

College-wide feedback on performance: new exams management system (standard 5.3)

Feedback to all exam candidates, including those who are successful, will be explored as part of the new exams management system within the lifelong learning project (standard 4). Results of repeated college trainee surveys and the Australian Medical Training Survey confirm that even trainees who are pass exams want personalised feedback on exam performance to assist them achieve their learning goals.

ANZCA Assessment Advisory Group (standard 5.4)

During 2020 and 2021, the Examination Advancement Advisory Group (EEAG, established 2016) focused on facilitating continuity of the college suite of exams in the face of COVID-19 challenges. As a cross-college group, the EAAG provide a forum for all exam chairs and staff to discuss developments and challenges.

In 2022 this group has reformed with a refocus on the broader assessment landscape, not just examinations. The new Assessment Advisory Group met in early February 2022, with a view to identifying a roadmap for development, innovation and continued renewal of assessment in the anaesthesia training program. The college has engaged Professor Anna Ryan from the University of Melbourne, Department of Medical Education Assessment, to providing guidance on contemporary assessment methodologies to assist the college's approach.

Improved assessment standardisation in anaesthesia introductory training (standard 5.4)

Over the past two years ANZCA has investigated changes to IT in more structured WBAs are implemented, a mastery assessment undertaken (using MCQ) and a progression panel review process implemented for trainees at risk or considered to be borderline in their progress. This will be supported by an enhanced portfolio system as part of the lifelong learning project (standard 4). A WBA working group is currently reviewing WBA reporting forms to encourage and enhance formative feedback to trainees. The goal is providing trainees with more pertinent and focused feedback to promote opportunities for deliberate practice in subsequent clinical experiences. Any changes to IT assessments will be evaluated and the benefits assesses before further consideration of wider implementation into other phases of the anaesthesia training program. See also training program evolution project in standards 3 and 8.

Reliance on point-in-time high-stakes examinations at one geographical location (standard 5.4)

The pandemic has exposed the reliance that the college has on point-in-time high-stakes assessments held in one geographical location. Trainees make a significant investment in preparing for these exams and report impacts on their wellbeing, particularly followed repeated failure. The college is moving towards a more programmatic assessment approach within the training program evolution project. The goal is more continuous assessment of performance recorded in an electronic portfolio system that creates a ‘picture’ of each trainee’s progress against expected outcomes. The college is also improving standardisation across training sites of workplace assessments like the IAAC (again within the training program evolution project). In future, these developments may create the opportunity for further review and evolution of high-stakes assessments.

Standard 6

Monitoring and evaluation

Standard 6: Monitoring and evaluation

Overview

The college notes the AMC definition of evaluation is “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”. This submission uses the AMC definition of internal stakeholders as trainees, directors, supervisors, fellows and committees; and external stakeholders as those with an interest in the outcomes of specialist medical education and training, 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 Aotearoa New Zealand.

The college recognises that monitoring and evaluation are areas for improvement and has dedicated resources to address these important quality processes. Initiatives in development include a college-wide monitoring and evaluation framework, reactivation of the anaesthesia graduate outcomes survey and establishing systematic processes for seeking external stakeholder input on graduate outcomes from all training programs.

The governance and decision-making of monitoring and evaluation is overseen for anaesthesia training by the Education Executive Management Committee (EEMC), for pain medicine training by the Training and Assessment Executive Committee (TAEC), for continuing professional development (CPD) by the ANZCA and FPM CPD Committee and for specialist international medical graduate (SIMG) assessment by the SIMG Committee. While the college undertakes many monitoring and evaluation activities, a college AMC-MCNZ gap analysis in 2020 identified the lack of an overarching monitoring and evaluation framework. A college-wide framework is in development. See standard 5 for monitoring and quality improvement of assessments, and standard 9 for CPD monitoring and evaluation activities.

FPM evaluates graduate outcomes via an exit survey. ANZCA last administered a graduate outcome survey in 2016. While there are well established pathways for trainee and supervisor input to monitoring and evaluation, there are limited mechanisms for input from employers, consumers and Aboriginal and Torres Strait and Māori communities and organisations. These are areas for reflection and future improvement.

Key resources:

- ANZCA trainee survey results 2015-2020.
- ANZCA provisional fellowship survey results 2017-2021.
- ANZCA graduate outcomes survey results 2014 and 2016.
- FPM exit questionnaire results 2017-2021.
- ANZCA and FPM fellowship survey 2021 – Executive summary.

See also: Standard 2 (program and graduate outcomes).

6.1 Monitoring

The AMC accreditation standards are as follows:	
6.1 Monitoring	
6.1.1	The education provider reviews its training and education programs. Its review processes address curriculum content, teaching and learning, supervisor 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.

Regular review of training and education programs

The college regularly reviews its training and education programs including curriculum content, teaching and learning, supervision, assessment and trainee progress. Examples of recent activities include:

- From 2019 to 2021, the FPM Learning and Development Committee reviewed the pain medicine curriculum in response to systematic monitoring results and changes in pain medicine practice (standard 3).
- The training program evolution (TPE) project used comprehensive mixed methodology designs to evaluate the anaesthesia training program against international best practice. The details of individual components are in standard 3 (ANZCA competency-based medical education), standard 5 (ANZCA initial assessment of anaesthetic competence and group decision-making), standard 8.1 (educator skills) and standard 8.2 (ANZCA and FPM accreditation and learning environment).
- In response to trainee and supervisor feedback, regular changes to the ANZCA training portfolio system (TPS) have occurred since 2013 (standard 4). The most recent changes improved TPS usability via more intuitive input. Additional categories of medical conditions and surgical cases and procedures were added, making case logging more accurate.
- College fellows have extensively researched workplace assessment in anaesthesia training, resulting in its progressive optimisation (standard 5).
- The ANZCA Primary Examination Sub-committee, ANZCA Final Examination Sub-committee, FPM and DHM Sub-committee monitor pass rates in each cycle of their respective examinations (standard 5).
- In 2017, the Australian Council for Educational Research (ACER) extensively reviewed the ANZCA primary and final examinations. It provides ongoing analysis and recommendations for improvement (standard 5).

- Implementation of each training program is reviewed regularly through the ANZCA Training Accreditation Committee (TAC), FPM Training Unit Accreditation Committee (TUAC) and Diving and Hyperbaric Medicine (DHM) accreditation (standard 8.2).
- In 2019 and 2020, TUAC reviewed the pain medicine accreditation process as part of their regular review cycle. Accredited units and FPM accreditation reviewers contributed to this process. The review resulted in the retirement of level two units, introduction of a formal accreditation process for practice development stage units and revision of the accreditation criteria. Accredited level two units were individually contacted to determine their ongoing accreditation status ahead of implementation of the changes. A revised by-law 19 and the FPM Accreditation Handbook were published on the college website.
- The ANZCA and FPM CPD program undergoes regular monitoring of compliance and the CPD Committee regularly reviews participant feedback. This input is being used in the current CPD redesign (standard 9).
- After each examination, the SIMG Committee reviews examination pass rates for SIMG candidates (standards 6.3 and 10).

AMC MCNZ gap analysis

In 2020, the director of professional affairs (DPA) education, in consultation with other staff and fellows, led a gap analysis. This reviewed current college performance against AMC and MCNZ standards, to identify strategic areas that require improvement for compliance and provide opportunities for best practice. In relation to monitoring and evaluation, the gap analysis concluded that, while the college undertakes a wide range of monitoring and evaluation activities, it lacks an overarching and unifying monitoring and evaluation plan and framework. In August 2020, preliminary results were presented to the EEMC for review. Following preliminary consultation with key internal stakeholders (listed below), in November 2020, ANZCA Council approved a proposal for a college-wide educational monitoring and evaluation strategy and framework.

Monitoring and Evaluation Framework

The college committed to develop and implement a systematic monitoring and evaluation framework across the organisation to ensure best practice standards of quality improvement are consistently met, and that the loop is closed in continually improving educational offerings. The planned monitoring and evaluation framework will facilitate a continuous cycle of quality improvement, identify where to focus resources and assist with AMC and MCNZ reaccreditation.

The initial focus of the monitoring and evaluation framework will be on the Education and Research unit activities, with the intention to expand its scope college-wide. To date, the following have occurred:

- In November 2020, a first-phase consultation paper was distributed to the Executive Leadership Team, chairs of the ANZCA and FPM CPD Committee and the Perioperative Medicine Steering Committee for their input on the feasibility of college-wide application of the monitoring and evaluation framework and to identify their broad user needs. The FPM and ANZCA training and SIMG committees were not part of this consultation phase.

- In the latter half of 2021, a part-time senior research officer was appointed in the Education and Research unit to design and develop a fit-for-purpose monitoring and evaluation plan and framework.
- Initial consultation within the unit and FPM has commenced. This has included internal Education and Research unit meetings to sketch out broad parameters for the monitoring and evaluation plan and framework.
- Consultation with other colleges, including the Royal Australasian College of Surgeons (RACS), College of Intensive Care Medicine (CICM) and Australasian College of Emergency Medicine (ACEM), has also commenced. This will focus on how they address monitoring and evaluation.
- As it is envisaged that the monitoring and evaluation framework will be incorporated into business-as-usual (BAU) activities across units, the Global Health Learning Centre's monitoring and evaluation fundamentals course has been offered to the Learning and Innovation team.
- A comprehensive audit of all monitoring and evaluation activities currently undertaken by the college is well underway, which will inform framework development.

It is expected that the framework will be completed in the last quarter of 2022. As mentioned above, the framework will be generic enough to apply college-wide, however, initial development and application will be within the Education and Research unit activities.

In the short-term, the following key activities are planned to progress framework development:

- Development of a monitoring and evaluation plan and strategy.
- Development of a college-wide collaboration and stakeholder plan to ensure stakeholder representation.
- Establishment of a working group to oversee and progress framework development and implementation.
- Continued engagement with key internal stakeholders to provide input to framework design and scope.
- Identification of a suitable monitoring and evaluation framework model.

In the longer-term, the following key activities are planned:

- College-wide implementation of the monitoring and evaluation framework.
- Inclusion of the monitoring and evaluation framework in BAU activities.

Supervisors contribute to monitoring and program development

Supervisor feedback is systematically sought, analysed and used for program development, through:

- Representation on college committees, openly sought via expressions of interest. For example, of the nine clinician members of the FPM Learning and Development Committee, four are current supervisors of training (SOTs), one is the supervisor of training advisor, two are examiners and one is a new fellow. Two members completed the 2015 training program.

- Fellowship surveys, although these have a more general focus (see below).
- Feedback at accreditation visits (standard 8.2).
- Consultation on specific projects, often at regional or national SOT meetings.
- Feedback from the ANZCA education officer (EO) network.
- Specific positions for SOTs on working and project groups.
- Attendance of education staff, online or in-person, at SOT and EO meetings.

Training program evolution (TPE) project

All TPE working group terms of reference included ANZCA SOTs (or EOs) and ANZCA trainees as members. As part of its consultation to understand supervisor perspectives and test key proposals, **the Competency Based Medical Education (CBME) Working Group** presented at anaesthesia SOT meetings in each training region in 2019 and 2020, seeking feedback on the existing trainee workplace performance assessment. This was followed by two surveys on proposed changes, in 2020 and 2021. See standard 3 and report at appendix 3.6.

The **Educator Skills Project Group** selected eight educator roles to be surveyed including ANZCA SOTs, FPM SOTs, ANZCA primary examiners, ANZCA final examiners, FPM examiners, ANZCA Educators Program (AEP) facilitators, Effective Management of Anaesthetic Crises (EMAC) instructors, and departmental scholar role tutors. Due to logistical issues, FPM examiners and FPM SOTs were not surveyed. Members of the ANZCA regional and national trainee committees were also surveyed. A seven-minute slideshow video recording was produced and shown at SOT and examiner meetings. This video also accompanied surveys sent to specific educator groups. In September 2020, an interim draft report was circulated to various ANZCA and FPM committees and sub-committees for comment and feedback. Additional consultation occurred with the Scholar Role Sub-committee and the Education Development and Evaluation Committee (EDEC), prior to the submission of the final report in November 2020. See standard 8.1 and final report at appendix 6.1.

The Accreditation and Learning Environment Project Group (ALEPG) membership included ANZCA and FPM accreditors and decision-makers, a trainee representative and those who held supervisory roles. Iterative consultation was built into the project plan. Methodology included survey of all ANZCA and FPM accreditation visitors for their insights into the current processes, including areas for improvement. To define benchmarks, literature review and extensive consultation was held with accrediting organisations in the UK, Ireland, Canada and US, and with selected colleges in Australia and Aotearoa New Zealand. Consultation on draft recommendations included further input from major committees and accreditors across the college, and trainees through the ANZCA Trainee Committee. See standard 8.2 and final report on the college website.

Fellowship survey

Fellowship surveys are conducted every three or four years to evaluate fellow attitudes and needs, to improve college services and inform strategic planning (standard 1.1).

2017 fellowship surveys

In 2017, separate ANZCA and FPM fellowship surveys were performed. Health and wellbeing sections, including on bullying, discrimination and sexual harassment (BDSH),

were included with completion of these sections voluntary. This marked the first time the college centrally had collected data in this area and was in the same year as the BDSH working group report (standard 7.4). The executive summary of the 2017 fellowship survey is at appendix 6.2. Abridged findings were published in the March 2018 *ANZCA Bulletin*, the e-newsletter and on the college website.

Response rates were 36% for ANZCA fellows and 31% for FPM fellows. The anaesthesia training program was rated as the most important ANZCA function, followed by quality and safety, the CPD program and education. Specialist pain medicine physicians rated the pain medicine training program as the most important FPM function, followed by education, and quality and safety standards. Many fellows reported volunteering for the college and approximately half were interested in such a role in the future. The most desirable roles were examiner, accreditation visitor, lecturer and SOT. Interest was highest among new fellows (72%) and those aged under 40 (74%), overlapping groups.

2021 ANZCA and FPM fellowship survey

The 2021 combined ANZCA and FPM fellowship survey focused on fellows' opinions on the future direction of the college. There were nine questions covering demographics and practice profile, with the focal question asking respondents to rate the importance of various college initiatives. Results were published in the *ANZCA Bulletin* and are publicly available on the college website, promoting transparency and visibility of how member feedback is used. The executive summary with more detailed information on survey outcomes is at appendix 6.3. Results will guide development of the 2023-2025 strategic plan (standard 1.1).

Response rates were 33% for ANZCA fellows and 32% for FPM fellows. Respondent demographics (years of practice, gender and geographical location) were similar to that of all members, supporting generalisability of results. The same question on the importance of 21 items was used in both 2017 and 2021 surveys, with an 11-point rating scale from ''not at all important'' to ''essential''. The four most highly-rated priorities were training for fellowship, safety and quality, CPD and professional documents, guidelines and statements.

Surveys prior to 2021 used different questions, often measuring fellow satisfaction with services. It is planned that the questions used in the 2021 survey are repeated to generate longitudinal comparisons.

Trainee contribution to monitoring and program development

Various pathways ensure that trainees are integrated into the monitoring and evaluation approach. Trainee feedback is systematically sought, analysed and used for program development, through:

- Consultation with the ANZCA Trainee Committee (ATC) and ANZCA national and regional trainee committees (standard 7.2).
- Representation on college committees, openly sought via expressions of interest (standard 7.2).
- Representation on project groups such as training evolution (standards 3, 5 and 8), the Trainee Wellbeing Project Group (standard 7.4), and the ANZCA and FPM CPD review project (standard 9).
- Involvement in key user groups for technology projects e.g. ANZCA TPS improvements and the lifelong learning project (standard 4).

- Trainee surveys including the ANZCA trainee survey, the ANZCA provisional fellowship position survey, the FPM exit questionnaire and the MBA Medical Training Survey (Australia only).
- Feedback at accreditation visits on learning environment at training sites (standard 8.2).
- Analysis of complaints and reconsideration, review and appeal outcomes (standards 1.3 and 7.5).

Trainees lead specific project groups. Examples are the Trainee Survey Project Group (below), Trainee Wellbeing Working Group and subgroups of the Trainee Wellbeing Project Group (standard 7.4).

ANZCA trainee survey

In 2013, the AMC/MCNZ requested the college 'consider the anonymous process for trainees to give feedback on their training experiences'. In response, the then ANZCA Education Training and Assessment Development Committee (ETADC), in consultation with the ATC, developed a structured process to seek anonymous anaesthesia trainee feedback. The intention was implementation of an annual trainee survey for ongoing quality improvement of the ANZCA training program.

The first survey was conducted in 2015 by the ANZCA regional trainee committees. Subsequent surveys were administered by the Education unit (now the Education and Research unit) with assistance from KPMG Acuity who provide the survey response link, then analyse and report results. In 2017, ATC and EDEC members agreed that the survey needed review. In 2018, a small working group of trainees, education unit staff and an EDEC member with survey design and analysis experience developed a survey that could be implemented annually over the medium term without change, thus enabling longitudinal analysis. This included some region-specific questions.

The aim of the current ANZCA trainee survey is identifying issues in ANZCA training and trainee support, including geographical variation. The focus is on trainee experience over the preceding 12 months. Key areas evaluated are satisfaction with the training program, satisfaction with the hospital environment and trainee wellbeing including workplace BDSH behaviours. The 2020 survey also included questions on the training impacts of COVID-19. The survey monitors trainee experiences, providing feedback that is systematically managed within the college.

KPMG Acuity conducted the data analysis and reporting, providing:

- An executive summary of all key results.
- Detailed training program report.
- BDSH report.
- Trainee wellbeing report.
- Eight regional hospital-level reports, including individual data for each hospital in the region or country.
- Training program open-ended comments.
- BDSH open comments.

State-based (Australia) and national (Aotearoa New Zealand) open-ended comments are summarised and action plans developed to address identified issues. Collated executive summaries of the survey results from 2017-2020 are at appendix 6.4. The stakeholders who receive the ANZCA trainee survey results are listed in standard 6.3.

Trainee input to training site accreditation

In addition to the ANZCA trainee survey, both ANZCA and FPM trainees provide feedback about training sites and units as part of the accreditation process (standard 8.2). Prior to each accreditation visit, trainees currently at that site are asked to complete an online anonymous survey (appendix 8.13). These survey questions are aligned with the seven accreditation standards, and are designed to assess the quality of the learning environment. If the site has a small number of trainees, then feedback is also requested from trainees who were placed at the site during the prior training period. This promotes safety for trainees at the site. De-identified survey results are provided to the accreditation visit team prior to the visit so they can further explore and triangulate the findings of this survey. The survey results are available to TAC members.

For anaesthesia training, when issues arise at an accredited site, ANZCA trainee survey data is cross-referenced against the information provided through the accreditation process (standard 8.2). This promotes a comprehensive and clear picture of that training site.

For pain medicine training, when issues arise at an accredited unit, an off-schedule accreditation visit would normally be arranged. The usual trainee survey and meeting between the trainees and reviewers would be undertaken to understand any issues.

Medical Board of Australia Medical Training Survey (MTS)

The MTS, an annual national, profession-wide survey of doctors in training, provides national, comparative, profession-wide data about the quality and experiences of training in Australia. Survey data are intended to strengthen medical training by identifying areas for improvement including issues that could impact patient safety (e.g. environment and culture, unacceptable behaviours and poor supervision). With the recent 2021 results released, there are now three years to allow longitudinal comparisons.

The college is provided with an executive summary of the MTS results which compare ANZCA trainee responses to those of other medical colleges and specialities. In 2020, the MTS results were collated alongside ANZCA trainee survey results with key findings included in a key results and recommendations report (appendix 6.5). This was shared with the ATC and relevant ANZCA governance committees. Subsequent to the report an action plan was developed to address the identified issues (appendix 6.6). Progress on this action plan is monitored by the Executive Leadership Team with support from the Learning and Innovation unit. A similar process will be used for the 2021 MTS survey results.

Unlike ANZCA, FPM do not receive a formal report with their results compared to other colleges, however the FPM results can be filtered on the MTS website. This filtered report is considered at the Learning and Development Committee in addition to other monitoring tools. The filtered report does not include all the survey questions asked as the number of FPM respondents does not meet the response threshold. The longitudinal data presented in the filtered survey results is helpful in understanding trends and identifying areas to address.

Developments since last accreditation (2012)

- In 2012, the college introduce a survey research policy reflecting best practice and ensuring that no fellow or trainee receives more than two college-wide surveys annually. All surveys undergo stringent peer review to ensure rigorous design.
- The research toolkit, introduced in 2020, following development by the Clinical Trials Network, supports researchers undertaking surveys by including information on survey distribution and recipient lists, tips for survey development, the college application process and reporting. This is useful for trainees and committees developing surveys for monitoring and evaluation.

6.2 Evaluation

The AMC accreditation standards are as follows:	
6.2 Evaluation	
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 needs.
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.

Standards against which program and graduate outcomes are evaluated

Standard 2 describes anaesthesia and pain medicine training program and graduate outcomes, based on the breadth and definition of each specialty, community need and the roles of the specialist expressed in the ANZCA and FPM roles in practice, respectively. Anaesthesia program and graduate outcomes are evaluated using the provisional fellow plan survey and the graduate outcome survey. Pain medicine program and graduate outcomes are evaluated by the FPM exit questionnaire. As the anaesthesia graduate outcome survey has not been performed since 2016, a key future plan is to re-examine and resume graduate outcome evaluation. Other areas for improvement include better alignment of these surveys with the outcomes described in standard 2 and consideration of evaluation using methods other than surveys.

Training program evaluation

The anaesthesia training program has undergone time-limited evaluations since implementation in 2013 (see also reviews under 6.1). These include the various training evolution projects, qualitative and quantitative evaluation of workplace-based assessments (WBAs), and various ad hoc projects. Regular review of the learning outcomes and projects such as the Indigenous health learning outcomes (IHLO) project (standard 3 *'Improvement opportunities and future plans*') are other examples of evaluation with progressive improvement.

The FPM Learning and Development Committee is responsible for the regular, systematic review of the pain medicine training program, curriculum, handbook and teaching and learning resources, to ensure accuracy and quality. In 2019, it commenced a comprehensive review of the 2015 curriculum. The review lasted three years with amended documentation

publicised ahead of the 2020 and 2021 hospital employment years (HEYs), and a fully revised curriculum published ahead of the 2022 HEY. The updated curriculum is available on the college website. With this curriculum review completed, focus is now on evaluation and review of the assessment philosophy and strategy (standard 5).

Since the implementation of the 2015 pain medicine training program, FPM has had an evaluation strategy in place. The first strategy covered 2015 to 2017 and all the activities in the strategy were delivered. The second strategy from 2018 to 2021 (appendix 6.7) is still underway, delayed somewhat by COVID-19. With many opportunities for fellows to participate on committees and in roles, there is broad opportunity for fellows' engagement with FPM business. New fellows are encouraged to participate and their views are sought through representation on a number of committees and the FPM Board.

Qualitative and quantitative data on program and graduate outcomes

ANZCA provisional fellowship survey

Introduced in 2015, this survey aims to understand provisional fellows (PFs) experiences of their study plans in preparing them for specialist practice. PFs are surveyed annually, towards the end of their anaesthesia training. Input is sought on areas including transition to independent specialist practice, sub-speciality experience, clinical support activities, supervision and overall assessment of the position. The 2020 survey evaluated the impact of COVID-19 on PFs experience with their pre-approved study plans. In 2021, the survey was reviewed by the senior research officer and improvements recommended to assist in collecting meaningful and usable data.

Survey results guide the Provisional Fellowship Program Sub-committee (PFPSC) in its evaluation of each pre-approved study plan, understanding of whether training sites are meeting study plan requirements, and efforts to address any trainee concerns. The PFPSC reports on issues to the ANZCA TAC. Results of PF surveys from 2017 to 2021 are at appendix 6.8.

Graduate outcomes surveys

The college evaluated graduate outcomes via the graduate outcomes survey (GOS), introduced at the time of the last AMC accreditation. Initially developed and led by the then-new fellow councillor, it was developed in the context of graduate concerns about future employment and jurisdictional findings of workforce maldistribution, with oversupply in metropolitan areas and undersupply in regional and rural areas. The GOS purpose was to evaluate work preparedness and working patterns among new graduates. Graduate outcomes were assessed across the following broad areas – professional training, working and professional status, factors that influenced current practice location and the future.

The first online GOS was distributed in 2014 to anaesthesia graduates within three years of admission to fellowship, and in 2016 to both anaesthesia and pain medicine graduates in the same time period from graduation. This allowed the college to track how each year's graduating cohort progressed across the three years after completing training. Results assisted college improvement in its services and informed interactions with government and other decision-makers on workforce issues.

After each survey, results were made available through *ANZCA Bulletin* articles (appendix 6.9). The 2016 survey results are in appendix 6.10. The survey has not been performed since 2016. Over time, the GOS was subsumed into the fellowship survey run through the Fellowship Affairs unit, with greater focus on college services for all fellows.

FPM graduate outcomes survey

The 2016 FPM GOS (appendix 6.11) found most had a positive training experience. Seven in 10 rated the relevance of their education and training as ‘excellent’ or 'very good’. There was also strong satisfaction with the level of practical experience received. The survey identified that FPM could improve the quality of supervision and services for trainees.

FPM exit survey

Since 2016, all pain medicine trainees complete an exit survey upon finishing the training program. This is the key faculty graduate outcome evaluation activity. Key areas covered by this exit survey are:

- Access to and appropriateness of supervisor feedback.
- Breadth of training experiences across the FPM roles in practice provided by the unit, including access to a broad case-mix and exposure to a range of medical specialty and allied health disciplines.
- The orientation and education provided by the unit.
- Utility of FPM learning resources in supporting training.
- Appropriateness of the assessment tools in the training program.
- Strengths and areas of improvement for the training unit and the FPM training program.
- Whether the training program prepared them adequately for independent practice as a specialist pain medicine physician (SPMP).

Survey results have been reviewed annually by the FPM Learning and Development Committee. The committee also further interrogates specific areas that align with contemporaneous FPM work. An analysis comparing 2021-2022 exit survey results against all data collected since 2016 is at appendix 6.12.

Stakeholder contribution to program and graduate outcomes

The college seeks feedback from a range of internal stakeholders on its program and graduate outcomes. These include trainees, anaesthesia provisional fellows, fellows, and supervisors (including SOTs). While individual fellows, SIMGs and anaesthesia provisional fellows undertake evaluative activities of their own patient outcomes as part of the ANZCA and FPM CPD program (standard 9), the college does not have a systematic process for seeking feedback on employer and community perceptions of its graduates. FPM is yet to have any formalised mechanisms to gain feedback from external organisations and other stakeholders on the FPM training program and sees this as an opportunity for future development.

Recent evaluation activities

Table 6.1 Examples of recent monitoring and evaluation activities

Activities	Issues arising	College response to issues
AMC and MCNZ gap analysis (mid-2020)	Highlighted the need for an overarching and unifying monitoring and evaluation framework.	Development of an overarching framework in progress (see 6.1).
Training evolution project (2018-2021)	Multiple streams – CBME, programmatic assessment, group decision making, initial assessment of anaesthetic competence (IAAC) standardisation, educator skills, clinical learning environment at accreditation with a broad range of improvement recommendations.	See 6.1 which references specific standards for each stream.
ANZCA trainee survey (2020)	Need for stronger communication and improved advocacy for flexible working options. Consider trainee needs regarding online learning resources. Review best practice reporting and communication channels to facilitate BDSH reporting and resolution.	Assessed key findings against the trainee wellbeing project outcomes and planned BDSH reporting improvements (standard 7.4). Liaised with the ATC and EEMC to draft a response to the key findings, and gain commitment to address the issues raised.
AEP curriculum feedback through participant surveys and facilitator report (ongoing)	Module format due for review. Alignment to new competency framework delivered through the educator skills project required.	Planned comprehensive review of the AEP, ensuring feedback is assessed throughout the review process.
Online CPD portfolio survey (ongoing)	CPD participants provided feedback on needed improvements in system functionality.	Feedback to be incorporated into the lifelong learning project (standard 4) and CPD review project (standard 9).

Activities	Issues arising	College response to issues
Online emergency response education sessions (2020- 2022)	Quantitative data on approved applications and entries to CPD portfolio collected, along with qualitative data from course providers.	During the pilot period (originally 12 months from Sept 2020, but extended to end on 1 January 2023), evaluate the uptake and success of offering online sessions as an alternative delivery model for emergency response education sessions.
FPM exit survey (mid-2016 onwards)	Feedback is gathered and issues are addressed as they are identified.	Feedback is monitored and presented to relevant committees for consideration of training improvements.
Engaged ACER to evaluate examination processes (2017 onwards)	ACER was engaged to evaluate the candidate scores for the anaesthesia and pain medicine examinations to ensure the validity of standard setting and other processes.	See standard 5.
TUAC and TAC visitor surveys in ALEPG project (2019-2020)	Strengths and areas for improvement identified in ALEPG interim report.	Stakeholder feedback on ALEPG interim report in March 2021. Resulted in amendments to final report of July 2021 (standard 8.2).
Fellowship survey (3-4 yearly)	Regular feedback on fellow priorities and experience of college services.	Used to inform strategic planning (standard 1.1).
FPM online exam participants survey (2021)	Following the first oral exam delivered via Zoom, FPM sought feedback from candidates, examiners and staff to identify areas of improvement for future Zoom delivered exams.	The FPM Examination Committee considered feedback from the February 2021 oral examination via Zoom and used this to plan the November 2021 oral examination delivered via Zoom.
FPM centralised trainee tutorial evaluation (2021)	Feedback on each topic and presenter gathered at the end of each tutorial. Feedback on the design and delivery of the program via survey in August 2021. Feedback session held over Zoom to identify	The FPM Learning and Development Committee monitored and evaluated delivery of the centralised tutorial program closely during its first year of delivery (2021) to make adjustments as the

Activities	Issues arising	College response to issues
	improvements for 2022 program delivery.	year progressed and inform planning for 2022.
FPM Procedures Endorsement Program pilot evaluation (2021)	Surveys and feedback sessions with endorsees. Feedback sessions with accredited supervisors. Participation by accredited supervisors in the first part of all committee meetings discussing program delivery during the pilot.	Adjustments were made to the FPM by-law and handbook for the Procedures Endorsement Program for transition to BAU in 2022.

6.3 Feedback, reporting and action

The AMC accreditation standards are as follows:	
6.3 Feedback, reporting and action	
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 who have 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.

Monitoring and evaluation reporting through governance and administrative structures

Currently, the college regularly reports the results of its monitoring and evaluation activities through its governance and administrative structures. Feedback is considered at relevant committees including the ANZCA EEMC, FPM TAEC, ANZCA and FPM CPD Committee and ANZCA and FPM SIMG Committee.

Feedback, reporting and action will also form part of the college-wide monitoring and evaluation plan and framework, currently in development. Following completion of the monitoring and evaluation framework (expected in the last quarter of 2022), monitoring and evaluation activities, including feedback, reporting and action, will be embedded in BAU activities.

Anaesthesia program monitoring

Trainee progress through the training program is monitored via the TPS. Twice a year, education unit staff extract TPS data to create an *ANZCA training program dashboard report.* The report is shared with the EEMC. An example report is at appendix 6.13.

ANZCA trainee survey results

Results from each ANZCA trainee survey are disseminated to the:

- ANZCA Trainee Committee and Australian regional and New Zealand national trainee committees.
- ANZCA EDEC.
- ANZCA EEMC.
- CEO office, executive leadership team and directors of professional affairs (standard 1).
- ANZCA EOs.
- Accreditation officers (standard 8).

Providing there are at least five trainee responses, de-identified site results are shared with the SOT and head of department at each accredited training site. Results from the survey, along with actions taken to address issues identified, are also shared widely in the *ANZCA Bulletin*. Collated *Bulletin* articles from 2017 to 2020 are in appendix 6.14.

Medical Board of Australia Medical Training Survey (MTS)

In 2020, the results of the MTS were collated alongside those of the ANZCA trainee survey. A key results and recommendations report (appendix 6.5) was shared with the ATC, EDEC, EEMC and the ANZCA Council. Subsequently, an action plan of improvement activities was developed (appendix 6.6). This action plan is monitored by the Executive Leadership Team with support from the Learning and Innovation unit. The college also wrote to the Medical Board of Australia (appendix 6.15) sharing how key results are being used.

Pain medicine evaluation and monitoring reporting

The Learning and Development Committee has carriage of the evaluation of the training program. Evaluation is a regular agenda item and committee minutes are tabled and discussed at TAEC meetings.

SIMG assessment monitoring

To facilitate monitoring, data are collected on the SIMG assessment process (standard 10):

- Numbers of SIMG applications by country of specialisation.
- Numbers assessed as ‘not comparable’ or ‘not equivalent to’ and therefore, ineligible to enter the pathway.
- Numbers assessed as ‘substantially comparable’ and ‘partially comparable’ (and corresponding MCNZ terminology).
- Clinical practice assessment progress – where there appear to be discrepancies, these are followed up with the supervisor and SIMG.
- Exam outcomes, including number of attempts, evidence of progression with progressive improvements on each attempt and “bad” fails.

Additional monitoring could include data on what happens to SIMGs once they have been awarded fellowship, including the nature and location of their practices as well as participation in other ANZCA and FPM roles.

All results are reported to the SIMG Committee, which meets five times per year. Two of these meetings are focused on review of individual SIMG exam results. At these meetings, decisions are made regarding actions to be taken for individual SIMGs. Any systematic issues identified are used to improve SIMG policies and processes.

Evaluation results available for key stakeholders and their views considered in program renewal

The college routinely disseminates and communicates program evaluation results to key stakeholders. Examples are below:

- Supervisors, assessors and business units: Anaesthesia program evaluation results are distributed to EOs, rotational supervisors (ROTs), SOTs and heads of department. Results are also distributed to the ANZCA CEO, DPAs, the executive leadership team, ANZCA Council and ANZCA business units that submitted survey questions, including Safety and Quality, Policy and Fellowship Affairs. The chair of the 2020 Trainee Survey Working Group also received the trainee survey results and distributed this to all working group members.
- Training sites (heads of department as representatives of employers): ANZCA trainee survey results are reported anonymously to training sites. Mechanisms are in place to ensure individual trainees cannot be identified. Specifically, the 2018 Trainee Survey Working Group determined two criteria to allow for a balanced reporting method which protects individual responder anonymity, while providing relevant and timely information to individual sites. All sites that meet the following two criteria automatically receive an individual site report: (i) no fewer than eight trainees have rotated through the site over the previous 12-month period and (ii) no fewer than three trainees from the site have responded to the survey. Furthermore, training site data are reviewed by regional trainee committee chairs and TAC officers to ensure trainee safety and confidentiality are maintained.
- The report is distributed to the head of department for information, and, in 2020, site SOTs and EOs for the country, state or territory were copied into the message. Inclusion of SOTs and EOs addressed previously identified issues where questions regarding the results could not be addressed by those actively involved in the training program (because they did not have access to the results). Results from the trainee survey are shared more broadly through articles in the *ANZCA Bulletin*, often accompanied by recommended actions to address issues identified by each survey.
- Trainees and fellows: Major findings of each trainee survey and the graduate outcome survey are published in the *ANZCA Bulletin* for trainees, SIMGs and fellows, and on the ANZCA website. FPM uses its publications and supervisor workshops to share the results of evaluation activities with trainees and fellows. An example is on page 67 of the summer 2021 *Bulletin*, which refers to feedback on the centralised trainee tutorial program and the Procedures Endorsement Program pilot.
- Jurisdictions and health workforce bodies: The college contributes to workforce planning in both Australia and Aotearoa New Zealand through information-sharing and other collaboration. The college contributes a comprehensive set of de-identified data on trainee and fellow numbers, including examination outcomes, to the Australian Government Department of Health. The college is also working with the department to provide de-identified data tracking trainees through their entire training program. The college is also represented on the Victorian Department of Health Medical Workforce Planning Advisory Group and collaborates with the Queensland Health Medical Advisory and Prevocational Accreditation Unit.

- In Aotearoa New Zealand, the college collaborates on workforce planning through surveys of heads of departments, regular engagement with District Health Boards and the provision of workforce data to the Ministry of Health's Medical Workforce Taskforce, in response to specific requests.
- Aboriginal and Torres Strait Islander organisations: The college reports regularly to the Australian Indigenous Doctors Association (AIDA) specialist trainees in medical workforce project.

The college routinely communicates with the Australian Society of Anaesthetists (ASA) and the New Zealand Society of Anaesthetists (NZSA) through their attendance as observers at ANZCA Council meetings (standard 1) and through joint activities (e.g. special interest groups, standard 4). There is no systematic communication with regulatory authorities and other health professions (for anaesthesia). FPM has collaborative relationships with the New Zealand and Australian pain societies which includes other health disciplines. These groups are also sometimes included in stakeholder consultation.

Processes for regular consultation with groups listed above

The college schedule of regular meetings with external stakeholders and matters covered are in standard 1.6.

Training and education program risk management

The college manages concerns about, or risks to, the quality of its training and education programs effectively and in a timely manner. ANZCA's risk management processes are managed by the risk and governance manager and are operationalised under ANZCA's risk management framework. More information about the college's risk management procedures is in standard 1.2.

Education-related projects and activities are centrally co-ordinated with risks flagged, responded to and escalated as needed. The current education and research strategic risk report is at appendix 6.16.

Impacts of COVID-19

COVID-19 presented the most recent risk to college training and education programs. The college has continuously reviewed and adjusted its communication to ensure trainees, SIMGs and fellows receive timely and relevant information regarding changes to exams and education activities due to the pandemic. In terms of monitoring and evaluation, the following actions were taken in response to the challenges presented.

Monitoring

To monitor the impact of COVID-19 on college training programs, the college increased the frequency of check-ins with trainees, supervisors and other fellows. This enabled the college to adapt the timing of activities to accommodate individual circumstances and to avoid disadvantaging exam candidates. A key additional component of these check-in activities was monitoring wellbeing. FPM unit directors and SOTs were emailed on several occasions to enable FPM to understand how pain medicine training was being impacted in different units and regions.

To monitor the risks associated with COVID-19 among anaesthesia and pain medicine CPD participants, and to adequately respond to their numerous pandemic-related requests, the

college undertook repeated analysis of CPD activity and category completion rates. Data were extracted from the online CPD portfolios and analysed on a monthly basis. These analyses identified key areas of impact including on conferences, workshops and other training activities, and the demand to prioritise growing workforce needs. This provided an evidence-base for cancelling the 2020 verification audit of CPD activities, in line with regulatory body responses (standard 9).

Evaluation

Questions that directly assessed the impact of COVID-19 on anaesthesia training were included in the 2020 ANZCA trainee survey and the provisional fellowship position survey. For the trainee survey this impacts on trainee wellbeing, training, and examinations.

Feedback and reporting

2020 ANZCA trainee survey results on the impact of COVID-19 were analysed and reported to the CEO's office, the Executive Leadership Team, the ATC, all educational governance groups and, more broadly, to all stakeholders via the *ANZCA Bulletin*. Results from the monthly analysis of CPD activities (completion rate per CPD requirement) were shared with relevant education unit members and the ANZCA and FPM CPD Committee. The college continued this process throughout 2021.

FPM Procedures Endorsement Program

During the pilot of the supervised clinical experience pathway an evaluation strategy (appendix 6.17) was developed and implemented. Data obtained from supervisors, endorsees, staff and committee members will be considered in the transition of the program from pilot to ongoing in 2022.

The evaluation of the ongoing program will be a responsibility of the Procedures in Pain Medicine Committee which was established in 2022.

Other training programs

Joint Consultative Committee on Anaesthesia (JCCA)

There are no formal processes for systematically monitoring and evaluating JCCA training. Interested individuals have completed occasional ad hoc surveys.

Diploma of Rural Generalist Anaesthesia (DRGA)

A curriculum consultation proposal (appendix 6.18) was submitted to and approved by the Tripartite Committee of Rural Generalist Anaesthesia (TC-RGA) in October 2021. The consultation proposal included three phases of consultation to engage a variety of stakeholders.

Supervisor input

As part of the DRGA curriculum consultation phase, the JCCA, at the request of the TCRGA, invited selected supervisors from each state to participate in an online webinar to provide feedback on the draft curriculum. The aims were to (i) confirm that what has been developed is an improvement on the current program; (ii) make minor amendments required for successful implementation; (iii) engage those who will deliver the program; and (iv) foster enthusiasm about being involved in the new qualification.

A total of 23 supervisors registered and 18 attended the curriculum consultation webinar. Feedback was incorporated into an updated version of the curriculum. This version was endorsed by the TC-RGA and approved by ANZCA Council in February 2022. The DRGA curriculum has been shared with a variety of organisations and services (via email) and a link provided to a feedback survey for individuals and organisations. Stakeholders advised of the DRGA curriculum and feedback survey include the: National Rural Health Commissioner, JCCA, Australasian College of Rural and Remote Medicine (ACRRM) RGA Working Group, Royal Australian College of General Practitioners (RACGP) Anaesthetics Working Group, ACRRM Education and Training Committee, ACRRM Quality and Safety Council, Rural Doctor's Association of Australia, including state bodies, National Rural Health Alliance, Australian Society of Anaesthetists (ASA), all state RG programs, ANZCA trainees and fellows, Society for Paediatric Anaesthesia in New Zealand and Australia (SPANZA), ANZCA, ASA and NZSA Obstetric Special Interest Group, AIDA and the National Aboriginal Community Controlled Health Organisation (NACCHO).

Members of ANZCA, RACGP and ACRRM were advised of the curriculum and feedback survey through internal communication channels such as e-newsletters and website news items.

Trainee input

In the DRGA curriculum consultation phase, the JCCA, at the request of the TCRGA, invited all current JCCA trainees and 2020 graduates to participate in an online webinar to provide feedback on the draft curriculum. 15 registered and seven attended the curriculum consultation webinar. Feedback was incorporated into an updated version of the curriculum, which was then distributed more widely for additional stakeholder consultation.

Future plans

Supervisor and trainee feedback and evaluation processes will be built into the 2023 DRGA implementation to ensure monitoring and continuous quality improvement of the program. This will be facilitated by the e-portfolio, planned under the lifelong learning project (standard 4). Processes for reporting outcomes of monitoring and evaluation are yet to be determined.

Advanced Diploma of Diving and Hyperbaric Medicine (DHM)

The college recognises the importance of evaluation to ensure continuous improvement of the diploma training program. The DHM Sub-committee is tasked with regularly reviewing all program components (learning outcomes, teaching and learning methods, assessments, processes and resources) to allow progressive evolution in response to changes in DHM practice and educational innovations.

Currently, there are no systematic processes to obtain feedback from DHM trainees and supervisors, except through accreditation (standard 8). Current and past trainees may be contacted to provide information about their training experiences as part of program evaluation. As part of the ANZCA DHM training agreement, trainees are informed that information held by the college may be used for audit and quality assurance purposes for curriculum improvements and unit accreditation. All information is handled with strict confidentiality and no trainee or patient is identified.

Diploma of Perioperative Medicine (POM)

The DipPOM program will include a monitoring and evaluation strategy that links to continuous quality improvement and reports back to the POM Steering Committee. The strategy will be under the overarching college-wide monitoring and evaluation framework, yet to be developed.

Dual FANZCA-FCICM pathway

Processes for monitoring, evaluation and reporting of the dual training pathway are yet to be determined. It is anticipated that in addition to trainees and supervisors, external stakeholders such as regional and rural hospitals and consumers, will contribute to these processes.

Strengths

ANZCA trainee engagement and electronic anaesthesia training data (standard 6.1)

The anaesthesia training program has a strong culture of engagement of its trainees through the trainee committee, providing mechanisms for ongoing input to monitoring and evaluation. The training portfolio system generates a wealth of anaesthesia training data for monitoring and evaluation. The latter are regularly reported to relevant groups within the college.

Accreditation and learning environment project (standard 6.2)

The accreditation and learning environment project provided a collaborative model for cross-program evaluation to support accreditation evaluation and process redesign (standard 8). This model could be adapted for other cross-program evaluation activities to support efficient and effective learning and resource use.

Improvement opportunities and future plans

A college-wide monitoring and evaluation framework (standard 6)

The AMC MCNZ gap analysis concluded that the college currently undertakes a wide range of monitoring and evaluation activities. However, it found the following areas for improvement:

- Monitoring is not clearly articulated.
- Evaluation lacks standardisation.
- Feedback, reporting and action – actionable results from evaluation surveys are not obvious or listed on an accessible register.

An overarching and unifying monitoring and evaluation framework will bring the numerous monitoring and evaluation activities under one umbrella and provide both strategic and tactical benefits. The framework will support and contribute to effective program improvement, facilitate a continuous cycle of quality improvement and identify where to focus resources effectively and efficiently.

Reactivation of the college graduate outcome survey (standard 6.2)

While regular fellowship surveys are conducted, the last graduate outcome survey was in 2016. The college recognises that this is a key evaluative activity and plans to recommence the survey. This provides an opportunity to review methodology to ensure incorporation of best practice.

Input from external stakeholders to program and graduate outcome evaluation of all programs (standard 6.2)

The college recognises that it requires systematic processes for seeking input from external stakeholders on graduate outcomes from all training programs, particularly seeking input from employers, community members and Aboriginal and Torres Strait Islander and Māori organisations and communities. See also standard 2 *'Improvement opportunities and future plans'*.

Trainee survey (standard 6.2)

In late 2022 the college will commence a review of the biennial anaesthesia training survey in line with the recommendations of the Accreditation of the Learning Environment Project Group report (refer standard 8.2). A new evaluation approach will be introduced to align with trainee clinical placements which will link with quality improvement measures including feedback to supervisors of training. Mechanisms will be included to achieve a high trainee response rate, and protection of trainee confidentiality. The review will be undertaken in consideration of the annual Medical Board of Australia Medical Trainee Survey and existing evaluations undertaken of trainees within the accreditation processes (refer section 8.2).

Standard 7

Trainees

Standard 7: Trainees

Overview

Trainee selection is a regional and local training site process undertaken by employers. There are college-wide selection guidelines and their application is evaluated at accreditation visits. Recognising the need to review this approach, a trainee selection project will commence in 2022.

The college has a well-established approach to **ANZCA trainee representation** at ANZCA Council, where they are invited observers, and on other training-related groups. There is a cultural expectation that trainees are represented on all projects that relate to anaesthesia training. FPM has had an FPM trainee represented on the ANZCA Trainee Committee for a number of years. Occasionally FPM trainees sit on faculty committees such as Learning and Development or Regional and National Committees. Embedding FPM trainee representation in the pain medicine committee structure is an area FPM will address in 2022. This process has commenced with a formalised trainee representative position being added to the Learning and Development Committee from the beginning of 2022.

Communication with all trainees occurs via multiple traditional and new mechanisms, including the college website, e-newsletters, email and social media. Training program changes are communicated through multiple channels. This usually includes e-newsletters, the website and the *ANZCA Bulletin*. Major changes are usually communicated in writing to each trainee.

Support for trainee wellbeing is a strong part of the college doctors' health and wellbeing framework. The ANZCA trainee wellbeing project (2019-2021), which included several FPM trainees and an FPM board member, initiated significant activities in this area, many of which are now part of business as usual. The college has pathways for prevention and **resolution of training problems and disputes**, although recognises that these are not always widely recognised by trainees. There are challenges in providing safety especially for trainees in smaller departments and units.

Key resources relevant to this standard:

- College trainee selection guidelines.
- College reconciliation action plan (standard 1).
- ANZCA trainee committee terms of reference and regulation 16 which includes FPM representation.
- College doctors health and wellbeing framework.
- Trainee wellbeing project group final report.
- ANZCA and FPM training agreements.
- College BDSH policies.
- College complaints policy.

See also: standard 1 (college governance).

7.1 Admission policy and selection

The AMC accreditation standards are as follows:	
7.1 Admission policy and selection	
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.

Clear, documented, sustainable selection policies supporting merit-based selection, consistently applied and preventing discrimination and bias

Each college-accredited anaesthesia department and pain medicine unit appoints prospective trainees to positions. These doctors then register with the college.

As outlined in regulation 37.4, the criteria for becoming an ANZCA trainee are a position in an ANZCA-accredited training site and completion of at least 104 FTE weeks of prevocational medical education and training (PMET) that includes at least 52 weeks of broad experience other than clinical anaesthesia, intensive care medicine and pain medicine. Successful application requires a signed ANZCA training agreement (appendix 7.1). Prospective ANZCA trainees can apply to become **applicants**. This requires 12 months of PMET but not a position in an accredited department, and provides access to college communications and resources such as the college library.

Eligibility criteria to join the FPM training program are specified in by-law 4 FPM Training Program and the FPM Training Handbook. Applicants must have a specialist qualification acceptable to the FPM Board or have completed three years training towards their primary specialist qualification, have secured a pain medicine training position within an FPM-accredited training unit and sign the FPM training agreement (appendix 7.2).

Whilst trainee appointment to accredited pain medicine and anaesthesia training sites is the role of employers, both training programs require each site to use the ANZCA selection principles. Selection processes must be consistent with relevant public sector employment legislation. The ANZCA guidelines complement employing authority policies and processes, and are intended for use in conjunction with them. Employer selection processes are evaluated at training site accreditation (standard 8.2).

The ANZCA selection guidelines outline principles, selection committee appointment, college representation and selection criteria development (section 1.7 of the ANZCA handbook for training). Principles include appropriate notice, equal employment opportunity, non-discrimination, formal procedures, lack of bias, rules of evidence and relevance, access to appeal and regular evaluation and review. The selection committee should include a college representative.

Selection criteria must be determined prospectively, be transparent to applicants and relevant to successful performance as a trainee. For anaesthesia training, the college does not regard prior anaesthesia experience as an essential selection criterion. The ANZCA Handbook for Training includes examples of selection criteria based upon the ANZCA roles in practice, as illustrated in table 7.1. All applicants must be assessed against the selection criteria using three components - written application (curriculum vitae and statement addressing selection criteria), the interview and referee reports. The college does not specify how these components are weighted.

FPM does not regard prior pain medicine experience as an essential selection criterion and has not articulated examples of selection criteria for use by training units.

Table 7.1 Examples of selection criteria based on the ANZCA roles in practice

ANZCA roles in practice	Examples of selection criteria
Medical expert: knowledge, skills and attitudes required to perform as an anaesthetist	Demonstrate an aptitude and commitment to acquiring the medical knowledge and clinical skills necessary to commence, continue and complete anaesthetic training. Demonstrate an ability to evaluate clinical problems and develop appropriate management plans.
Communicator: communicating with staff, patients and families	Have good communication skills, both verbal and written, appropriate for an anaesthetist and an ability to effectively facilitate relationships with staff, patients and their families.
Collaborator: working within a healthcare team	Demonstrate an aptitude for and commitment to achieving effective interpersonal collaboration and teamwork. Have an aptitude for and commitment to acquiring the skills and professional attitudes to prevent and manage interpersonal conflict.
Leader and manager: management of self, healthcare team and system	Demonstrate an ability to effectively organise and manage time and resources. Have a comprehensive understanding of the requirements of anaesthesia training. Demonstrate appropriate

ANZCA roles in practice	Examples of selection criteria
	self-care, ability to cope with stress and willingness to consider feedback.
Health advocate: advancing the health of patients and community	Demonstrate a commitment to the heath care of patients from all areas of the region/state/country; the wellbeing of individual patients and the community, including metropolitan, rural and Indigenous populations.
Scholar: continued self-learning, research and teaching	Have an appropriate academic history and a commitment to ongoing medical education. Have an understanding of the clinical review process, audit and research.
Professional: ethical practice, personal behaviour and profession-led regulation	Demonstrate integrity, punctuality, reliability and a high standard of personal behaviour in the conduct of their professional career. Have an understanding of medical ethics and its application to professional anaesthetic practice and profession-led regulation.

Published criteria and weightings, evaluated for validity, reliability and feasibility, transparent, rigorous and fair, capable of standing up to external scrutiny, with a process for formal review of decisions

Processes for selection into training

Anaesthesia training

The following table details the selection process in Aotearoa New Zealand and each Australian state and territory, along with where prospective trainees in each region and country access information on the selection process and appeals mechanism. The information is also freely available on the ANZCA website.

Table 7.2 Selection processes for anaesthesia training program rotations

	Rotations	Selection process
Aotearoa New Zealand	Four training schemes across the country (Northern, Midland, Central, Southern).	Rotational supervisors from each scheme advise when and which hospitals are recruiting.
ACT	ACT Rotational Training scheme.	Positions advertised on the ACT Health website July each year for commencement January of following year. Any mid-year positions are advertised in May for commencement August of same year. Selection interviews usually conducted in early September for short-listed candidates (July if mid-year intake).

	Rotations	Selection process
NSW	39 accredited training sites 11 major rotational hospitals (accredited for 156 weeks) with trainee placements across metropolitan and rural hospitals.	NSW training positions administered through NSW Ministry of Health. Further details can be found here.
Qld	Four accredited rotations (Northern, Central, Southern and Gold Coast), overseen by The Queensland Anaesthetic Rotational Training Scheme.	QARTS advises employing organisations, administers registrar selection and placement, in conjunction with Qld Health and Directors of Anaesthesia Group. Applications for the QARTS made via QLD Health RMO Campaign.
Tas	The Tasmanian Anaesthetics Training Program (TATP), offers training at all three Tasmanian Health Service (THS) hospitals.	Annual TATP recruitment advertised on the job vacancies page and at the THS jobs website.
SA and NT	The South Australia and Northern Territory Rotational Training Scheme (SANTRATS) offers rotation through 11 hospitals in South Australia and Northern Territory. SANTRATS is overseen by the rotational supervisors, with assistance from the directors of anaesthesia and the ANZCA SA/NT regional committee.	Two intakes per annum: hospital employment year (applications open June/July) and mid year (applications open March/April). These are advertised on the SA Health Careers website. Based on SANTRATS recommends and the scheme department directors appoint.
Vic	North Western, Eastern and Monash rotations make up the Victorian Anaesthesia Training Scheme. Joint decision-making by Victorian Anaesthesia Training Committee (includes representatives from each rotation, VRC, VTC).	Centralised application process, CV and three referees. Each rotation conducts own shortlisting and interviews. If shortlisted for more than one program, applicants complete an online preference form.
WA	WA anaesthetic rotational training program (for introductory training, basic training and advanced training).	Single advertisement for all positions in June each year. Interviews, simulations and presentations conducted from August to September.

Pain medicine training

Employers rather than FPM appoint trainees to accredited pain medicine departments or training sites. As a condition of accreditation by FPM, the employing authority undertakes to appoint pain medicine trainees according to ANZCA's selection principles as outlined in section 1.7 of the ANZCA handbook for training. The pain medicine training program does not include rotations and does not require trainees to train at multiple training sites.

Potentially due to being a post-specialist qualification, pain medicine appears less competitive to enter than other specialist training programs. Units often have to proactively target potential trainees to take on pain medicine training and the FPM supports units by publishing training opportunities on the website. There is a list of accredited pain medicine training units to allow prospective trainees to approach a unit in they might wish to train.

Review of selection processes

Currently, there is no formal process for systematic review of selection processes. This is an area for improvement, see *'Improvement opportunities and future plans'* at the end of this standard.

'Independent' anaesthesia trainees

As the pain medicine training program does not have rotations, there are no independent pain medicine trainees.

Definitions

The college accredits training sites, not individual training posts, with each accredited site required to be part of a rotation. 'Rotations' are groups of hospitals that collectively provide a complete training experience (standard 8.2). The term 'independent trainees' is not a term the college uses in any policies or curriculum documentation. The term, however, has common usage in the college community of supervisors, trainees and employing departments. The remainder of this section uses these term 'independent trainees', although the lack of a consistent definition may confound the data reported.

The use of the term 'independent trainee' varies between the two countries and across Australian training regions. It is primarily linked to how trainees are employed.

In Aotearoa New Zealand, all trainees appointed to registrar positions in hospitals are termed 'rotational trainees'. Some choose not to engage in their rotation, in part because many of the rotations require a relocation of their place of residence to manage the geographical separation of training sites. The resident medical officer (RMO) award in Aotearoa New Zealand allows doctors in registrar posts to stay in the same position as long as they remain college trainees. This does not apply to senior house officers (SHOs) who are employed in one anaesthesia rotation to test their 'fit' for anaesthesia a career. As they are performing similar jobs to those in registrar posts, they can credit this SHO experience towards ANZCA training.

The RMO award means a trainee who has not passed a required examination can remain in position until they exceed the allowable ANZCA extended time limits for that core unit (104 weeks for basic training and 156 weeks for advanced training), or exceed the allowable number of examination failures (usually five attempts, unless an individual exception is granted by the DPA assessor). This compares with the Australian situation where many of these trainees would be regarded as independent. One rotation has used a restricted

definition (in the absence of one from the college) and lists a number of its trainees as 'independent' but they are treated the same as the other trainees in that same rotation.

In Australia, 'independent' trainees, sometimes called 'non-rotational trainees', are those who are not appointed to an 'anaesthesia rotation' and are appointed by directors of departments independent of the anaesthesia rotation. In some regions there is a single rotation with a common selection process (e.g. WA, SA, Qld). In others (e.g. NSW and Vic), employment is primarily by hospitals. Regardless, the term 'rotational trainees' is recognised in all Australian regions as designating trainees who are part of an 'anaesthesia rotation', and who have confirmed employment and clinical placements for the first four years of their training, usually subject to expected progression in minimum timeframes. Some regions provide trainees with employment durations beyond these minimums (e.g.QARTS in Queensland allows three years for 'rotational' trainees to complete basic training). Rotational trainee placements are controlled by rotational supervisors who ensure their clinical placement support them meeting all training requirements.

A key difference for independent trainees is they lack confirmed clinical placements for IT, BT and AT (in Australia), including planned access to subspecialty rotations. If they remain independent trainees, they need to arrange their own employment and clinical placements. Trainees in provisional fellowship training are excluded from this issue and from the data below as they are not part of rotations and, by design, organise their own clinical placements in line with the defined objectives of that training period.

Trainees may commence their training with either rotational or independent status. Some trainees join rotations part-way through training; thus, there are lower proportions of independent trainees in AT than in IT and BT. Other trainees start in rotations and then become independent trainees, most often due to repeated examination failure.

Drivers

Key drivers of independent training include:

- The college accredits hospitals not training posts (standard 8.2). Pre-2004, those in accredited and unaccredited posts worked in similar roles. This was changed due to perceptions of unfairness and legally indefensible discrimination.
- Rotational training capacity is limited by trainee positions in specialist hospitals and tertiary hospitals for required subspecialty experience, especially paediatric, cardiothoracic and neurosurgical anaesthesia (standard 3).
- Service requirements within accredited hospitals and junior staff numbers for adequate rostering with suitable work hours mean that departments employ 'non-rotational' doctors to meet staffing requirements. Having sufficient doctors on the roster also promotes trainee wellbeing through safe working hours (standard 7.4).
- The college commitment to support training in rural and provincial practice leads to accreditation of suitable hospitals which provide a generalist experience without sufficient subspecialty experience to meet all training requirements (see regional and rural workforce strategy, standard 1.6). Accreditation of these sites is contingent on them being part of a 'rotation', a group of hospitals (standard 8.2). In some regions, many independent trainees commence training in these regional hospitals.

- Some trainees choose to plan their own clinical placements, not those mandated by the rotation, especially where geographical re-location is involved. Trainees who have partly completed overseas training and become ANZCA trainees may also elect to remain as independent trainees.

College policy and independent training

College policy is that all trainees receive the same supervision and guidance within their employing, accredited hospital, regardless of whether they are independent or part of a rotation. By the end of training, all trainees (whatever their employment status) must meet training requirements to achieve graduate outcomes. The college provides the same support for all trainees, regardless of status, providing the same access to central teaching and learning resources, assessments, and support processes such as the trainee support process (TSP), exam remediation courses, and Converge International.

Over time, the college has increased the flexibility and support for all trainees to complete training. For example, the 2013 curriculum better articulated the outcomes expected in the subspecialty area of paediatric anaesthesia. Volumes of practice are designed to allow trainees to meet outcomes without a clinical placement at a specialised paediatric hospital (although many rotations and trainees prefer such placements to the experience obtained caring for children in general hospital settings). There is also support for some retrospective recognition of non-anaesthesia placement experience undertaken prior to formal anaesthesia placements.

Whilst the college does not control trainee employment, it has taken a role in advocating for training to improve access to subspecialty and other clinical experience required to achieve training outcomes. Examples include through the specialist training program (STP), standard 1).

College monitoring

Whilst the college does not formally recognise the term ‘independent’ in any of its policies, it collects data on the training status as either ‘independent’ or ‘rotational’ and regularly monitors these data. These data are collected in the training portfolio system (TPS) under the field ‘rotational status’ with this status designated at the start of each year when trainees advise of their new placements for the year. All trainees must be in a rotation or be designated as ‘independent’ in order for them to be assigned to a hospital placement in the TPS. Updates are also made on an ad hoc basis if the college is notified of a change in status (usually by the supervisor of training or rotational supervisor). The trainee usually notifies the college if they are in a rotational job or not. If they advise they are not in a rotation or do not know what a rotation is, ANZCA staff designate them as ‘independent’. Occasionally, the college also receives notifications from ROTs or SOTs about particular trainees’ rotational statuses. The college also receives full schedules from certain rotations allowing cross checking of these data if required.

Data management

Data were extracted from the TPS which was instituted in 2013 when the current curriculum was introduced and are for anaesthesia only. Any trainee who was in provisional fellowship training (PFT) or PFT pending as at the date data were extracted were excluded; thus data only include those in IT, BT and AT. Given the variable definitions of independent trainees between Australia and Aotearoa New Zealand, the data are for Australian trainees only. Standard deviation for training duration was calculated using Microsoft Excel.

Data were extracted as of the following dates for each year. The date chosen is the first day of the hospital employment year (HEY).

- 2019: data as at 4/2/2019; n=1448 trainees.
- 2020: data as at 3/2/2020; n=1561 trainees.
- 2021: data as at 1/2/2021, n=1555 trainees.

Numbers of independent and rotational trainees by location

Table 7.3 shows the proportion of trainees in the Australian regions who were recorded as 'independent' at the start of training years 2019 to 2021. In 2021, nearly one in five trainees is independent at the start of each hospital employment year and this has been steady for the past three years. There is considerable variability across regions. These proportions appear stable across the years reported. The largest number of independent trainees is in NSW (127 in 2021).

Table 7.3 Trainees in an independent position in Australia on the first day of the hospital employment year for 2019, 2020 and 2021

	2019				2020				2021			
	Rotational	%	Independent (position)	%	Rotational	%	Independent (position)	%	Rotational	%	Independent (position)	%
ACT	34	3.0% (94.4 %)	2	0.2% (5.6%)	36	3.1% (97.3 %)	1	0.1% (2.7%)	38	3.2% (100%)	0	0.0% (0.0%)
NSW^	252	22.4% (72.6 %)	95	8.5% (27.4 %)	248	21.4% (67%)	122	10.5% (33%)	258	21.6% (67%)	127	10.6% (33%)
Qld	260	23.1% (88.7 %)	33	2.9% (11.3 %)	259	22.4% (88.4 %)	34	2.9% (11.6 %)	266	22.3% (89.6 %)	31	2.6% (10.4 %)
SA/ NT	69	6.1% (78.4 %)	19	1.7% (21.6 %)	70	6.0% (80.5 %)	17	1.5% (19.5 %)	68	5.7% (81.9 %)	15	1.3% (18.1 %)
Tas	17	1.5% (77.3 %)	5	0.4% (22.7 %)	16	1.4% (61.5 %)	10	0.9% (38.5 %)	17	1.4% (58.6 %)	12	1.0% (41.4 %)
Vic	218	19.4% (86.2 %)	35	3.1% (13.8 %)	222	19.2% (86%)	36	3.1% (14%)	236	19.7% (87.7 %)	33	2.8% (12.3 %)
WA	78	6.9% (91.8 %)	7	0.6% (8.2%)	79	6.8% (90.8 %)	8	0.7% (9.2%)	81	6.8% (86.2 %)	13	1.1% (13.8 %)
TOTAL	**928**	**82.6%**	**196**	**17.4%**	**930**	**80.3%**	**228**	**19.7%**	**964**	**80.7%**	**231**	**19.3%**

** The black percentage is of the total cohort, the red percentage in brackets is for that region*

^ A more detailed breakdown of NSW independent trainees by training stage for 2020-2022 is at appendix 7.3.

Comparison of outcomes for independent and rotational trainees

Table 7.4 compares training metrics for new graduates admitted to ANZCA fellowship from 1 November 2020 to 30 November 2021 who either spent their entire training as 'rotational' or spent *any* time in independent training. Overall training durations are similar. The training outcomes for the rotational group appear better, especially for primary examination pass rates at first attempt, although the numbers for most outcomes are small.

Table 7.4 Trainees in Australia admitted to fellowship from 1 Nov 2020 to 30 Nov 2021 stratified by whether rotational or independent #

	Rotational trainees n = 139	**Independent trainees n = 71**	**Difference for independent compared with rotational trainees**
Training duration (in years, mean ± SD)	5.22 years SD: 0.41	5.61 years SD: 0.77	+ 0.39 years
Approved deferral of training requirements from a core unit to subsequent training period at any stage during training	26 (18.7%*)	18 (25.4%*)	+ 6.7%
Period of interrupted training at any stage during training	39 (28.1%)	28 (39.4.%)	+ 11.3%
Trainee support process at any stage during training	6 (4.3%)	5 (7.0%)	+ 2.7%
Trainee review process at any stage during training	0	0	0
Withdrawal from training	0	0	0
Passed primary exam on first attempt (from 2013 onwards)	111 (79.9%)	41 (57.8%)	- 22.1%
Primary exam failure during training (from 2013 onwards) @	24 (17.3%)	21 (29.6%)	+ 12.3%
Passed final exam on first attempt (from 2013 onwards)	118 (84.9%)	51 (71.8%)	- 13.1%
Final exam failure during training (from 2013 onwards)	21 (15.1%)	20 (28.2%)	+ 13.1%

** Percentages in this table are the percentage of rotational or independent trainees, as relevant, who experience a particular training outcome*

 # In this dataset, rotational trainees are those who spent their entire training on a rotation and independent trainees are those who spent any training time in independent training (excluding PFT)

@ Note that some trainees may have completed the primary exam prior to 2013 (when the TPS was introduced) but these data are not readily available

Rotational trainees who repeatedly fail exams are likely to move to independent status, confounding the metrics in table 7.4. Table 7.5 addresses this by examining reported training status at the start of training. Given that the minimum time to complete training is five years, data for the 2015 training year are presented. Note that some of these trainees are still training, as there is significant flexibility to extend each training period (standard 3.4). Training times are equivalent. These data also support that rotational trainees are more likely to pass exams at their first attempt, although numbers are again small.

Table 7.5 Training outcomes for Australian doctors who commenced training in the 2015 hospital employment year by rotational or independent training status at the start of their training #

	Rotational trainees at commencement of ANZCA training n = 186	**Independent trainees at commencement of ANZCA training n = 56**	**Difference for independent compared with rotational trainees**
Training completed	159 (84.1%)	39 (69.6%)	- 14.5%
Training duration (in years, mean ± SD) for those who completed training	5.23 years SD: 0.43 years	5.36 years SD: 0.45 years	+ 0.13 years
Removal from training	8 (4.3%)	5 (8.9%)	+ 4.6%
Voluntary withdrawal from training	2 (1.1%)	4 (7.1%)	+ 6.0%
Passed primary exam on first attempt (from 2013 onwards	140 (75.3%)	27 (48.2%)	- 27.1%
Primary exam failure during training (from 2013 onwards)	43 (23.1%)	25 (44.6%)	+ 21.5%
Passed final exam on first attempt	141 (75.8%)	32 (57.1%)	- 18.7%

	Rotational trainees at commencement of ANZCA training n = 186	Independent trainees at commencement of ANZCA training n = 56	Difference for independent compared with rotational trainees
Final exam failure during training (from 2013 onwards)	30 (16.1%)	14 (25.0%)	+ 8.9%
Approved deferral of training requirements from a core unit to subsequent training period at any stage	18 (9.7%)	5 (8.9%)	- 0.8%
Period of interrupted training at any stage during training	69 (37.1%)	28 (50.0%)	+ 12.9%
Trainee support process at any stage during training	15 (8.1%)	2 (3.5%)	- 4.6%
Trainee review process at any stage during training	0	0	0

** Percentages in this table are the percentage of rotational or independent trainees, as relevant, who experience a particular training outcome*

 # In this dataset, rotational trainees are those who were on a rotation at the start of ANZCA training and independent trainees were not on a rotation at the start of ANZCA training

Education officer survey

A March 2022 survey of education officers (EOs) for Aotearoa New Zealand and all Australian regions except the ACT (which has no independent trainees) confirms that independent trainees have equivalent access to SOTs during clinical placements, local remediation and the TSP if required, and ANZCA resources such as the library, Networks and the TPS. The areas that EO perceive as different for these trainees in their regions/countries are trainee selection, their access to exam preparation courses and to clinical experience for completion of volumes of practice, particularly in paediatric, cardiothoracic and neurosurgical anaesthesia. EO survey results are summarised in appendix 7.4.

Future plans

The college supports equitable training opportunities for all trainees. It recognises this issue which is regularly discussed at the EO network and SOT meetings in each region. The EOs in many regions have undertaken or are in the process of reviewing current approaches and incorporating trainees into 'rotations', where possible. There are many challenges, not least of which is the ongoing service requirements to staff departments that often lead to additional appointments into positions to support roster coverage and safe working hours. At present, these junior doctors can register as ANZCA trainees.

The key future opportunity to address this issue is through the ANZCA and FPM trainee selection project (see *'Improvement opportunities and future plans'* at the end of this standard). As part of training evolution, this project will investigate 'independent' ('non-rotational') trainees, including the drivers for and consequences of their situations. This was delayed due to COVID-19 and is planned for 2022 and 2023.

The college has also progressively improved the centralised resources available to all trainees (standard 4).

Whilst the college monitors this issue, it also needs to address the issue of data integrity by standardising definitions in this area.

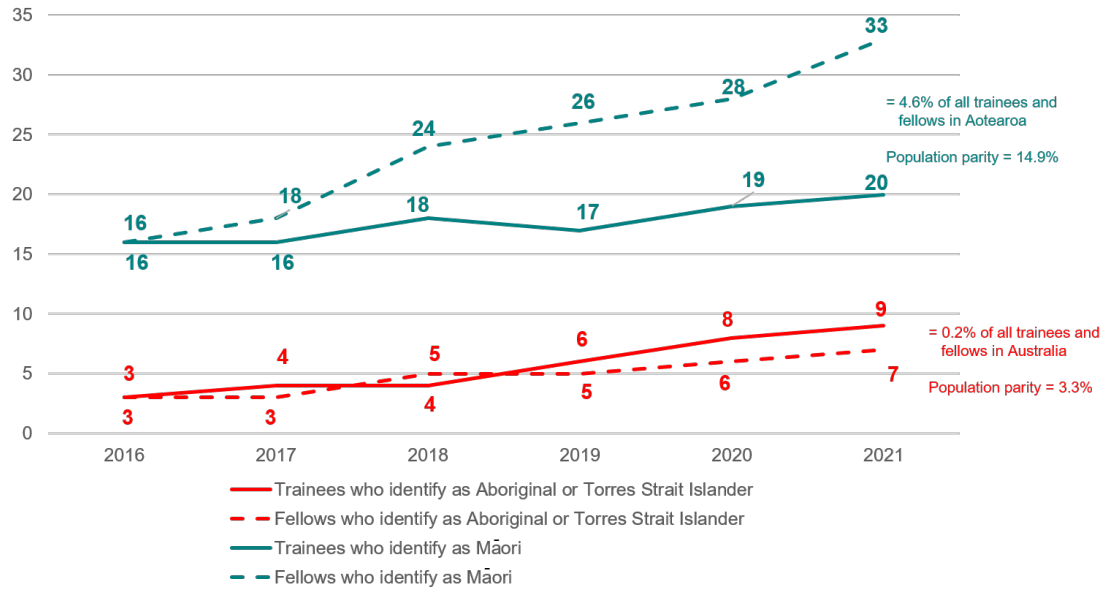
Supports for recruitment and selection of Aboriginal and Torres Strait Islander and/or Māori trainees

Trainees are appointed to positions by accredited hospitals not the college. The college recognises there is a gap in the systematic selection of junior doctors who identify as Aboriginal, Torres Strait Islander and Māori for training to become specialist anaesthetists and specialist pain medicine physicians. Addressing this crucial area is a key aim of the 2022 trainee selection project (see *'Improvement opportunities and future plans'* at the end of this standard).

Figure 7.1 shows the growth in trainees and fellows who identify as Aboriginal and Torres Strait Islander and Māori over the past five years. While the consistent progress is encouraging, the rate of growth is slow. There are standards addressing Māori trainee recruitment at a New Zealand Health board level that are following by training units in Aotearoa New Zealand. At least one Aotearoa New Zealand anaesthesia rotation addresses equitable recruitment and selection of trainees who identify as Māori in their processes. While the proportion of Māori trainees is less than Māori in the national population (16%), as the increased proportion of Māori graduating from medical school moves through the training grades, the college anticipates it will approach this proportion . .

The college acknowledges that, in the absence of dedicated Aboriginal and Torres Strait Islander and Māori entry pathways to specialist training in anaesthesia and pain medicine, it will be many years before the number of Aboriginal and Torres Strait Islander and Māori trainees and fellows in the college approaches population parity.

Figure 7.1 Number of college trainees and fellows who identify as Aboriginal, Torres Strait Islander or Māori 2016-2021



There are currently two pain medicine trainees who identify as Māori and two who identify as Aboriginal. There are five fellows who identify as Māori or Pacific Islander but none who identify as Aboriginal. It is hoped that greater promotion of pain medicine as a career will start to address the low numbers of Aboriginal and Torres Strait Islander and Māori trainees. That pain medicine is a post specialist qualification may be a disincentive for doctors who identify as Aboriginal and Torres Strait Islander and Māori and those with an interest in rural and remote area practice. Early discussions are underway to explore developing a primary pathway to FPM fellowship that might reduce some of the barriers to pain medicine training.

The college Indigenous Health Committee has implemented a number of initiatives to support recruitment of Aboriginal and Torres Strait Islander and Māori trainees, primarily through early career support as follows:

- Scholarships for Aboriginal, Torres Strait Islander or Māori medical students and pre-vocational doctors to attend the annual scientific meeting to learn about anaesthesia, pain medicine and perioperative medicine as a potential career and foster networks. At least three previous award recipients have gone on to join the ANZCA and FPM training programs.
- A prevocational advice service to provide Aboriginal and Torres Strait Islander and Māori prevocational doctors with advice and tips about careers in anaesthesia and pain medicine.
- Financial support for Aboriginal, Torres Strait Islander and Māori trainees to cover registration costs of college exam preparation courses.

The AMC requested data on the number of Aboriginal and Torres Strait Islander and Māori applicants to the anaesthesia and pain medicine training programs. Given the college does not recruit trainees, it does not collect data on the number of training program applicants. The number of Aboriginal and Torres Strait Islander and Māori trainees entering the anaesthesia and pain medicine training programs from 2019-2021 is included in tables 7.6 and 7.7.

Future plans

The college observes the values and aims of the Treaty of Waitangi and the 2020 Closing the Gap Partnership Agreement (see standard 1). The college actively strives to attract and support doctors who identify as Māori, Aboriginal and/or Torres Strait Islander to join the college and achieve fellowship. The college is developing a Reconciliation Action Plan (RAP) to support its commitment (see standard 1). An action of the RAP is to develop strategies to increase and retain Aboriginal and Torres Strait Islander anaesthesia and pain medicine workforce, including through the forthcoming trainee selection project (see *'Improvement opportunities and future plans'* at the end of this standard).

Future challenges include the need to support Aboriginal and Torres Strait Islander and Māori trainee selection, particularly as the college is not directly involved in trainee selection and training selection process differs between countries, states and health districts. The small number of Aboriginal and Torres Strait Islander and Māori trainees at present also has the potential to put a considerable cultural load on these doctors and causes a burden with which other trainees do not have to contend (see *'Improvement opportunities and future plans'* at the end of this standard).

Mandatory requirements published

Although rural and regional experience is supported and promoted through accreditation of rotations (standard 8.2), there is no mandatory requirement within training for such placements. Trainees are unable to spend all their training at one training site and must train for at least 52 weeks at a second site. Most trainees undertake clinical placements at multiple hospitals. This is well publicised through training communications and at training orientation. As anaesthesia trainees are selected at a regional level, mandatory rotations are determined by the rotation and notified to trainees.

There are no mandatory requirements for pain medicine, either for rural placements or rotation through more than one training site.

Monitoring consistent application of selection policies across training sites and regions

Selection processes are monitored as part of training accreditation (standard 8.2).

For anaesthesia, the criterion under 'clinical governance' is 'trainees appointed using a transparent process as outlined in section 3 of the ANZCA handbook for training', assessed by head of department interview and confirmation with the regional or national committee representative (ANZCA handbook for accreditation).

For pain medicine training, the criterion under 'clinical governance' is 'trainees are appointed to training positions on the basis of merit, without evidence of discrimination in accordance with ANZCA and FPM policy' (FPM accreditation handbook).

If an accreditation visit identifies a deficit in applying ANZCA principles to trainee recruitment and selection, that deficit must be remedied for continued accreditation. The ANZCA accreditation process does not differentiate between 'rotational' and 'independent' trainee selection and appointment. A key driver for the trainee selection project (see *'Improvement opportunities and future plans'* at the end of this standard) is to increase the consistency of selection across training sites and regions.

Numbers entering anaesthesia and pain medicine training

Anaesthesia trainee numbers

Trainee numbers entering the program are usually consistent at approximately 330 annually. In 2020, at the start of COVID-19, numbers entering mid-year (June-August) decreased. The reasons for this are unclear. ANZCA is committed to achieving gender equity in its fellowship, and diversity among its trainees (see *Gender equity*, standard 1). It actively monitors trainees accordingly.

Table 7.6 Trainees entering the ANZCA training program 2019-2021

Region or country	ACT	NSW	NT	QLD	SA	TAS	VIC	WA	NZ	Total
2019 Total	**9**	**87**	**0**	**61**	**20**	**7**	**67**	**24**	**57**	**332**
Aboriginal and Torres Strait Islander	0	0	0	0	0	0	0	0	0	0
Māori	0	0	0	0	0	0	0	1	3	4
Pacific Islander	0	1	0	0	0	0	0	0	1	2
All Other trainees	7	86	0	61	20	7	67	23	53	326
2020 Total	**8**	**84**	**4**	**56**	**15**	**6**	**52**	**19**	**37**	**281**
Aboriginal and Torres Strait Islander	0	2	0	1	0	0	0	0	0	3
Māori	0	0	0	0	0	0	0	0	3	3
Pacific Islander	0	0	0	0	0	0	0	0	2	2
All Other trainees	8	82	4	55	15	6	52	19	32	273
2021 Total	**5**	**88**	**1**	**64**	**19**	**7**	**69**	**22**	**52**	**327**
Aboriginal and Torres Strait Islander	0	0	0	0	0	0	0	1	0	1
Māori	0	0	0	0	0	0	0	0	5	5
Pacific Islander	0	0	0	0	0	0	0	0	1	1

Region or country	ACT	NSW	NT	QLD	SA	TAS	VIC	WA	NZ	Total
All Other trainees	5	88	1	64	19	7	69	21	46	320

Table 7.7 Trainees entering the FPM training program 2019-2021

Region or country	ACT	QLD	NSW	NT	SA	TAS	VIC	WA	NZ	Total
2019 Total	0	7	5		1	2	6	1	3	25
Aboriginal and Torres Strait Islander	0	0	0	0	1	0	0	0	0	1
Māori	0	0	0	0	0	0	0	0	0	0
Pacific Islander	0	0	0	0	0	0	0	0	0	0
All other trainees	0	7	5	0	0	2	6	1	3	24
2020 Total	0	2	14	0	3	1	5	5	0	30
Aboriginal and Torres Strait Islander	0	0	0	0	0	0	0	0	0	0
Māori	0	0	0	0	0	0	0	0	0	0
Pacific Islander	0	0	0	0	0	0	0	0	0	0
All other trainees	0	2	14	0	3	1	5	5	0	30
2021 Total	1	11	6	0	1	1	6	1	1	28
Aboriginal and Torres Strait Islander	0	1	0	0	0	0	0	0	0	1
Māori	0	0	0	0	0	0	0	0	0	0
Pacific Islander	0	0	0	0	0	0	0	0	0	0
All other trainees	1	10	6	0	1	1	6	1	1	27

7.2 Trainee participation in education provider governance

The AMC accreditation standards are as follows:	
7.2 Trainee participation in education provider governance	
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.

ANZCA Trainee Committees

Governance

All ANZCA trainee committees are governed by regulation 16 and do not appear in the ANZCA Constitution. **Terms of reference** outline their roles, approvals, membership and reporting processes (appendix 7.5).

The binational ANZCA Trainee Committee (ATC) reports to the Education Executive Management Committee (EEMC). Its purpose is to represent and advocate for ANZCA trainees at all levels, including considering national and state training and education matters and providing input on matters affecting trainees to the EEMC and ANZCA Council. The ATC comprises the chairs of each of the Australian regional trainee committees, the Aotearoa New Zealand national trainee committee and an FPM trainee representative appointed by the FPM Training and Assessment Executive Committee, following a call for expressions of interest from all FPM trainees. When multiple expressions of interest are received, all applicants are found an FPM committee or working group role to enable their participation. ATC membership includes the ANZCA President, EEMC chair and the Executive Director, Education and Research to support engagement and empowerment of trainees. Junior trainee non-voting observers from each regional and national trainee committee may also attend teleconferences. At its first meeting of the year, the ATC elects a chair or co-chairs from amongst its members.

Regional and national trainee committee elections

Australian regional and Aotearoa New Zealand ANZCA trainee committees are elected by all trainees within the respective geographical area. The number of trainee positions on each regional or national trainee committee is determined by the trainee numbers in that region or country. Nominations for membership are sought from all trainees in the region each October and include nominee consent and support from two other trainees in the region. An election is held if nominations exceed the number of available positions. Terms are for one year with eligibility to stand for reelection to a maximum of five years. Each new committee takes office for a calendar year and at its first meeting members elects a chair or co-chairs (and deputy chairs as relevant) who is an ex officio member of the ATC.

Participation in college governance

One ATC co-chair is invited to each ANZCA Council meeting as a non-voting observer. As reported in the 2012 submission, council decided on observer status rather than trainee director status for the following reasons:

1. As a director, the trainee would have responsibility for the whole organisation and would not just represent trainees.
2. Trainees are not ANZCA members.

3. The chairs usually serve one to two years only and thus may have insufficient time to assume a directorial role and attendant responsibilities.
4. Directorship training would be needed to meet the fiduciary responsibilities of directorship, which would be onerous in addition to the other obligations of trainees within the training program.

As reported in the 2018 progress report, this decision was revisited and affirmed in recent years. An additional consideration is the introduction of co-chairs has halved the experience of each trainee leader at council (as only one attends each meeting), potentially complicating directorship issues. The attendance of the ATC co-chairs at council has been an effective mechanism for trainee input to high-level decisions. For example, in recent years, they have been important participants in board discussions and decisions on COVID-19-related contingency planning, including for exams, volumes of practice, training time and fees.

ANZCA trainee representation on committees and other groups

The college is committed to promoting trainee participation at every level of governance. Consequently, trainees are members of most ANZCA committees and project groups, with the ATC co-chairs also representing ANZCA on external committees (table 7.8). Trainee representatives to these groups are selected via expressions of interest or nomination by the ATC.

Table 7.8 Current and recent groups with ANZCA trainee representation

College committees and subcommittee	College working/project groups (years active)	External committees
Education Development and Evaluation Committee (EDEC) Training Accreditation Committee (TAC) Provisional Fellowship Sub-committee (PFSC) Effective Management of Anaesthetic Crises (EMAC) Course Sub-committee Emerging Investigators Sub-committee (EISC) ANZCA Educators Sub-committee (AESC) ANZCA New Zealand National Committee	Accreditation and Learning Environment Project Group (2019-2021) Competency-Based Medical Education (CMBE) Working Group (2019- present) CPD Review Project Group (2021- present) Lifelong Learning Project Group (2021- present) Trainee Wellbeing Project Group (2019-2021) Training program project (project 110, 2017-2019) Training Program Evolution and Managing Change	AMA Council of Doctors in Training (AMACDT) Australian Society of Anaesthetists trainee member group (ASA TMG) New Zealand Society of Anaesthetists trainee representative Royal Australasian College of Surgeons Trainees' Association (RACSTA)

College committees and subcommittee	College working/project groups (years active)	External committees
ANZCA regional committees	Working Group (2019 - present)	

Communication with national and regional trainee committees and the broader trainee body

The ATC co-chairs and members have direct access to the EEMC chair, the chair of exams and the chairs of their respective regional and national committees. They are encouraged to raise and discuss matters of educational governance with these people in leadership roles.

While not a formalised process, ATC members, as chairs of their respective regional and national trainee committees disseminate updates and relevant information to other members who communicate with trainees in their hospitals and rotations. Some regions (NSW, Qld, SA/NT and Vic) also have closed Facebook groups, to facilitate interactions between trainees across the region. The groups are also used to promote trainee social events. The ATC co-chairs also provide an update in the training e-newsletter published bi-monthly.

Pain Medicine: trainee representation

As pain medicine is an 88-week training program, FPM finds it difficult to have trainees involved in committees. One FPM trainee sits on the ATC to represent pain medicine trainees. This trainee is a point of contact for FPM trainees and drafts a welcome message for the bi-monthly *FPM Trainee E-Newsletter*. An FPM trainee also sat on the Trainee Wellbeing Project Group (standard 7.4). FPM regional and national committees include a position for an FPM trainee. An FPM trainee who is nearing completion of their training is from time to time invited to be member of the Learning and Development Committee. The Learning and Development Committee has recently amended their terms of reference to formalise trainee representation on the committee. Expressions of interest have been sought and were waiting confirmation at the time of submission.

Anaesthesia: new fellow representation

There is a well-established new fellow position on the ANZCA Council. The Fellowship Affairs unit work closely with this councillor to promote expressions of interest for committee vacancies via the New Fellow Facebook group and the Emerging Leaders Alumni WhatsApp group. The ANZCA New Zealand National Committee and regional committees also have new fellow members.

Pain medicine: new fellow representation

There are a number of designated new fellow positions on FPM committees, including on the FPM Board. FPM actively encourages new fellow participation in other FPM activities such as conferences. FPM committees with new fellow positions are: the FPM Board, FPM regional and national committees, Learning and Development Committee, Training Unit Accreditation Committee and Examination Committee.

Feedback from individual trainees

Avenues for feedback from individual trainees include via their national and regional trainee committees, hospital accreditation surveys and visits, and through regular trainee surveys (standard 6). ANZCA and FPM trainee committee events are also held as part of the annual

scientific meeting, and regional and national meetings. These enable trainees to meet with fellows and staff involved in training and to provide their perspectives. Some of these avenues have been in abeyance during COVID-19 due to restrictions on travel and gatherings.

7.3 Communication with trainees

The AMC accreditation standards are as follows:	
7.3 Communication with trainees	
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.

Training program specific communication mechanisms

As one of the largest stakeholder groups, ANZCA and FPM trainees receive regular communications as part of the college's overall communications strategy (see standard 1.6). The college's strategy is to communicate with trainees via a variety of channels (expanded below). Due to their effectiveness, emails are used to communicate important updates. The college encourages fellows, trainees and specialist international medical graduates (SIMGs) to maintain up-to-date contact details via e-newsletters and the website. The college communications team oversees communications to trainees, in addition to reviewing trainee surveys and acting on feedback. The library is also an important source of information through hubs (e.g. training and exams hub for anaesthesia training and pain medicine training and exams as part of the pain medicine hub) and library guides (standard 4). Trainee toolkits on the website are also important sources of training information.

All training programs

Targeted emails

Email is one the main forms of communication with trainees, individually and in groups. The college uses targeted email addresses for individual trainee enquiries and applications (e.g. assessor-request@anzca.edu.au for individual training requests, training@anzca.edu.au for TPS and other training enquiries, primaryexam@anzca.edu.au and finalexam@anzca.edu.au for exam applications, feedback requests and enquiries). Targeted bulk communications are sent via the direct mailing platform Informz.

Anaesthesia training program

The college regularly sends updates to ANZCA trainees from the Education and Research unit, and others, including the ANZCA Chair of Examinations and chairs of the ANZCA Primary Examination Sub-committee and ANZCA Final Examination Sub-committee. These communications generally have open rates of about 80% (e.g. "ANZCA Primary exam update" sent on 22 October 2021 open rate 80.0%, "ANZCA Final exam update" sent on 10

September 2021 open rate 76.7%, New Zealand Final Exam update sent on 24 August 2021 open rate of 91.5%).

Additional key mechanisms for communication with ANZCA trainees are:

- *Individual training-related decisions:* In 2020, trainees, fellows and staff on the Trainee Wellbeing Project Group reviewed all templates for individual ANZCA trainee communications (e.g. assessor training-related decisions). This changed the language and tone to formal yet friendly with a clear call to action for trainees. The transactional focus was altered to be more empathetic and reference to key support resources was added.
- *Training portfolio system:* The bespoke online TPS provides anaesthesia trainees with information on their training progress. The TPS underwent a major update in late 2018 which introduced new dashboards for trainees and their supervisors. The dashboard displays a snapshot of individual progress towards requirement of the current core unit. TPS also provides important notifications, for example when clinical placement reviews are due and reminders towards the end of AT to inform the college of their provisional fellowship training plans. The TPS also has a system notification feature, for example fee payment dates and training requirements. These notifications are targeted to user roles and are visible on every module in the TPS.
- *ANZCA Training E-Newsletter:* Circulated to all ANZCA trainees and supervisors every two months, this newsletter was created during the launch of the ANZCA curriculum in 2013. Communications with trainees and supervisors at this time were critical. In 2022, it remains an important mechanism for communicating with ANZCA trainees. The September 2021 edition (appendix 7.6) had an open rate of 44.2%, a strong result based on industry standards.
- *ANZCA training agreement:* outlines college expectations of trainees and college commitment to trainees (appendix 7.1).
- *ANZCA handbook for training:* a practical plain-English guide to getting started, outlining training requirements, special circumstances (including flexible training), and supervisor and tutor roles.
- *Webinars:* These are held ad hoc and were an important mechanism during COVID-19, particularly for information about and questions on examinations.

Pain medicine training program

The key mechanisms for communication with FPM trainees are:

- *Individual training-related decisions:* Pain medicine trainees receive emails from the FPM unit. These may be administrative in nature or advise of an individual training decision, for example from the assessor or FPM chair of examinations.
- *FPM training handbook:* This is designed as a point of reference for general information on the training program, including entrance requirements, roles and responsibilities, training options and opportunities, support resources, assessment processes and fees.
- *FPM Training E-Newsletter:* This bi-monthly e-newsletter provides trainees with advice on upcoming deadlines and event dates and information on educational and wellbeing resources. The October 2021 *FPM Training E-Newsletter* (appendix 7.7) had an open rate of 65.9%. An important element of this newsletter is that it includes an update from the FPM trainee representative (see standard 7.2).

- *Basic Clinical Skills Course:* Held annually in mid-February, a key purpose of this course is to facilitate trainee networking. As the course could not run in 2021, FPM set up an optional trainee WhatsApp group, which was very popular with core training stage trainees. As these trainees were also participating in a weekly online tutorial program (see standard 4), they built up relationships with key FPM staff and fellows and were able to reach out to FPM as required.
- *Zoom meetings*: On occasion FPM trainees are invited to a Zoom meeting that covers particular decisions and allow discussion. In 2020, when the decision was made to delay the examination and deliver the oral component via videoconference, several Zoom meetings with trainees were arranged to allow questions to be asked. The process was repeated in 2021 ahead of the 2021 fellowship examination.

How digital communications are reviewed

Informz has the capacity to review communications sent via the platform, with statistics on open rates and link clicks available for each mailing.

ANZCA trainees are surveyed every two years by the college and all college trainees are surveyed annually through the Medical Board of Australia's Medical Training Survey. These surveys provide important insights into the college's communications with trainees (standard 6).

In December 2021, a facilitated workshop for the communications team was held to formulate a college-wide communications strategy in 2022. One of the outcomes was to explore how the college can better engage with trainees, including a trainee journey mapping exercise.

Timely communication about activities from the decision-making structure

There are regular updates to trainees on the website. These updates are from the Executive Director – Education and Research, the ANZCA DPA assessors or the FPM unit and are branded by staff from the Communications team.

Timely communication about program costs, requirements and changes

The fees for anaesthesia and pain medicine training are publically published on the college website. Once fees for the year are set by the ANZCA Council, trainees are emailed individually with information on the fees and due dates, including how to apply for a bursary, in the event of financial hardship, or a reduction in their training fees based on their flexible learning plans for the following year (i.e. planned part-time or interrupted training).

Changes to the anaesthesia training program are communicated as follows:

- Minor changes to the training program are communicated in ANZCA e-newsletters and news items on the college website.
- Where changes affect a specific cohort, this cohort is sent direct correspondence via email.

Changes to the pain medicine training program are communicated as follows:

- Changes to requirements are published primarily through the FPM *Training E-Newsletter* and *Synapse*. If there is a significant change then individual letters or emails are sent.

- Significant changes are often also advised to supervisors via workshops to enable discussion.

Communication with prospective trainees

The college website includes information for prospective trainees (medical students and junior doctors) on a career in anaesthesia and pain medicine, including indicative costs. The college is in the process of developing a postcard-sized give-away for prospective anaesthesia and pain medicine trainees that directs them to relevant information on the website.

The anaesthesia training program has an 'applicant' category for doctors interested in pursuing a career in anaesthesia but who are not yet eligible to join the training program. Applicants are given access to ANZCA resources, such as the library and Networks and also receive the monthly *ANZCA E-Newsletter* (which links to the online version of the quarterly *ANZCA Bulletin*), and the *Training E-Newsletter.*

Timely information about training status

The TPS provides anaesthesia trainees with real-time information their training status, conveniently summarised in a dashboard for their current training period (see standard 4). Their training agreement includes a commitment to maintaining this record of training (appendix 7.1). The DPA assessors can generate confidential reports from the TPS which provide a summary of training progress and assessment outcomes. DPA assessors use the reports to review trainee progression at key time points, in addition to determining whether trainees are eligible to sit the primary or final examinations. The quick TPS report generation allows DPA assessors to advise trainees of key decisions that affect them in a timely manner. EOs also receive quarterly monitoring reports for trainees in their region, with information regarding trainees approaching training time limits.

Throughout their training, FPM trainees maintain a learning portfolio which must be kept up to date (FPM training handbook section 5.4), as per their training agreement (appendix 7.2). FPM trainees can print a report from the college website that identifies what training information the FPM has on them. This same report is used by staff in the FPM unit and the FPM assessor to advise the trainee as requested.

7.4 Trainee wellbeing

The AMC accreditation standards are as follows:	
7.4 Trainee wellbeing	
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.

Strategies to support a supportive learning environment

Strategies to enable a supportive learning environment for trainees can be understood in terms of college-wide initiatives that target trainees, SIMGs and fellows across the clinician

lifecycle, and initiatives that target trainees as a cohort. Governance of health and wellbeing at the college is in standard 1.

Some college systematic initiatives to support trainee wellbeing include:

- The Bullying Discrimination and Sexual Harassment (BDSH) working group report (2017) and outcomes.
- Wellbeing advocates and networks.
- Wellbeing policies and tools.
- The Trainee Wellbeing Working Group report (2018) with recommendations implemented by the Trainee Wellbeing Project Group (2019-2021) and outcomes such as the critical incident debriefing toolkit.
- The accreditation and learning environment project (2019-2021) (see standard 8.2).
- Mentoring support (see standard 4).
- Wellbeing in the ANZCA and FPM CPD program undertaken by ANZCA provisional fellows (see standard 9).
- Awards including the Ray Hader Award for Pastoral Care established in 2008 and awarded annually . .
- Introduction to anaesthesia training, a one-day course where trainees meet others in their cohort and receive information on health and wellbeing, including available resources and support.

BDSH working group 2017 report and outcomes

Following the 13 recommendations of the 2017 BDSH working group report, the college has undertaken the actions shown in table 7.9.

Table 7.9 Actions arising from the 2017 BDSH working group report

Actions arising	Outcomes
1. Adopt an ANZCA professionalism framework for BDSH	Zero tolerance model situated within a framework of graded intervention, based on the Vanderbilt model, recognising overlapping roles and responsibilities, the need for preventive education and 24/7 support
2. Revise ANZCA complaints policy	Existing BDSH policy (2011) revised in 2020, development of supporting process document underway Complaints policy redeveloped as Notification and management of complaints and concerns policy (2017) in line with professionalism framework and AS/NZS 10002:2014 Guidelines for complaint management in organisations, review of notifications policy to separately manage BDSH notifications and complaints underway (standard 7.5)

Actions arising	Outcomes
3. Update regulation 26	Reviewed and updated in 2018 (standard 9.3)
4. Identify and expand BDSH support resources for SOTs and EOs	Acquired RACS Operating with Respect eLearning module, available to all fellows, trainees and SIMGs Orientation module for new SOTs in development. includes content on BDSH that aligns with the RACS Operating with Respect module
5. Identify and expand BDSH support resources for trainees	Acquired RACS Operating with Respect eLearning module available to all fellows, trainees and SIMGs
6. Develop a college-wide values statement	Not achieved as ANZCA Council did not support (standard 1), the college has adopted respective *Good Medical Practice* as code of conduct in Australia and Aotearoa New Zealand
7. Ensure *'Supporting Anaesthetists' professionalism and performance guide*' reflects BDSH principles	Guide includes a BDSH section with behavioural markers under the Leader and Manager, and Professional roles, 2022 review planned (standard 9.3).
8. Expand connections with other organisations	See Doctors health and wellbeing (standards 1 and 7.4)
9. Implement access line for complaints about BDSH to the college	The ceo@anzca.edu.au mailbox, which is continuously monitored and triaged, is the single contact for all complaints, including those on BDSH.
10. Develop, maintain and report on complaints and concerns register	All cases reviewed by a triage group (CEO, Vice President, and Executive Director of Professional Affairs) Records kept with de-identified information reported to the ANZCA Executive Committee, and thence to ANZCA Council via minutes
11. Identify, develop and maintain resources for complainants and alleged perpetrators	Delayed by COVID-19
12. Implement audit and review process for complaints	Delayed by COVID-19

Actions arising	Outcomes
13. Continue surveys including of mid-career and older practitioners	See fellowship survey, standard 6 No specific surveys of mid-career and older practitioners

The policy on bullying, discrimination and harassment for fellows, trainees and specialist international medical graduates acting on behalf of the college describes the expected behaviour of all fellows, trainees and SIMGs acting on behalf of the college. A 2020 revision of the policy took into account the college's limited powers when dealing with allegations that arise in another employer's workplace and with another employer's workforce. The process to support the policy is under development. It is planned to more formally include the training site accreditation process if the problem identified is a more general one with BDSH by other than those acting on behalf of the college. While the accreditation process does not make any findings of BDSH against specific individuals, its can require each employer has and uses an effective process for dealing with such allegations in the workplace. The majority of allegations and complaints by trainees are against others, not those acting on behalf of the college, and so are discussed by the ANZCA TAC or the FPM Training Unit Accreditation Committee (TUAC). This provides a mechanism for review and action, such as an out-of-cycle inspection. Since the revised BDSH policy was adopted, there have not been any complaints by trainees about those acting on behalf of the college.

Wellbeing advocates and networks

The wellbeing advocate role was first proposed in a Wellbeing SIG resource document over a decade ago. Subsequently, many departments appointed a member to this the role for support and guidance on available health and wellbeing resources and referral pathways, noting that the role is not a therapeutic one. Wellbeing Advocates are recommended, although not mandated, for all ANZCA and FPM-accredited training sites and units. See PS49: *Guideline on the health of specialists, specialist international medical graduates and trainees*. There are now established wellbeing advocate networks in each of the Australian regions and in Aotearoa New Zealand. Importantly these networks provide support and guidance for those in the wellbeing advocate role for their health service or region.

Wellbeing policies and tools

The college has professional documents on wellbeing including PS43 *Guideline on Fatigue Risk Management in Anaesthesia Practice* and PS49: *Guideline on the health of specialists, specialist international medical graduates and trainees* which is intended to assist fellows, trainees and SIMGs. Further information about doctors' wellbeing is in standard 1 and 9.1.

A wellbeing guide, including resources available through the ANZCA library (standard 4).

Wellbeing Charter. In 2020, ANZCA worked with three other medical colleges to create the Wellbeing Charter for Doctors. The charter has been endorsed and adopted by five additional medical organisations and colleges, including endorsement from the Council of Presidents of Medical Colleges (CPMC).

Long Lives, Healthy Workplaces. This initiative provides a toolkit to support better mental health and wellbeing for anaesthetists and anaesthetic trainees. In 2021, the Long Lives,

Healthy Workplaces Steering Group developed supplementary resources to support the toolkit. The toolkit is for anaesthesia departments and practices to support their wellbeing activities through action plans that:

1. Improve the culture of medicine to increase wellbeing and reduce stigma.
2. Improve the training and work environment to reduce risk.
3. Improve capacity to recognise and respond to those needing support.
4. Better impact anaesthetists and trainees impacted by mental ill-health and suicide.
5. Improve leadership, coordination, data and information on the health and wellbeing of our professions.

ANZCA Trainee Wellbeing Working Group

Chaired by the 2017 ATC co-chairs, this working group completed an environmental scan and critique of existing college practices to generate commendations and 30 recommendations under the themes of education and training, specific groups, building mental health and data collection.

Trainee Wellbeing Project Group

To address recommendations of the 2018 Trainee Wellbeing Working Group report (appendix 7.8), ANZCA Council established a Trainee Wellbeing Project Group (TWPG) chaired by the DPA education, to oversee practical outcomes. TWPG terms of reference are in appendix 7.9. From 2019 to 2021, the TWPG model supported trainee leadership of subgroups to address specific recommendations. The group also sought involvement of trainees and fellows from both anaesthesia and pain medicine with an interest in specific aspects of trainee wellbeing to join the subgroups.

The final TWPG report with outcomes achieved and ongoing work is publicly available on the college website. It highlights and showcases to all fellows, trainees and SIMGs and the broader community this important work. Key outcomes listed in the report include review of trainee orientation (standard 4), improved individual trainee communication templates (standard 7.3), exploration of a trainee representative role (standard 7.2, in progress), renaming the trainee experiencing difficulty process (standard 5), and development of the critical incident debriefing toolkit (standard 4). Some of the recommendations are being addressed by other projects within the college, for example training evolution (standard 3), review of the learning management system and wellbeing resources (standard 4) and work on the learning environment at accreditation (standard 8.2). A proposal to include a trainee representative role description in the ANZCA handbook for training is also in development. It is envisaged that this optional role will focus primarily on representation and advocacy for trainees within accredited departments.

Pain medicine trainee wellbeing

Pain medicine can be a challenging speciality area and self-care is a consistent theme in education provided by FPM and is covered in every training e-newsletter. FPM has a mentoring program which it encourages trainees to join. The mentoring program is promoted in every training e-newsletter and in the FPM Training Handbook. Self-care is also included as a topic at the Basic Clinical Skills Course run each February. The FPM Training Handbook also points trainees towards the resources that are available for college doctors' health and wellbeing. Before written exam results are circulated FPM SOTs are advised via email so that they are prepared to support their trainees if required. When the results from

the oral examination are displayed, several examiners are available to speak to and support trainees.

MCNZ requirement: ensuring a culturally safe environment for all trainees, including those who identify as Māori

All Aotearoa New Zealand employers, including ANZCA and FPM accredited training sites, have a duty to provide a culturally safe environment. The FPM has introduced evaluation of cultural safety within accreditation (standard 8.2). The ANZCA and FPM accreditation and learning environment project identified cultural safety evaluation as an important area for improvement (see *'Improvement opportunities and future plans'* standard 8.2). See also standards 1 and standard 4.

Collaboration with other stakeholders to support trainees experiencing difficulty

Doctors' Support Program

The Doctors' Support Program is a confidential and independent counselling and coaching service available to all anaesthesia and pain medicine fellows, trainees, SIMGs and immediate family members via a helpline, online live chat, face to face meetings or the app The doctors' health and wellbeing helpline, operated by Converge International, has been located on the homepage of the college website since November 2018. The college promotes the Converge "live chat" service available to its members. The most recent usage report is at appendix 7.10.

The college regularly evaluates services provided by this helpline. To provide a tailored service, Converge International briefed their consultants to promote awareness of the specific issues faced by anaesthetists and specialist pain medicine physicians. This deeper understanding of day-to-day challenges has led to a curated approach to services. When fellows and trainees call Converge, they can expect to talk with their most experienced and qualified senior mental health professionals and coaches, all of whom have direct experience and knowledge of working with anaesthetists and pain medicine specialists.

Converge International offer specialised support from their Aboriginal and Torres Strait Islander consultants who demonstrate the in-depth cultural understanding and required approaches for specialist advice for Aboriginal and Torres Strait Islander peoples.

MCNZ requirement: flexible processes for trainees who identify as Māori to meet additional cultural obligations

The college recognises that trainees who identify as Māori may have additional cultural obligations and support the need for flexibility for them. The flexible processes to address this are described in standard 3.4.

7.5 Resolution of training problems and disputes

The AMC accreditation standards are as follows:	
7.5 Resolution of training problems and disputes	
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.

Trainee support for problems with supervision, training requirements and other issues

Trainee pathways for addressing collective training problems and disputes

- Accreditation process.
- Complaints process.

Individual trainee pathways for addressing training problems and disputes

1. The college has a formal Notifications and management of complaints and concerns policy which is available to all trainees. The policy and a link to a confidential form to make such a complaint is accessed through the doctors' health and wellbeing section of the website. The CEO's office manages complaints.
2. All trainees can raise a complaint with regulatory authorities and other bodies. It is expected that the college would also be notified by the trainee if this occurred.
3. Anaesthesia trainees can raise issues through their Australian Regional or New Zealand National Trainee Committee which can be escalated to the ATC.
4. Anaesthesia trainees can contact the ANZCA rotational supervisor or the ANZCA education officer for advice if they feel they cannot raise their issue at their place of work with their head of department.
5. FPM accredited units are usually small and from time to time trainees may be in conflict with their supervisor. In some cases the trainee is able to approach the unit director who can arrange with the FPM for an alternative supervisor to be appointed for that trainee. In other situations, the trainee may decide that they would be better completing their training in a different unit.
6. Both ANZCA and FPM training programs encourage all trainees to have a mentor and the college has developed mentoring resources (standard 4). Mentors are another source of advice and support for the trainee experiencing a dispute with their supervisors.

Complaints process

The college is committed to best practice in managing complaints and concerns. The AS/NZS 10002:2014 Guidelines for complaint management in organisations was used to develop the ANZCA Notification and Management of Complaints and Concerns Policy.

Trainees, Fellows and SIMGs can complete a confidential online form to notify the college of inappropriate behaviour.

The ANZCA Executive Committee has oversight of the policy and its implementation. All complaints are received by the ANZCA Professional Conduct Triage group, comprising the CEO, vice-president and Executive Director – DPA. The triage group assess the complaint and determine the appropriate pathway towards resolution. In managing complaints, the college commits to the general principles of confidentiality, procedural fairness, indemnification, collaboration with established health agency pathways and exclusions if a notification comes under the mandatory process of a statutory body.

The college's primary role under this policy is to facilitate agreed outcomes in the interests of maintaining high standards of professional conduct, consistent with the code of conduct and the *Supporting Anaesthetists Professionalism and Performance Guide*. BDSH notifications under this policy are in table 7.10.

Table 7.10 BDSH notifications re trainees and accredited training hospitals December 2018 – January 2022

Context	Year	Complaint	Actions
Anaesthesia - by persons acting on behalf of the college	2018	1 complaint bullying of trainee by SOT	Successful hospital investigation and resolution (SOT replaced)
Anaesthesia -not by persons acting on behalf of the college	2019	1 hospital, multiple complaints	Complex hospital investigation, resulting legal processes not yet complete but subsequently significant improvement in department of anaesthesia culture
	2019 - 2021	6 complaints bullying of trainee(s), single complaints multiple sites in multiple regions	Successful hospital investigations and resolution
	2019 and 2021	1 bullying, 1 sexual harassment, different regions	Complainants advised that no further action could be taken as complainants wished to remain anonymous
	2021	1 complaint bullying of trainees	Hospital investigation underway, and recent hospital accreditation visit, outcome not yet completed

Context	Year	Complaint	Actions
Pain medicine	2019	2 complaints about one training site	Subsequent accreditation visit by the FPM and significant changes in roles related to training resulted

Pathways for resolution of disputes between trainees and their supervisors

The college recognises that trainees have close working relationships with SOTs, clinical supervisors and assessors in their workplaces (standard 8.1) and that there is an inherent power imbalance.

Prevention

The standards expected of SOTs are outlined in the ANZCA and FPM SOT agreements and the ANZCA and FPM training agreements, including that the ANZCA and FPM, respectively, will 'encourage a climate conducive to learning' (ANZCA training program agreement, appendix 7.1) 'and 'provide appropriate educational supervision' (FPM training agreement, appendix 7.2).

To prevent conflict between FPM trainees and their supervisors, there are supports for supervisors when they need to raise performance-related concerns with trainees. The supervisor of training adviser's role includes providing advice to SOTs about trainees who are not meeting the knowledge, skills, behaviours and attitudes required, the remedial pathways that are available and the trainee performance review (TPR) process (standards 5 and 8.2). There are also online modules and modules in the ANZCA Educators Program specifically targeted at having difficult conversations (standard 4).

Resolution

Trainee surveys demonstrate unacceptable levels of BDSH and show that this is sometimes perpetrated by consultants, noting the surveys do not distinguish whether these consultants hold formal supervisory roles. Disputes may also arise from other issues such as rostering, performance feedback and interpersonal conflict. Whilst some of these issues will be addressed by the employer, the college is committed to effective and safe pathways for trainees to raise and resolve issues with their supervisors. The trainee pathways for resolution of these disputes are outlined above.

Support person for trainees during dispute resolution

Trainees are encouraged to bring a support person to all dispute resolution and formal feedback processes. This includes examination feedback and the TPR process.

Impacts of COVID-19

Trainee selection (standard 7.1)

There were no changes to anaesthesia and pain medicine trainee selection as a result of COVID-19, although some processes were conducted virtually. The college also noted less geographical movement of trainees, particularly during the ANZCA provisional fellowship training when some trainees would relocate internationally.

Trainee participation in governance (standard 7.2)

ATC co-chairs have continued to attend council meetings via Zoom. The binational ATC has continued to meet at the same frequency and has provided input into COVID-19-related training decisions, including regarding exams, volumes of practice, training time and fees. Regional and national trainee committees have continued to meet, sometimes virtually. Trainee representation on committees, sub-committees and working/project groups has continued, although there has been greater recognition that continued contribution may be problematic for individual trainees so opportunities have been offered to suspend or terminate contribution or to contribute less.

There was no change to trainee participation in FPM governance as a result of COVID-19.

Trainee communication (standard 7.3)

For anaesthesia training, targeted emails have been a particularly important mechanism during the COVID-19 pandemic when trainees needed information about training changes to training. Examples include impact of ICU redeployment on volumes of practice, changing the requirements for doing the compulsory Effective Management of Anaesthetic Crises (EMAC) course, and changes to college exams affected by travel restrictions on trainees and examiners. In 2021, the college has encouraged the chairs of examinations committees and sub-committees to communicate more regularly with trainees about changes.

From March 2020 (when the pandemic began to impact the college) to 4 November 2021, ANZCA sent 53 training and exam communications to specific groups of ANZCA trainees and their supervisors, with a further 21 general college-wide communications that included updates about all training and exams. An email about ICU redeployment of ANZCA trainees during the pandemic sent on 26 October 2021 had an open rate of 87.1% for SOTs and 65.3% for heads of departments. The college also published FAQs on COVID-19 related changes to the anaesthesia training program and underlying educational principles.

FPM trainees were generally less impacted by COVID-19 in their training environments . .The majority of communication with trainees occurred via the usual mechanisms.

Trainee wellbeing (standard 7.4)

Through trainee committee representatives, correspondence and forums, trainees have reported a negative impact on wellbeing arising from the uncertainties associated with COVID-19. This has included exam delays and impacts on training from cancellation of elective surgery and ICU redeployment . .

While there has been a strong focus on wellbeing messaging to pain medicine trainees as a result of COVID-19, no additional activities were developed.

Resolution of training problems and disputes (standard 7.5)

There have been no changes to dispute resolution that directly relates to the pandemic.

FPM Procedures Endorsement Program

Endorsees must be either an FPM fellow or a FPM trainee in the practice development stage. A template expression of interest form has been developed to assist in the selection process and provides standardised information on all applicants for consideration by the employing unit.

Fees associated with the program are included on the website and the fee structure is outlined in FPM by-law 20 and the Procedures Endorsement Program handbook.

Other training programs

Joint Consultative Committee on Anaesthesia (JCCA)

Trainees are selected by the Australasian College of Rural and Remote Medicine (ACRRM) or Royal Australian College of General Practitioners (RACGP), designated GP training contractors (vary from state to state), government agencies and individual employing authorities. JCCA training is by the individual employer in JCCA-accredited departments. Trainees are not involved in JCCA governance. Communication is via the JCCA website and emails. There are no fees for the JCCA qualification and no formal process to advise trainees of their training status. Trainee wellbeing is managed through their primary college. The JCCA has no systematic process for managing disputes between trainees and their supervisors.

Diploma of Rural Generalist Anaesthesia (DRGA)

Trainee selection will be by the ACRRM or RACGP and for DRGA training by the individual employer in sites with accredited departments. Current trainees are not involved in DRGA governance. However, there is a position on the Tripartite Committee for Rural Generalist Anaesthesia (TC-RGA) for a recent JCCA (of future DRGA) graduate. Communication is via the ANZCA website and emails.

Fees for the DRGA are being considered by the TC-RGA and will be publicised in the DRGA handbook and on the ANZCA website. Trainees will be advised of their training status through the TPS. Trainee wellbeing will be managed through their primary college. It is anticipated that disputes between trainees and supervisors will be handled through usual college processes.

Advanced Diploma of Diving and Hyperbaric Medicine (DHM)

Trainee selection for DHM diploma is undertaken by each employing unit, with a requirement for accreditation that it is undertaken in accordance with ANZCA selection principles (as per the ANZCA handbook for training). The college supports flexible training with trainees having five calendar years to complete all requirements, ability to train concurrently with their primary specialist qualification, and part-time training allowable to a minimum of 0.2 FTE. Training can be completed discontinuously but must be in minimum blocks of at least one week FTE. The college must be notified of leave that is longer than 26 weeks, in which case re-entry to DHM practice is required.

Communication with DHM trainees is via usual direct email communication mechanisms. Information on costs and changes to the DHM diploma is provided on the college website.

The processes for managing trainees not meeting training outcomes are analogous to those used in the anaesthesia training program, including the trainee support process and the trainee performance review. DHM trainees have access to the same wellbeing support resources and pathways as anaesthesia trainees. Disputes between trainees and their supervisors would be handled using the same pathways as for anaesthesia trainees.

At present the DHM Sub-committee (DHMSC) is considering a proposal to mandate an ex-offico position on the subcommittee for a DHM trainee. We expect to resolve this in 2022.

No changes to training requirements have been implemented to date. Given the small number of accredited training sites, the intention of the DHMSC is to consult with all training sites prior to the implementation of any such changes.

Diploma of Perioperative Medicine (POM)

The DipPOM will be available to advanced (or equivalent) trainees and fellows of ANZCA, RACS, CICM, RACGP, Royal New Zealand College of General Practitioners (RNZCGP), ACRRM and Royal Australasian College of Physicians (RACP). Eligibility and entry requirements are in development and plan to be finalised in mid-2023. Finalisation of diploma fees is anticipated in 2023 ahead of the program launch in 2024. A DipPOM handbook will be developed to ensure information is available publicly for trainees and prospective trainees. Other aspects of standard 7 are yet to be addressed.

Dual FANZCA-FCICM pathway

The processes for communicating training decisions, trainee selection, handling of fees and training disputes, and trainee involvement in governance of the dual training pathway are yet to be developed. As both colleges already offer vocational training, it is anticipated that these will be modelled on existing processes, with clarity about which college is responsible under what circumstance. Both the curriculum working group and conjoint committee (both yet to be formed) will include trainee representation. Trainees will have access to wellbeing supports and pathways through both colleges. Whether trainees will identify primarily with one college or have simultaneous access to both is yet to be determined. Fee structures, based on cost recovery, are yet to be determined.

Strengths

ANZCA trainee participation in governance (Standard 7.2)

There is well-established anaesthesia trainee participation across educational committees and project groups. The trainee committee structure with a central group of chairs of each of the New Zealand national and Australian regional committees promotes effective communication between the various regions and the central body. Evidence for the role of these groups in leadership development and succession planning is the number of former trainee committee chairs who go on to broader college roles as fellows. The ATC also maintains effective and reciprocal relationships with relevant external trainee bodies.

Trainee wellbeing (7.4)

There has been a strong focus on enhancing wellbeing resources and promoting the importance of wellbeing over recent years. ANZCA and FPM trainees were involved in the leadership of many wellbeing activities under the auspices of the Trainee Wellbeing Project Group.

Improvement opportunities and future plans

Trainee selection project (standard 7.1) (page 256)

The college recognises it could significantly improve current trainee selection processes, including monitoring for site and jurisdictional variation and potential inequities. Compared to many other specialty colleges, the college has a minimal role in the selection process and policy.

Within the training program evolution (TPE) project scope and funded for 2022, the trainee selection project will explore the merits of introducing a more standardised selection system to:

- Prevent discrimination and bias, meet community and sector standards, increase recruitment of Aboriginal and Torres Strait Islander and Māori trainees, and assure consistent application across sites, regions and countries. The college will take more responsibility for selection to balance recruitment of Aboriginal and Torres Strait Islander and Māori trainees and those destined for rural and regional specialist practice. This aligns with the draft Reconciliation Action Plan (RAP, standard 1.1, appendix 1.10) and regional and rural workforce strategy (standard 1.6, appendix 1.29).
- Introduce monitoring and evaluation of selection processes to validate the quality of the intake in terms of capacity to complete training and achieve graduate outcomes.
- Increase college input into matching trainee numbers to training capacity and workforce requirements, in collaboration with Australian jurisdictions and the Ministry of Health in New Zealand. As the college accredits sites rather than posts, trainee numbers are driven by hospital service needs and the college has limited influence on this, potentially resulting in workforce supply and maldistribution issues.
- Investigate issues associated with independent anaesthesia trainees to support equitable progress through the training program.

In accordance with the draft RAP (standard 1), in 2022 and 2023, this project will include a review of strategies to increase and retain the Aboriginal, Torres Strait Islander and Māori anaesthesia and pain medicine workforce. The key project objectives for 2022 are to establish working groups to support the project and report preparation process and to deliver a report on the current state of trainee selection, an environmental scan to identify best practice and recommendations for changes to anaesthesia and pain medicine trainee selection.

The college is also committed to continue working with the Australian Indigenous Doctors Association (AIDA) on the Specialist Trainees in the Medical Workforce project. The college is participating in a consortium with AIDA and other medical colleges on a four-year proposal to the Australian Government Department of Health under the Flexible Approaches to Training in Expanded Settings Program. The project will establish a multi-college support network for trainees who identify as Aboriginal and Torres Strait Islander, as well as developing cultural safety resources and other support initiatives. The project will also work with colleges to develop tailored strategies to support trainee selection.

In Aotearoa New Zealand, the college is engaging with the Māori Anaesthetists Network of Aotearoa (MANA) and the Pasifika Anaesthetists in Aotearoa (PAIA) to achieve population parity by supporting trainees from these groups.

FPM trainee representation (standard 7.2)

The FPM recognises it can improve the involvement of trainees within the governance of their training. The challenges of a two-year program notwithstanding, this is an issue that the faculty will explore with its trainee body to understand how best to processes and structures for greater trainee participation.

ANZCA trainee communication (standard 7.3)

Both ANZCA trainee surveys and the Australian Medical Training Survey longitudinally demonstrate concerns about the quality of communication from the college to anaesthesia trainees. Recent developments include reviewing individual communication templates to improve their transactional tone, acknowledge significant events and achievements, and provide information on support resources. Perhaps the college could be more proactive with its communications. The plan is to involve the ATC to understand and address this issue.

ANZCA and FPM trainee wellbeing and BDSH (standard 7.4)

Sadly, monitoring through trainee surveys shows that BDSH remains a major issue. The college plans to address outstanding recommendations of the Trainee Wellbeing Working Group report (table 7.9). Pathways for dealing with BDSH are under review. Significant changes will include improved links to the training site accreditation process to strengthen college assistance for training sites to deal with BDSH successfully.

Resolution of training disputes between all trainees and supervisors (standard 7.5)

Whilst the college has policies and pathways for responding to disputes between trainees and their supervisors, it is not clear that these processes are always clear to trainees or that they are willing to engage in them. Trainees in smaller hospitals may find difficulty in identifying a colleague to assist and support them. Anaesthesia trainees need to be aware of how to reach out to Australian regional and New Zealand national trainee committees for assistance if support is not available in their workplace. Furthermore, the time taken to complete the process and reach a decision means there is a risk that trainees may withdraw from the program prior to receiving a final decision. There is an opportunity to develop training for the trainee committees on how to support their colleagues if they are in dispute with their supervisor of training.

Standard 8

Implementing the program – delivery of education and accreditation of training sites

ANZCA
FPM

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

Overview

Delivery of education

All training programs have well established and recognised clinical supervision frameworks that guide trainees in the progressive acquisition of skills to achieve program and graduate outcomes. The college has defined supervisor responsibilities and appointment processes. It provides professional support for them to ensure they are appropriately resourced for their roles. This resourcing is evaluated at accreditation. For anaesthesia supervisors, no specific training for their roles is mandated. Pain medicine supervisors are required to attend regular training workshops. While trainees provide feedback on departments through accreditation and trainee surveys, there is no process for individual supervisor performance evaluation and feedback.

The college has procedures for selection of workplace-based assessment (WBA) assessors (for anaesthesia) and examiners (for all exams). For pain medicine training, all fellows may undertake workplace-based progressive feedback (WBPF). There are compulsory workshops for examiners and processes for feedback on examiner performance, although this does not include input from trainees. For WBA assessors and supervisors undertaking WBPF, the college offers training in workplace-based performance assessment and giving feedback, although this is not mandated. There is no process for individual WBA and WBPF assessor performance evaluation and feedback.

Key resources for supervisors and assessors include:

- The ANZCA handbook for training (sections 2.5 supervision and 4 supervisors and tutor roles).
- The FPM Training Handbook (section 2 training roles and responsibilities).
- The ANZCA Educators Program modules (standard 4).
- The ANZCA training portfolio system (TPS) and FPM ‘paper-based’ trainee portfolio (standard 4).
- The ANZCA and FPM CPD program including recognition of supervision, assessment and cultural safety activities (standard 9).

See also: Standard 3 (curriculum framework), standard 4 (teaching and learning resources), standard 5 (assessment), standard 9 (CPD program).

Accreditation of training sites

Accreditation of anaesthesia and pain medicine training locations is based on seven accreditation standards – quality patient care, clinical experience, supervision, supervisory roles and assessment, education and training, facilities and clinical governance. The process is governed by the ANZCA Training Accreditation Committee (TAC) and the FPM Training Unit Accreditation Committee (TUAC), supported by staff in the Training Assessment and FPM units.

ANZCA accredits training sites which are anaesthesia departments and all facilities within the same complex. It also recognises training experience in sites accredited by other colleges, particularly the College of Intensive Care Medicine (CICM) and the Australasian College for Emergency Medicine (ACEM). ANZCA regional and national committees accredit anaesthesia rotations which are groups of hospitals in each Australian region and Aotearoa New Zealand which can provide a complete training experience to achieve graduate outcomes. The FPM accredits multidisciplinary pain management units, both hospital-based and community-based services such as private practices. The FPM program does not have rotations, but rather uses the term 'suite of training' for individual trainee experiences which may occur across more than one unit.

ANZCA and FPM accreditation processes are separate. As part of training evolution, the college recently completed an ANZCA and FPM Accreditation and Learning Environment Project (ALEP), a collaborative piece involving both disciplines. Using mixed methodology to benchmark the college against international best practice in accreditation, the ALEP final report *An evolutionary direction for accreditation of college training programs* provided 15 recommendations as a roadmap for future accreditation optimisation. This was endorsed by ANZCA Council in mid-2021.

The key ALEP recommendation is cross-program accreditation redesign with generic and specialty-specific standards and processes that are scalable for all future college training programs. Other recommendations include better monitoring of accredited sites, improved volunteer accreditor support, mapping of standards to graduate outcomes, improved data with an outcomes focus, bi-directional data sharing with units, strengthened trainee input, and more robust accreditation of anaesthesia rotations. An implementation plan will be developed in 2022. The lifelong learning project will deliver an online accreditation management system for all training programs which will facilitate monitoring (standard 4).

Key resources:

- ANZCA handbook for accreditation.
- ANZCA regulation 37.27 and 37.28.
- FPM accreditation handbook.
- FPM by-law 19.
- Handbook for advanced diving and hyperbaric medicine accreditation.
- The college will provide the AMC team with access to the ANZCA electronic accreditation management system and the 'paper-based' FPM datasheet, used for data collection, which is password-protected and accessed via the

See also: Standard 1 (reconsideration, review and appeal), standard 6 (monitoring and evaluation) and standard 8.1 (accreditor selection and training).

8.1 Supervisory and education roles

The AMC accreditation standards are as follows:	
8.1 Supervisory and education roles	
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.

Effective system of clinical supervision to support trainees to achieve program and graduate outcomes

All training programs have an effective framework for clinical supervision. These are regularly reviewed. Most recently, supervision in the anaesthesia training program was reframed to include not only the supervisor role but also the role of the trainee (table 8.1). Information on mentoring and other trainee wellbeing supports that often occur concurrently with supervision are in standard 7.4.

Anaesthesia training supervisory system

Training occurs primarily in ANZCA-accredited health services during clinical care. The system for effective supervision includes all specialists and provisional fellows who provide direct day-to-day supervision, those in formal supervisory roles and a supervision framework that allows increasing independence as trainees become more competent. This supervisory system includes minimum requirements for one-to-one supervision for trainees in all training stages, including clear guidance on when to seek supervisor input. Key to this system are also publicly available curriculum and training requirements (standard 3), supervisor training resources (standard 4), WBA requirements and regular performance feedback (standard 5), and regular supervisor communications. Training accreditation ensures training sites provide adequate resources, including staffing, to support appropriate clinical supervision (standard 8.2).

A guide for required supervisor of training (SOT) time is one scheduled clinical support session per week per five vocational trainees. There is no mandated trainee to trainer ratio,

but anaesthesia departments can appoint more than one SOT to accommodate workload. Other supervisor and tutor roles are appointed to deliver curriculum components in accordance with the case mix and size of the department (table 8.3).

Clinical supervision principles are:

- All clinical work must be supervised at a level appropriate to the trainee's clinical experience, the patient's condition and the clinical situation.
- The same standards of supervision apply at all times.
- Direct supervision must be provided by a supervisor with appropriate experience who meets ANZCA guidelines for being a clinical supervisor.
- Supervision must occur in all areas where trainees work, not just the operating theatre.
- Trainees must be encouraged to seek advice and/or assistance as early as possible when they are concerned about the patient's condition or their ability to manage it.
- Emergency experience is an essential training component. While this may occur in hours, it is important that it is also experienced out-of-hours for trainees to understand working under a resource-constrained environment.
- Part-time training is subject to the same supervision requirements as full-time training.

The widely recognised and long-established **supervision level framework** is in table 8.1.

Table 8.1 Clinical supervision levels in anaesthesia training

Supervision level	Supervisor	Trainee	When required
Level 1: ability to intervene immediately	• Exclusively available to that trainee. • Usually present, can attend within one to two minutes if briefly absent. • Fully aware of details of case, plan, progress and dynamic situation.	• Negotiates role in case with supervisor. • Knows location of supervision and how to get immediate help. • Only undertakes significant interventions with supervisor knowledge.	• All trainees for unfamiliar areas. • Introductory training until initial assessment of anaesthetic competence (IAAC) completion (standard 5).
Level 2: ability to intervene quickly	• Available without delay, other duties only if can be immediately abandoned.	• Knows how to contact supervisor for assistance or advice.	

Supervision level	Supervisor	Trainee	When required
	• Can attend within five minutes. • Fully aware of details of case and plan. • Can be provided level 2 to one or two trainees.	• Can initiate management of complication or change in patient condition. • Aware of limitations and need for help.	
Level 3: available on site	• Available after only short delay, always available for consultation. • Within same institution. • May be unaware of care or procedure. • Can be provided to more than one trainee.	• Knows who supervisor is and how to contact. • Knows how to manage complication or change in patient condition, and can commence and continue treatment until help arrives. • Recognises patient, anaesthetic and surgical factors that increase risk to inform planning decisions and need for help.	• Encouraged as progress through core units.
Level 4: available off-site	• Always available for consultation and free of commitments that would prevent attendance. • Exclusively on call for the institution and able to attend in reasonable time	• Knows who supervisor is and how to contact. • Knows how to manage complication or change in patient condition, direct others to assist if needed, and continue until	• Encouraged as progress through core units.

Supervision level	Supervisor	Trainee	When required
	(usually 30 minutes depending on local guidelines). • May be unaware of case or procedure.	issue is resolved or supervisor help is provided. • Able to accurately anticipate risk or deterioration.	

Acceptable clinical supervisors are anaesthetists who hold FANZCA, those employed as specialist anaesthetists with Australian Health Practitioner Regulation Agency (AHPRA)/Medical Board of Australia (MBA) specialist registration or Medical Council of New Zealand (MCNZ) vocational registration, specialist international medical graduates (SIMGs) in anaesthesia specialist or provisional fellowship posts under specified conditions (ANZCA handbook for training page 22), FFPMANZCAs (for pain medicine experience), CICM-approved supervisors (for intensive care medicine experience), and ANZCA provisional fellows.

Guidance on appropriate supervision levels by training stage is in table 8.2. Section 2.5 of the ANZCA handbook for training also provides guidance on supervision for years of experience in clinical anaesthesia, for paediatric anaesthesia, and for trainees in the trainee support process (TSP).

Table 8.2 Appropriate supervision levels for elective and emergency workload in anaesthesia training by percentage of hours worked

	IT before IAAC	IT after IAAC	BT	AT
Level 1 and 2	100% level 1	Maximum 50%	Minimum 50%	Minimum 30%
Level 4	NA	Maximum 10%	Maximum 20%	Maximum 40%
Emergency workload *	15-30%	25-20%	25-50%	25-50%

* may be higher in some placements (e.g. retrieval medicine, obstetric anaesthesia) but should be met for training overall

Pain medicine supervisory system

Each pain medicine trainee has a nominated supervisor who is an FPM fellow. In the core training stage (CTS), trainees train at an accredited level one training unit under the supervision of an appointed SOT. In the practice development stage (PDS) trainees may elect to train under the supervision of a PDS supervisor in a level one accredited unit, a PDS-accredited unit or in a non-accredited unit following approval by the FPM assessor. The roles of PDS supervisors were introduced as part of the 2015 training program and have allowed for significantly more FPM fellows to be involved in training program delivery.

Supervisory roles: Responsibilities of supervisors and the college and communication of program and graduate outcomes

Anaesthesia training program supervisors

The program includes departmental roles, as well as wider roles for rotations, Australian regions and for Aotearoa New Zealand (table 8.3). Section 4 of the ANZCA handbook for training includes their duties; selection, appointment, tenure and reappointment; resources and support; and access to trainee information via the training portfolio system (TPS). There is at least one education officer (EO) for Aotearoa New Zealand, each Australian state and the ACT (the NT is combined with SA). Many regions have deputy EOs for sharing of workload and duties. There is one rotational supervisor (ROT) for each rotation.

The pivotal role is the ANZCA SOT who is broadly responsible for training at the site and appoints other departmental supervisors and tutors, in consultation with the head (or director) of department. SOT duties include trainee supervision and management, managing and assisting trainees requiring more support (standard 5.3.3), education for trainees and WBA assessors, and other duties (ANZCA handbook for training section 4.3).

Table 8.3 Responsibilities of supervisors and tutors in the anaesthesia training program

Role	Responsibilities
Education officer	Central coordinator of anaesthesia training within their region or country, including liaison between the central college and trainees, supervisors, heads of department, and members of their regional or national committee (of which they are a member). Monitors accredited sites and notifies concerns to Education Executive Management Committee (EEMC) and TAC. Trainee management: manages disputes between trainees and supervisors, gives advice to trainees on matters they can't raise with their SOT, gives advice to SOTs on borderline or unsatisfactory trainee performance, assists SOTs with trainees in the TSP and progression to trainee performance review (TPR), organises and leads exam remediation interviews. Education: of supervisors and tutors, ensures exam courses run in their region or country, convenes SOT and ROT forums, attends EO network and reports on their region or country. Appointment of SOTs, on recommendation from the head of department.
Rotational supervisors	Coordinate the training and rotation of ANZCA trainees among the hospitals in their accredited rotation. Allocate trainees to clinical placements. Liaise with departments.

Role	Responsibilities
	Monitor clinical experience and volumes of practice at each training site in the rotation, notifying the EO of any concerns about access to training opportunities. Ensure the TPS reflects the correct rotation and clinical placement for their rotational trainees.
Supervisors of training (SOT)	Broadly responsible for anaesthesia training at each ANZCA-accredited training site. Require strong understanding and experience of ANZCA activities.
Heads of department	Ensure compliance with accreditation standards and criteria including working with management to secure adequate equipment, facilities, staffing and other resources for high-quality training (standard 8.2). Ensure orientation of trainees to the department (checklist in the ANZCA handbook for training page 85). Assist management of trainees in the TSP. Consulted by SOT for appointments to other supervisory roles.
Introductory training tutors	Oversee introductory training (IT) within their department. Work with the SOT to ensure opportunities to complete IT. Coordinate the IAAC (standard 5). Assist trainees to identify when ready for the IT core unit review (standard 5). Identify trainees not progressing as expected through IT. Advise on balancing study for the primary exam with developing a solid foundation in clinical anaesthesia.
Clinical fundamental tutors	Experts and primary resources within the department for one of the seven clinical fundamentals (standard 3). Not a formal appointment, in smaller departments may be undertaken by the SOT. No specific TPS access provided.
Specialised study unit supervisors	Oversee training in each of the 12 specialised study units (SSUs) to assist trainees to meet training requirements (standard 3); the mix of SSU supervisors within each department is determined by casemix. Guide trainees in setting goals and gaining experience in their SSU.

Role	Responsibilities
	Oversee WBA completion for the SSU. Review SSU progress including three questions from the bank (linked to learning outcomes). Ensure learning goals are met and 'signoff' SSU completion. Where SSU requirements are not completed at the end of a clinical placement, assist trainee planning for meeting requirements in subsequent clinical placements. For the specific duties of intensive care medicine supervisors, see *ANZCA handbook for training* section 4.6.2.
Departmental scholar role tutors	Assist trainees to identify opportunities to undertake scholar role activities (SRAs). Provide feedback and guidance on SRAs. Provide advice on jurisdictional regulations on audit and research. Observe and assess trainees completing SRAs. Submit data to TPS.
Provisional fellowship supervisors	Oversee the individualised training requirements of provisional fellows working in their department.

Some ANZCA supervisors sign an agreement outlining their roles and responsibilities before commencement of their duties. The agreements for education officers, SOTs, ROTs and departmental scholar role tutors are at appendix 8.1.

Regular communications with those in anaesthesia supervisory roles include:

- Training e-newsletters, shared bi-monthly.
- Scholar role supervisor e-newsletter, shared quarterly (appendix 8.2).

Pain medicine training program supervisors

Pain medicine training program supervisory roles, responsibilities and appointments are summarised in table 8.4. Further information is in the FPM training handbook section 2. Before commencing their role, all supervisors sign an agreement which outlines their roles and responsibilities (appendix 8.3).

Table 8.4 Responsibilities of supervisors in the pain medicine training program.

Role	Responsibilities of practitioner
Supervisor of training (SOT) advisor	A centrally appointed role. Advises SOTs on the FPM training program including where trainees are not meeting the knowledge, skills, behaviours and attitudes required for training, including remedial pathways. Assists SOTs to optimise their educational development and works with faculty staff to provide opportunities for SOTs to network and discuss the training program. Disseminates information about training program developments from the Learning and Development Committee to SOTs and provides advice to the committee on matters directly related to SOTs, their roles and the support required to adequately perform these.
Supervisor of training (SOT)	FPM training representative within each accredited training unit. Oversees clinical performance, WBPF, in-training assessments (ITAs) and core training stage review.
Practice development stage supervisor	Oversees progression and performs ITAs, MSF WBPF and PDS review. Duties can be performed by an SOT or another specialist.
Placement supervisor	Oversees trainee clinical performance and WBPF during the placement, including regular feedback. Maintains regular contact with the PDS supervisor and provides feedback to them about trainee performance.

Number of anaesthesia and pain medicine supervisors

The tables below include all centrally-collected data on supervisors. Note that some supervisory roles are appointed at a departmental level and not centrally recorded.

Table 8.5 Number of education officers, rotational supervisors, supervisors of training and department scholar role tutors in the anaesthesia training program at the start of each hospital employment year, 2017-2021

Supervisor type	Year	ACT	NSW	NT	Qld	SA	Tas	Vic	WA	NZ	Total
Education officers	2019	1	3	0	3	1	1	2	2	1	14
	2020	1	3	0	3	1	1	2	2	2	15
	2021	1	3	0	3	2	1	3	3	2	18
Rotational supervisors	2019	0	12	0	5	2	1	5	1	4	30
	2020	0	12	0	6	0	1	5	1	5	31
	2021	0	11	0	6	1	1	5	1	6	31
Supervisor of training	2019	4	96	5	62	19	7	73	26	50	342
	2020	6	102	5	59	18	7	73	29	54	353
	2021	6	104	5	63	20	7	78	28	60	371
Department scholar role tutors	2019	1	16	1	13	7	4	25	3	13	83
	2020	1	29	1	26	8	4	36	8	20	133
	2021	2	35	2	31	16	4	49	9	31	179

Table 8.6 Number of supervisors of training and practice development supervisors in the pain medicine training program, 2017-2021

Supervisor type	Year	ACT	NSW	NT	Qld	SA	Tas	WA	Vic	NZ	Total
Supervisor of training	2021	1	15	0	6	2	1	5	14	3	46
	2020	1	16	0	5	2	1	5	13	5	47
	2019	1	18	0	6	2	1	5	15	4	52
	2018	2	16	0	6	2	1	5	14	4	50
	2017	2	14	0	6	2	1	5	15	3	48

Supervisor type	Year	ACT	NSW	NT	Qld	SA	Tas	WA	Vic	NZ	Total
Practice development stage supervisor	2021	1	11	0	7	2	2	7	4	1	35
	2020	1	7	0	7	2	2	3	5	2	29
	2019	1	6	0	6	2	1	2	11	2	31
	2018	1	3	0	3	1	1	3	7	1	20
	2017	1	6	0	4	1	1	3	9	2	27

Selection and training of supervisors

Anaesthesia supervisors

Selection of supervisors of training

Each SOT must hold FANZCA or a comparable qualification acceptable to the ANZCA Council. They should have an interest in education and a good understanding of the anaesthesia training program. They must not be a head of department**.** Prospective SOTs for each ANZCA-accredited training site are nominated by the head of department to the EO for formal approval, although many EOs view this as a formality with very few nominations declined. The EO then notifies the ANZCA training and assessments team of the appointment. On appointment, and re-appointment, SOTs must sign an agreement that outlines mutual obligations between the college and the supervisor (appendix 8.4). The initial appointment is for a three-year term.

The college notifies the EO when an SOT is nearing the end of their three-year term, they will review and give consideration for a further term. The review process provides an opportunity to consider succession planning and other possible development roles for the SOT. The SOT may be appointed for a total of four three-year terms. If there are concerns regarding SOT conduct, this would be referred to the relevant EO. The EO would also review the situation if the SOT was able to fulfil the requirements of the role as per the signed SOT agreement.

Training and support for SOTs

Departmental support

As a condition of ANZCA accreditation, SOTs must be provided with appropriate clinical support time, physical facilities and other resources to undertake their roles.

These include:

- Regular, scheduled clinical support time for the duties outlined in the *ANZCA handbook for training* section 4.4.1.
- Access to appropriate facilities, a private space to meet with trainees with internet and computer access to enable regular (daily) updates to the TPS and ANZCA website.

- Support from other departmental members for WBAs, other supervisory and tutor functions, and the TSP.

Australian regional and Aotearoa New Zealand national support

- In Aotearoa New Zealand and each Australian region, SOT meetings are coordinated by the EO team and held about two to three times per year (table 8.7). These allow networking, mentoring of junior SOTs and educational workshops. They have continued during COVID-19 either online or using a blended online and face-to-face model. Sample programs are at appendix 8.5.
- The EOs in turn interact through the EO network (terms of reference appendix 8.6).

Table 8.7 Educational topics at SOT meetings for each Australian region and Aotearoa New Zealand, 2019-2021

Country or Australian region	2019	2020	2021
Aotearoa New Zealand	WBA workshop Trainees in difficulty Primary exam remediation process Accreditation visits	Training program evolution project recommendations Director of professional affairs (DPA) Q and A session Trainee in difficulty process	Feedback to enhance learning (AEP module) Cultural safety and equity
ACT/ NSW	WBA: Relaunch – theory and reality DPA assessor – Q and A session	Impact of COVID-19 on trainees and SOTS Supervision (AEP module)	Primary and final examination update/ workshop Supporting trainees with exam preparation, difficult conversations, support for SOTs
Qld	The beginning and the end: Clinical Placement Review and Core Unit Review How do we teach and assess non-technical skills DPA assessor workshop Mental Health First Aid Workshop		Recognising and managing trainees who need assistance and support Supporting trainees on a TSP Writing a plan that helps trainees achieve their goals

Country or Australian region	2019	2020	2021
SA/NT		Feedback to enhance learning (AEP module)	
Tas	Wellbeing update	Selection and interview techniques AEP module	SIMG update AEP module
Vic	Mentor/ mentee workshop Feedback to enhance learning (AEP module) Organisation of education in departments (AEP module) Legality issues QandA panel		Planning effective teaching and learning (AEP module) Helping the previously unsuccessful candidate to re-sit the (final) exam Technology in teaching and learning (AEP module) Critical incident debriefing toolkit
WA	Part one exam: How to help the trainees with preparation Information and updates from the ANZCA part one Remediation Interview Workshop Clinical supervision (AEP module) WBA workshop	How to write and deliver a Part 1 Viva Competency-based medical education Part one exam: General information and how to help trainees improve	Interactive learning and teaching (AEP module) Feedback to enhance learning (AEP module) Difficult conversations Supporting trainees (AEP module) Difficult conversations TPS documentation

College resources and support

College wide

In the ANZCA and FPM CPD program, credit can be earned for activities relevant to SOT performance including reading educational articles, attending SOT workshops, and performing WBAs or WBPFs. These are automatically accredited in the CPD portfolio for TPS entries of WBAs and formal ANZCA events.

There are not currently targeted CPD requirements for supervisors and these could be considered. There may be an opportunity for development of peer review and MSF surveys targeting performance in specific supervisory roles. 'Easy targets' for assessing SOT performance include timely completion of training reviews for each program, and attendance at SOT meetings, although it is not clear that these correlate with SOT performance.

Anaesthesia supervisors

There are currently no mandatory training requirements for anaesthesia SOTs. While the college always intended to mandate participation of anaesthesia supervisors of training in the ANZCA Educators Program (standard 4), currently it is voluntary. In the three years pre-COVID-19, approximately 50 per cent of SOTs had completed the course (source: dashboard on training program).

Anaesthesia SOT induction course and resource hub (STP support project)

This project is being led by the Learning and Innovation team of the Education and Research unit and aims to develop an online module for educating and upskilling SOTs and strengthen current support resources. The project will deliver a:

- Suite of online learning activities to support new SOTs in the requirements, skills and activities associated with supervising ANZCA trainees. The format is intended to be interactive and available as an ongoing resource and reference for SOTs.
- New SOT support hub library guide, which links to information and resources to support and upskill supervisors of training (including the suite of online learning activities developed as part of this project). The library guide topics are aligned to the topics of the online learning activities and include:
    - Key things a SOT should know and do.
    - Using the TPS.
    - Effective mentoring.
    - Mechanisms for supporting trainees.
    - Support resources.
    - Understanding professionalism and managing communication.
    - Responding to bullying, discrimination and sexual harassment.
    - Wellbeing resources.
    - Cultural awareness.

During the consultation process to identify the needs of SOTs, it was recognised that SOTs desired clearly defined roles and responsibilities for their role. To address this, the working group, in collaboration with ANZCA DPA assessor Dr Maggie Wong, drafted a position

description (PD) for ANZCA supervisors of training (appendix 8.7) that identifies key result areas and selection criteria. The SOT PD will be embedded across key resources and activities once ratified by the EEMC later in 2022.

ANZCA supervisors e-newsletter

The college also circulates an e-newsletter to anaesthesia supervisors of training every two months to inform them of important issues around training that impacts trainees. This newsletter is sent out a couple days before the *Training E-Newsletter* allowing supervisors to support trainees through any changes and issues raised in the *Training E-Newsletter*.

Pain medicine supervisors

SOTs and PDS supervisors at accredited units are nominated by the unit director and appointed by the FPM Training and Assessment Executive Committee (TAEC). PDS supervisors at non-accredited units are appointed for individual trainees and approved by the FPM assessor. All SOTs and PDS supervisors sign an agreement before commencing the role which outlines their roles and responsibilities (appendix 8.3).

Both SOTs and PDS supervisors can access the education provided by the college such as the ANZCA Educators Program and online modules, and FPM-specific resources such as FPM supervisor workshops and support via the SOT advisor. The SOT advisor coordinates workshops for FPM supervisors and is a member of the Learning and Development Committee so that issues raised by supervisors are understood by the governance of FPM. The SOT advisor terms of reference are at appendix 8.8.

FPM SOTs and PDS supervisors must attend at least one FPM SOT workshop within 12 months of appointment and at least one other every two years thereafter. A number of resources for pain medicine supervisors have been collated on the website to make accessing them easier for clinicians. FPM don't circulate a specific SOT e-newsletter, but SOTs receive the *FPM Training E-Newsletter.*

Routine evaluation of supervisor effectiveness including feedback from trainees

Supervisor performance is not systematically evaluated. No college training program provides supervisors with individual performance feedback. The college recognises that this is a gap in current processes.

Trainees contribute to surveys which evaluate the performance of entire departments rather than individual supervisors. These pathways include the training accreditation processes and regular trainee surveys (standard 6). This may include feedback on individual supervisors. Some departments may undertake departmental surveys and feedback on SOT performance may occur formally or informally to heads of department. This feedback is not systematised and not viewed by the college.

There are pathways in place for management of bullying, discrimination and sexual harassment (BDSH) and trainees are encouraged to develop mentoring relationships (standard 7.4). Pathways exist for trainees to escalate concerns about SOT performance or decisions to the ANZCA CEO if there is conflict between the trainee and the SOT, and the trainee can initiate a trainee performance review, although this would not necessarily indicate poor SOT performance.

Anaesthesia training

SOTs are appointed for three years and then reviewed before reappointment for a further three years. Reappointment for an ongoing three-year term implies head of department and EO satisfaction with SOT performance, but this is an assumption. Not all SOTs continue in the role for 12 years, as some progress into other college or hospital leadership roles. The reason for leaving the role could be captured in an ‘exit survey’ when SOTs resign. The ANZCA handbook for training indicates anaesthesia trainees experiencing difficulties with their SOT should contact their EO, but trainee understanding and use of this mechanism is unclear.

Pain medicine training

The pain medicine training program does not have a specific role to support trainees who are experiencing difficulties with their nominated supervisor. This is a gap that FPM recognises that it needs to address. All trainees are encouraged to have a mentor in addition to their supervisor. Most trainees will reach out to the faculty when there are concerns and there are a number of fellows in specific roles that may be called upon. The doctors' health and wellbeing resources and complaints processes are publicised widely in the FPM Training Handbook, website and e-newsletters (standard 7.4).

Assessor selection, training, support and professional development

Anaesthesia training program

ANZCA WBA assessors and WBA leads

WBA assessors are an essential resource in the training program and as every supervisor of anaesthesia trainees is expected to engage in WBAs and performance assessment for learning, there is no formal selection process. There is little, if any, evaluation of supervisor performance with WBAs. The large number of assessors creates opportunity for trainees to be exposed to feedback through multiple lenses while also presenting a challenge to provide equitable training and support.

ANZCA WBA leads have supported the delivery of WBA workshops across the ANZCA community and undertaken their roles in accordance with their terms of reference (appendix 8.9). WBA leads are required to go through a selection process. The ANZCA Educators Sub-committee is responsible for the appointment, reappointment and support of ANZCA WBA leads. Data are collected on WBA numbers by department and circulated to departments for benchmarking against similar-sized hospitals.

Prior to the launch of the 2013 training program, which introduced WBAs as an assessment tool, WBA introduction workshops were offered at training sites across Australia and Aotearoa New Zealand to familiarise supervisors with the tools and processes required for implementation. These workshops were delivered across a 12-month period by a group of 30 WBA leads.

Starting in 2013, there has been ongoing investment in educating supervisors as WBA assessors. ANZCA Educator Program (AEP) modules “Authentic assessment” and “Feedback to enhance learning” included education on WBAs as a learning process and guidance on engaging in a feedback conversation with trainees. Since 2013, 683 people have attended the “Authentic assessment” module and 863 people have attended the “Feedback to enhance learning” module.

In 2018, the college identified issues with WBAs in relation to purpose and misunderstandings about formative and summative use of the tools. There were also issues interpreting the rating scales used (highlighted in the 2018 AMC comprehensive report). Additionally, audit documentation in the TPS found that both quantity and quality of actionable feedback was poor. To address these issues, WBA forms were redesigned (standard 5) and a face-to-face WBA education workshop was created. This re-education workshop was incorporated into the AEP “Authentic assessment” module.

In 2019, specialist training program (STP) funding was established for 12 months to deliver a bi-national rollout of WBA education workshops at all training sites across Australia and Aotearoa New Zealand. 29 consultant anaesthetists (WBA leads) were educated to deliver these workshops. During this time, 99 workshops were attended by 1344 trainees and consultants. Initial evidence found a positive increase in the quality of actionable feedback.

Throughout 2020-2021, the intended bi-national rollout of WBA education workshops to all training sites was put on hold as educators could not travel due to COVID-19. Furthermore, in late 2020, an organisational restructure initiated a review and prioritisation of college educational projects and identified the resources required to transition WBA education to a business as usual activity. As a result, the WBA education workshops continue to be delivered as part of the ANZCA Educators Program, which pivoted to online delivery. Consultation is currently underway to consider approaches for the widespread delivery and impact evaluation of the WBA education workshops.

Departmental support

All WBA assessors should be provided with appropriate time, physical facilities (private space for meetings with trainees, secure document storage and a computer with internet access), and support from other departmental members for their role. Some departments have identified WBA champions to provide informal support to members of their department to try and improve the amount and quality of feedback provided to trainees. Some have regular ‘WBA days’ during which trainees and supervisors are encouraged to complete WBAs.

Regional support

The SOT, head of department, education officer and regional WBA lead are available for guidance, assistance and any input necessary to enable a WBA assessor to fulfil their duties.

ANZCA examiners

Primary and final examiners apply to the Primary or Final Examination Sub-committee (PESC or FESC), respectively, to join the panel of examiners. The court of examiners is the subgroup of examiners who examine for a specific examination sitting. PESC and FESC appoint and reappoint examiners and notify the EEMC. Examiners serve three-year terms and may be reappointed to a total of 12 years. Examiners must complete a probationary period, following which their performance is assessed and they are either appointed for a full term or their appointment is not confirmed. ANZCA examiner terms of reference are at appendix 8.10.

The criteria used for appointment are:

- Willingness to commit to the examination process.
- Post-fellowship experience (three years minimum for the primary exam and five for the final exam).
- Attendance at an examiners workshop.
- Knowledge of the ANZCA vocational training program curriculum relevant to the exam for which the examiner is applying.
- Ability to recognise and manage potential bias and conflicts of interest.
- Advanced communication skills.
- Specific expertise as required by the panel from time to time.

The examiner cohort comes from wide and diverse backgrounds in anaesthesia. They work across sites in Australia, Aotearoa New Zealand and Hong Kong and at a combination of private and public practice, have a diversity of gender, race and cultural backgrounds, and a range of experience from five to more than 20 years post-fellowship.

Examiners have ongoing opportunities to access learning resources and attend regular examiner workshops for new and current examiners. Examiner training is mandatory. There are workshops at each exam which provide ongoing education around the different exam components as well as education or assessment updates. New examiners attend a two-day face-to-face workshop prior to their first exam.

Primary exam

Mentors for new examiners are allocated during their probationary period. Examining at the AMC testing centre allows examiners to be assessed without an extra person in the room, improving fidelity. Appointments are for three years with reappointment by PESC guided by examiner assessor (EA) reports on individual performance.

Final exam

New final examiners attend a full day introductory workshop which outlines the processes of exam preparation and delivery. New examiners are paired with three or four senior examiners for their first exam. This facilitates observation of different examination styles and introduces them to examiners who may act as mentors. There are workshops at each exam which provide ongoing education on different exam components and education or assessment updates.

Accreditation visitors

A team of trained ANZCA fellows conducts the inspection of hospital departments for ANZCA accreditation (standard 8.2). Fellows self-nominate to become accreditation visitors and applications are reviewed at TAC meetings. Applicants must be college fellows and supply at least one reference from a current TAC visitor or lead visitor, along with their CV. Selection criteria for TAC visitors, as reflected in the terms of reference for the position (appendix 8.11), include:

- Willingness to commit to on-site inspections.
- Relevant training/attendance at a visitors' workshop.

- Knowledge of the ANZCA training program and relevant policy.
- Experience with the ANZCA vocational training program.
- Ability to recognise and manage potential bias and conflicts of interest.
- Advanced communication skills including ability to interact with senior colleagues and administrators.

Newly appointed TAC visitors must attend a compulsory training workshop held at the college Annual Scientific Meeting (ASM) each year. They then undertake several visits as a 'junior visitor', overseen by a senior TAC visitor.

Pain medicine training program

Examiners

FPM examiners are appointed by the FPM Examination Committee. Interested fellows submit an application form and provide a brief CV. Two reference checks are undertaken prior to consideration by the committee. Appointment of examiners takes into account the following factors:

- Undertaking by applicant to comply with the roles of an examiner.
- Post-fellowship experience (usually three years minimum).
- Regular attendance at examiners' workshops.
- Knowledge of the FPM curriculum and training program relevant to the assessments and examinations.
- Ability to recognise and manage potential bias and conflicts of interest.
- Advanced communication skills.
- Specific expertise as required by the panel from time to time.

FPM examiners have an annual training day prior to the oral component of the fellowship examination. New examiners ghost mark the written paper in their first year and observe the oral examination. New examiners are paired with an experienced examiner when they start to examine. All examiners participate in calibration sessions for the content they will examine at the oral component of the examination.

Accreditation reviewers

FPM training unit accreditation reviewers are appointed by TUAC. Their terms of reference are in appendix 8.12. Interested fellows provide a brief CV with an accompanying letter outlining their relevant experience, skills and attributes against the selection criteria:

- Willingness to commit to training unit reviews (minimum one per year).
- Relevant training, attendance at TUAC workshops.
- Knowledge of the pain medicine training program and relevant policy.
- Being a TUAC reviewer is open to FPM fellows who have been a fellow for a minimum three-year period. The role also ideally suits fellows who have leadership experience.
- Ability to recognise and manage potential bias and conflicts of interest.

- Advanced communication skills including ability to interact with senior colleagues and administrators.

TUAC reviewer workshops are generally held every second year but these are not compulsory. New reviewers participate in a review team as an observer to learn the process before being paired with an experienced reviewer for their first few reviews.

Routine evaluation of assessor effectiveness including feedback from trainees

Anaesthesia training program – Examiners

Examiner performance assessment

For both primary and final exams, reports on examiner performance are obtained from fellow examiners and an examiner assessor (EA). EAs are experienced, retired examiners who are one to four years post-retirement from the court of examiners. They attend each exam and provide feedback on the exam process and individual examiner performance. They report to the relevant exam sub-committee and the court of examiners at the completion of each exam. Immediate constructive, qualitative individual feedback is provided to examiners. The EA discusses individual performance with the examiner, and will raise any concerns with the chairs. Such concerns are investigated and discussed with the examiner.

In 2019, the PESC has moved from an ad hoc EA appointment to a two-year appointment of a single EA, allowing greater scrutiny of examiner performance and enabling more useful and personalised feedback.

Trainees are given the opportunity to give feedback after each examination, which is considered by the exam sub-committee. The chair of each committee delivers a response to any communication and the trainee feedback is considered when planning subsequent examinations. Trainees do not have input to evaluation of individual examiner performance.

ANZCA WBA assessors

There is currently no formal process for performance assessment of WBA assessors and no pathway for trainees to provide feedback on the performance of these assessors.

Pain medicine training program

There is currently no formal process for performance assessment of WBPF assessors or examiners, and no pathway for trainees to provide feedback on the performance of their assessors.

8.2 Training sites and posts

The AMC accreditation standards are as follows:	
8.2	**Training sites and posts**
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 the 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.

Criteria and processes for accrediting and monitoring training sites: Applied, publicly available, and consistently applied

The college directly accredits training sites for anaesthesia, pain medicine and diving and hyperbaric medicine (DHM) training (see *Other training programs* at the end of this standard). It relies on other colleges' accreditation of sites for intensive care medicine (CICM) and retrieval medicine (ACEM, CICM). It does not determine the number of trainees at each training site (standard 7.1). The anaesthesia and pain medicine accreditation processes occur independently of each other.

In the anaesthesia training program, clinical anaesthesia time (CAT) is only credited if it occurs in ANZCA-accredited training sites. Exceptions are training at non-accredited sites approved prospectively by the DPA assessor, for example overseas experience, under regulation 37.27. DPA assessors also prospectively approve experience in other clinical time (OCT) if undertaken at sites recognised by the relevant college or similar education

provider as meeting all requirements for its own vocational training program (regulation 37.8.7).

In the pain medicine training program, core training time can only be accrued in accredited units. These are accredited for core training and/or practice development stages. Outside the accreditation process, the FPM assessor approves other units for individual trainees to undertake the practice development stage.

Table 8.8 Summary of current anaesthesia and pain medicine accreditation

	Anaesthesia training program accreditation	**Pain medicine training program accreditation**
Aims	To ensure site can provide training and supervision to the required standard	To ensure site can provide training and supervision to the required standard with a multidisciplinary team, integrated processes and within a sociopsychobiomedical framework
Decision-making body	ANZCA TAC, in accordance with delegations from ANZCA Council	FPM TUAC, reports via FPM TAEC to the FPM Board
Staff support	Training and Assessment unit	FPM unit
Accreditation management system	ANZCA electronic accreditation management system	'Paper-based'
Review of decisions	Reconsideration, review and appeal (standard 1)	Reconsideration, review and appeal (standard 1)
Accreditation standards	1. Quality patient care 2. Clinical experience 3. Supervision 4. Supervisory roles and assessment 5. Education and teaching 6. Facilities 7. Clinical governance	
What is accredited	Training sites Training rotations	Training units
Key process components	Pre-visit datasheet (electronic) Trainee survey Accreditation visit	Pre-visit datasheet ('paper-based') Trainee survey Accreditation visit
Accreditation team membership	2-4 fellows	At least 2 fellows

	Anaesthesia training program accreditation	Pain medicine training program accreditation
Accreditation cycle	5 years	5 years
Periods of accreditation	156 weeks + 104 weeks extended training 104 weeks + 104 weeks extended training 52 weeks + 52 weeks extended training 26 weeks + 26 weeks extended training	Units are accredited to deliver training in either the core training stage and practice development stage, or the practice development stage There are no maximum time periods trainees can train in each unit and each trainee's entire pain medicine training time (minimum 2 years FTE) can occur in a single unit if accredited for core training
Levels of accreditation	Accredited sites Satellite accreditation Additional campus accreditation	Level one accredited unit (core training stage, practice development stage*) Practice development stage accredited unit*
Contribution of trainees	Pre-visit trainee surveys Meeting with visitors at site	Pre-visit trainee surveys Meeting with visitors at unit
Contribution of supervisors	Meeting with visitors at site	Meeting with visitors at unit
Changes leading to accreditation status review	Routine re-accreditation Request for accreditation duration increase Out-of-sequence review if issues detected	Routine re-inspection. Request for a change in accreditation (for example, from a practice development stage (PDS) training unit to a level one training unit) Out-of-sequence accreditation inspections requested by a unit, hospital or any FPM committee, after review by TUAC chair
Monitoring of accredited sites	Primarily reactive TAC reviews sites which have had changes to accreditation status on an annual basis – for example TPS data are reviewed if	Primarily reactive

	Anaesthesia training program accreditation	Pain medicine training program accreditation
	sites have had duration of accreditation increased	
Monitoring of accredited rotations	Regional and national committees ad hoc	NA

* Note trainees can also undertake the practice development stage in a non-accredited unit if approved by the FPM assessor on individual application

Criteria underpinning the seven common accreditation standards (table 8.8)

Anaesthesia training site accreditation

ANZCA-accredited departments must meet training requirements as specified in the ANZCA handbook for training, ANZCA handbook for accreditation, regulation 37, college professional documents and ANZCA policies. These are mapped against the seven standards in appendix 1 of the ANZCA handbook for accreditation which includes criteria under each standard, minimum requirements (with reference to ANZCA policies and professional documents), and how each criterion is evaluated. Some examples are in table 8.9.

Table 8.9 Criteria underpinning accreditation standards – anaesthesia

Standard	Criterion	Minimum requirements	Mode of evaluation
1	Systems in place to ensure the safe administration of injectable drugs	Compliance with professional document PG51(A)	Self-assessment Facilities inspection
2	Caseload and complexity suitable for training stages offered	See curriculum (standard 3)	Self-assessment Trainee portfolios Trainee opinions Trainee and SOT interviews
3	Sufficient FTE anaesthetists to provide supervision for all trainees	Adequate supervision levels Specialists involved in post-anaesthesia care and acute pain service	Trainee experience surveys Trainee feedback Trainee portfolio system Trainee, SOT and head of department (HOD) interviews
4	Undertake WBAs with feedback	Minimum mandatory WBA including feedback	Trainee feedback Training portfolio system

Standard	Criterion	Minimum requirements	Mode of evaluation
5	Formal teaching program	Meets trainee needs Adequate opportunities for scholar role activities	Copy of education program Trainee feedback
6	Ready access to computer facilities including for completion of TPS and WBAs	Mandatory	Trainees, SOT, tutor, head of department interviews
7	Organisation supports staff wellbeing	As per PS49(G) Organisational BDSH policy	Self-assessment Head of department and hospital management interviews

Anaesthesia rotation accreditation

As a condition of accreditation, each accredited anaesthesia site must be part of an anaesthesia rotation. Accreditation of rotations is the responsibility of ANZCA regional and national committees, according to accreditation principles outlined in the ANZCA handbook for accreditation. These include that the rotation is overseen by nominated supervisors who monitor the training delivered and progress of all trainees within that rotation. Each rotation must facilitate part-time training. The regional or national committee receives regular updates via the ROTs and EOs that each rotation provides all the essential requirements of training for all trainees in that rotation. Discussion and decisions about how to manage issues, such as training bottlenecks, are made by the regional or national committee. Significant changes to sites within rotations are notified to TAC.

An issue highlighted by the accreditation and learning environment project is that there is currently no standardised process to accredit anaesthesia rotations (see *Improvement opportunities and future plans* at the end of this standard).

Pain medicine accreditation

FPM units must meet criteria as outlined in the FPM accreditation handbook. Examples are in table 8.10.

Table 8.10 Criteria underpinning accreditation standards – Pain medicine

Standard	Criterion	Minimum requirements	Mode of evaluation
1	Nursing and allied health input to unit	Minimum 3 FTE	Names and qualifications
2	Multidisciplinary patient treatment programs	Mandatory, coordinated by at least 3 staff	Datasheet Site visit
3	Adequate clinical support time for SOT	1 session per fortnight for 1 to 2 trainees	SOT interview

Standard	Criterion	Minimum requirements	Mode of evaluation
		1 per week for 3 or more	
4	Undertake WBAs	Number in past 12 months, multiple fellows contributing	Datasheet
5	Provision of education to junior doctors, nursing and allied health staff	Trainee involved	Trainee survey Trainee interview
6	Trainee access to appropriate office space and technology	Mandatory	Site visit
7	Organisational statement on patient rights and responsibilities	Mandatory	Site visit

Evidence to support accreditation

Anaesthesia training accreditation

The TAC accreditation process includes triangulation via both quantitative and qualitative measures (see appendix 1 in the ANZCA handbook for accreditation). Key pieces of evidence include:

- Self-assessment by the site using the accreditation management system (AMS).
- Pre-visit trainee survey (appendix 8.13).
- Training portfolio report (see below).
- Site visit meetings separately with head of department, trainees, supervisor(s) of training, and other specialists.
- Site visit meetings with hospital executive representatives.

Prior to each visit, the team receives a report extracted from the ANZCA TPS for the prior 12 months. For all ANZCA trainees at the site, it includes supervision levels, WBA compliance and SSU completion. Sample reports for a major metropolitan and a smaller regional hospital are at appendix 8.14.

Pain medicine training accreditation

The TUAC accreditation process includes triangulation via both quantitative and qualitative measures. Key pieces of evidence include:

- Self-assessment by the site using the interactive datasheet (appendix 8.15).
- Pre-visit trainee survey.
- Site visit meetings separately with head of department, trainee(s), supervisor(s) of training, other specialist pain medicine physicians, and allied health staff.
- Site visit meetings with hospital executive representatives.

Duration of accreditation

Anaesthesia training sites

Sites are accredited for 26, 52, 104 or 156 weeks of training (table 8.11). They are also accredited for identical durations of extended training, except for the 156-week sites which are only accredited for 104 weeks of extended training. The criteria that determine these durations are:

- A department in which each trainee can meet the requirements of one complete specialised study unit, or a greater number of partial specialised study units (with partial units adding up to at least one in total), may be eligible for up to 26 weeks accreditation.
- A department in which each trainee can meet the requirements of three complete specialised study units, or a greater number of partial specialised study units (with fractions adding up to at least three in total) may be eligible for up to 52 weeks accreditation.
- A department in which each trainee can meet the training requirements of more than five complete specialised study units, or a greater number of partial specialised study units (with fractions adding up to more than three in total) may be eligible for up to 104 weeks accreditation.
- A department in which each trainee can meet the training requirements of 10 complete specialised study units, or a greater number of partial specialised study units (with fractions adding up to at least 10 in total) may be eligible for up to 156 weeks accreditation.

Table 8.11 Anaesthesia training sites in each region/country stratified by accreditation duration (does not includes satellite hospitals)

	Number of sites by duration of accreditation				Total site number
Region	26 weeks	52 weeks	104 weeks	156 weeks	
ACT	0	0	1	1	2
Aotearoa New Zealand	0	8	4	6	18
NSW	0	14	7	12	33
Queensland	1	11	4	4	20
SA/NT	3	2	1	3	9
Tasmania	0	1	1	1	3
Victoria	1	14	6	4	25
WA	0	5	2	2	9

Pain medicine training units

Prior to 2022, FPM approved two levels of multidisciplinary units for training. While level one accredited units had the breadth of practice to meet all training requirements, level two units were strong in specific areas, often paediatric, cancer or private pain medicine, but did not offer the full breadth of clinical pain medicine experience. Following 2021 review, the concept of level two units was retired and a new category of PDS accreditation was introduced.

When the two-year program was introduced in 2015, trainees in their second year could design their own program to meet individual objectives and foster special interest areas. While trainees were encouraged to consider experience outside the 'usual' accredited units, early experience found a majority chose to remain within accredited units. It is anticipated that former level two units which previously employed a first-year trainee for six months will now consider appointing a second-year trainee for a full year. By accrediting PDS units it is anticipated that there will be increased predictability for trainees and better funding for these positions. Trainees who wish to undertake their second training year at an unaccredited unit can apply to the FPM assessor for approval of an individualised program.

Table 8.12 Pain medicine training units in each Australian region or country (does not include satellites)

Region	Level 1 unit	PDS only	Total
ACT	1	0	1
Aotearoa New Zealand	3	0	3
NSW	11	1	12
Queensland	4	0	4
SA/NT	2	0	2
Tasmania	0	0	0
Victoria	7	4	11
WA	3	2	5
Hong Kong	4	0	4
Singapore	1	0	1

Accreditation management

Anaesthesia

The anaesthesia accreditation team consists of two FTE staff, who are part of the Training and Assessment team of the Education and Research unit. Their roles are to support TAC, organise training site visits and visitors, and provide administrative support for all associated processes.

Anaesthesia training sites, visitors (accreditors) and ANZCA administration have access to an accreditation management system, a central electronic reporting tool that streamlines accreditation visits. Restricted access is given to both hospitals and accreditation visitors. In 2017, the training site accreditation platform version 2 was released which includes more than 70 specific recommendations that inspectors can choose from, promoting consistent accreditation standard application throughout the process. A video-based learning resource presented by the TAC chair is available to orient new visitors to the AMS.

Pain medicine

Staff in the FPM unit support TUAC, organise training unit reviews and reviewers, and provide administrative support on all associated processes.

With fewer accredited units, FPM supports its units and visitors through restricted access areas within Networks (standard 4). Prior to unit review, units complete a datasheet (appendix 8.15) which covers administrative details, staffing, self-assessment by the unit against the accreditation criteria, details of clinical experience the unit offers trainees, and feedback from the unit on previous accreditation conditions or requirements and progress against these.

Promulgation of accreditation requirements for new sites and units

Information on accreditation of all training programs is publicly available on the college website. This includes types of accreditation, how to apply, application forms (for pain medicine, linked to the password-protected FPM datasheet in Networks), the accreditation handbooks and a list of accredited training sites. Changes to accreditation are promoted via the website, e-newsletters, the *ANZCA Bulletin*, SOT workshops and direct correspondence to unit directors. For example, the summer 2021 *ANZCA Bulletin* (p66) outlined changes to FPM by-law 19 and the FPM accreditation handbook.

Decision-making and monitoring

Anaesthesia

Following an accreditation inspection, the accreditation team prepares a report with recommendations based on published accreditation standards and ANZCA professional documents. This report is reviewed at the next TAC meeting. If an issue requires more urgent consideration, TAC teleconference or videoconference is arranged. TAC may make further amendments to the recommendations, following additional consultation with the accreditation team and the department, as necessary.

Following the TAC meeting, the report and recommendations are sent to the director/head of department with an invitation to correct any factual inaccuracies within a specified timeframe. A letter incorporating the final recommendations is then sent to the director of medical services/chief medical officer and senior hospital management and copied to the director/head of department and the supervisor(s) of training with the outcome, which is one of the following:

1. Unqualified accreditation: All standards and criteria are met. The training site is accredited for five years from the inspection date and may employ anaesthesia trainees from the beginning of the next hospital employment year. A certificate of accreditation is provided to the hospital.
2. Conditional accreditation: The training site is granted full accreditation subject to corrective actions to address the accreditation standards and criteria within a specified

timeframe, sometimes subject to reinspection. Conditional accreditation is usually granted for one hospital employment year only. Unqualified accreditation depends on full compliance with mandatory corrective actions.

3. Accreditation not approved: For new applications or applications for a change in status, where accreditation is not approved, feedback is given to the site about what conditions must be met for future approval. Once these are addressed, a new application and reinspection is required.
4. Withdrawal of accreditation: If a site can't comply with accreditation standards and criteria, and where there is significant impact on training quality or professional standards, ANZCA may withdraw accreditation from that site. This requires approval by ANZCA Council.

ANZCA actively works with hospitals to meet requirements. Directors/heads of department or other staff members are encouraged to contact ANZCA to discuss any matters of concern.

There is no written agreement with accredited sites. Once accredited, the head of department/director must agree to notify TAC of any changes that might affect training. Importance is placed on changes such as alterations in workload and case-mix, new facilities and increases or decreases in senior staffing and trainee numbers in the department. Concerns may also be raised via other avenues such as the relevant ANZCA national or regional committee, the national or regional trainee committee or individual fellows or trainees. The college recognises that it requires a more systematic process for monitoring accredited training sites (see *'Improvement opportunities and future plans'* at the end of this standard).

Pain medicine

Each accreditation visit is undertaken by two FPM fellows who have joined the panel of accreditation reviewers. At the end of the visit the reviewers advise the unit director of what they anticipate will be the outcome of the accreditation visit and what conditions and requirements they might expect. One of these reviewers will present a verbal summary of the accreditation visit to the TUAC meeting where the visit report is discussed and the recommendations approved. Having a reviewer attend the meeting in a non-voting capacity allows for clarification to be sought from members ahead of a decision being made.

Following an accreditation decision the unit is usually asked to provide progress reports against specific areas for improvement identified during the accreditation review. These are followed up by staff in the FPM unit and progress reports submitted to TUAC for consideration.

Newly accredited units are followed up after one year via videoconference to clarify and address any issues. TUAC is also starting to adopt this process for units undergoing reaccreditation, because these conversations are helpful in understanding and supporting issues experienced by units.

Quality management

Anaesthesia

Following each accreditation visit, the head of department is asked for feedback on the process and visit via SurveyMonkey. This feedback is reviewed and discussed at the next TAC meeting.

Pain medicine

Following each accreditation visit, units are asked to provide feedback to FPM on the process. Consolidated feedback is considered by TUAC as part of their ongoing quality improvement processes. A sample report is at appendix 8.16.

Links between accreditation criteria and outcomes

Alignment of accreditation criteria with program and graduate outcomes

Anaesthesia

The seven ANZCA accreditation standards are designed so trainees work in sites that support their training to become high-quality, independent specialists able to work across a broad range of clinical settings (standard 2). Sites must demonstrate safe and high-quality patient care, and have governance structures to deliver and monitor safe patient care in a safe workplace, with trainee involvement in clinical governance activities. Sites must provide access to a range of experiences and volumes of practice for trainees to complete training requirements, with appropriate supervision for their level of training at all times. Supervisors must be appropriately trained and provided with resources required for their roles. Sites must ensure that trainees have access to formal and informal educational programs that meet their needs, and provide appropriate training facilities and systems.

Trainees are exposed to a range of clinical environments from smaller regional settings to large metropolitan teaching hospitals in both public and private settings, in line with program outcomes. Under ANZCA regulations, it is not possible for a trainee to spend all their training time at a single site, so trainees work at multiple sites over a minimum of five years to complete all the training requirements. Training sites must be part of rotations which provide all the clinical experience required to complete the training program. Rotational supervisors oversee the training pathways of all trainees in their rotation (standard 8.1). Each rotation is accredited and informally monitored by the relevant ANZCA regional or national ANZCA committee to ensure that the rotation as a whole is able to provide all training components, and to identify and minimise training roadblocks.

At present, the accreditation criteria are not mapped to the ANZCA roles in practice (standard 2). In preparation for this accreditation, table 8.13 presents the ANZCA roles in practice and examples of data collected at accreditation that reflect how sites prepare trainees for that specialist role.

Table 8.13 Examples of alignment of anaesthesia accreditation data with the ANZCA roles in practice

ANZCA roles assessed	Anaesthesia accreditation requirement
Medical expert, communicator, collaborator, leader/manager, health advocate, professional	Workplace based assessment completion rates
Scholar, leader/manager, professional, collaborator	Scholar role completion rates
Medical expert, communicator, collaborator, leader/manager, health advocate, professional	Adequate pre-anaesthetic consultation and consent
Scholar, leader/manager, professional, collaborator, communicator	Trainee involvement in QA and research activities e.g. PS58(A)
Communicator, collaborator, leader/manager	Adequate systems for handover of care
Professional, leader/manager	Hospital/department has a policy on bullying and harassment that pertains to trainees and their supervisors
Professional, leader/manager	The organisation supports the health and wellbeing of its staff e.g. PS49(G)
Professional, Leader/manager, medical expert	Protocols for clinical care standards
Scholar, leader/manager	Teaching program that reflects trainee needs

Pain medicine

FPM accreditation criteria align with program outcomes by ensuring that accredited multidisciplinary units have input from a broad range of medical and allied health disciplines, provide multidisciplinary treatment programs and case conferencing, and expose trainees to relevant experiences (e.g. multidisciplinary case conferences and communication with primary care specialists). Although the measures are not organised in terms of the FPM roles in practice, many of these roles are specifically evaluated at accreditation, primarily via process measures rather than quality and outcome ones.

Table 8.14 Examples of alignment of pain medicine accreditation data with the FPM roles in practice

FPM role in practice	Pain medicine accreditation datasheet
Clinician	Unit numbers each for acute, chronic and cancer pain Compliance with professional documents
Professional	Organisational support for staff health and wellbeing and BDSH policy

FPM role in practice	Pain medicine accreditation datasheet
Scholar	Trainee teaching of peers, junior medical, nursing and allied health staff Active research and audit program, encourage trainee research and audit
Communicator	Motivational interviewing with psychiatrist supervision Statement on cultural awareness
Collaborator	Formal multidisciplinary case conferencing
Leader and manager	Criteria for professional development stage accreditation in development
Health advocate	Statement of patient rights and responsibilities

Adequacy of clinical experience and initiatives in expanded settings

Anaesthesia

ANZCA accreditation supports flexible training experiences through different accreditation levels. “Satellite accreditation” allows for smaller sites to enter a partnership with a larger accredited site to meet the accreditation standards. “Additional campus accreditation” allows for trainees to work at a campus separate from the main accredited site that is under the same governance and staffing. For example, since the last AMC accreditation, private hospitals in Mackay and Wagga Wagga have achieved these accreditation standards, enabling trainees to gain clinical experience not available at the local public hospitals. By increasing the breadth of training experiences they are able to provide in these cities, the public hospitals in Mackay and Wagga Wagga are now accredited for 104 weeks duration, increased from 52 weeks. It is anticipated that this will help grow the future anaesthesia regional and rural workforce.

An emerging challenge is ensuring that all trainees on a rotation have equitable access to the required clinical experience for the five years of ANZCA training. Trainee numbers increase as sites increase clinical services (standard 7.1). Increasing requirements to have onsite anaesthesia coverage 24/7 means more trainees are required to support safe rostering practices, potentially reducing individual clinical experience. However, expansion in training opportunities for specialised areas such as paediatrics, neurosurgery and cardiothoracics are more limited. There is potential for training ‘roadblocks’ if expanded training settings are not fully utilised. Some minimum volumes of practice in specialty areas have been altered (standard 4), primarily due to changing clinical practice. For example, expansion of interventional cardiology services has decreased reliance on open surgical procedures that require cardiopulmonary bypass. These curriculum adjustments to reflect current practice have also helped mitigate against training roadblocks.

Pain medicine

Key changes since the last AMC accreditation are broader backgrounds of entering FPM trainees, introduction of the practice development year, and the development of procedural pain medicine training. Achieving required training outcomes requires a degree of individualisation that accounts for the trainee's primary specialty (e.g. acute pain exposure for those without such experience in their primary fellowship training). In general, most experiences are feasibly obtained within units. The accreditation process supports all units to provide the broad range of experiences required to practice as a specialist pain medicine physician. There is some variability with specific units in exposure to acute pain, palliative care and drug dependency management, as well as access to rehabilitation and psychiatry.

The TUAC accreditation for the practice development year is in evolution with investigation of formal criteria for subspecialist units such as paediatric pain medicine. When the 2015 training program was introduced, it was expected that PDS trainees would define their own individualised program and train at a variety of non-accredited units that aligned to their learning goals. In reality, most trainees remained in level one accredited units rather than seeking approval of individualised programs. Creating a formalised accreditation process for PDS units is in response to trainee feedback. It is expected that PDS unit accreditation will facilitate training involvement of more private pain units and units with a specific focus such as paediatric pain medicine. This will increase options for trainees in their second year of training.

Balancing training and service

Anaesthesia training accreditation

Anaesthesia rosters in public hospitals cover 24 hours a day, seven days a week, to deliver the required clinical services. This is commonly achieved through onsite rostering of trainees overnight, supervised by on-call specialists. Some clinical services, such as obstetric anaesthesia, have a higher after-hours workload. Sites must demonstrate that they provide a safe working environment for all staff, including that a range of methods are utilised to mitigate against the risk of fatigue.

After-hours service requirement limits available time for, and access to, in-hours activities, such as formal teaching programs. Remote supervision limits the opportunities for supervisors to complete WBAs. However, there are minimum training standards assessed at accreditation including provision of a formal training program that meets trainee needs, required supervision, numbers of WBAs performed, and the maximum allowable proportion of emergency work each trainee undertakes. Sites must demonstrate that, despite the challenges of 24/7 rostering, they provide a safe working environment that overall meets minimum training accreditation standards.

Pain medicine training accreditation

As pain medicine practice primarily focuses on chronic disease management, there were resourcing pressures on units during the pandemic. However, even pre-pandemic, FPM identified significant unmet need in our communities for pain services. For appropriate supervision, accredited units require a minimum of two FTE specialist pain medicine physicians. This has proved a barrier for some prospective training units. Given the high demand for pain medicine care, the provision of adequate clinical support time has also been a challenge at some sites. The provision of a centralised FPM tutorial program has relieved pressure on what are mostly small units, although at accreditation visits units are

advised that local teaching is also required. No systematic issues with trainees being released weekly for the online tutorial program have been identified.

Regional and rural sites

Anaesthesia training

A significant benefit of the **anaesthesia** rotational training schemes throughout Australia and Aotearoa New Zealand is that by including regional centres, trainees are routinely exposed to non-metropolitan settings. Trainees also require exposure to all subspecialty areas to complete training and these are predominantly provided in major metropolitan teaching hospitals. Well-established rotations such as the Northern Queensland rotation enables trainees to complete all training requirements in Townsville, Cairns, Mackay and Darwin. Other recent initiatives include the Victorian Rural Training Network, and new rotations in NSW centred around the regional centres of Wagga Wagga and Albury Wodonga.

Accreditation for anaesthesia training sites requires a minimum specialist staffing level and an appropriate range of experiences and volumes of practice to achieve training outcomes. This limits the ability of some smaller regional and rural locations to achieve accreditation. However, where an accredited training site supports a smaller site with outreach clinical services, then additional campus accreditation supports trainees to gain exposure to these more remote sites. Recent examples of additional campus accreditation supporting smaller rural hospitals include Casino Hospital in NSW (parent hospital Lismore Base Hospital) and Thames Hospital in Aotearoa New Zealand (parent hospital Waikato Hospital, Hamilton)

Pain medicine training

The FPM training program provides limited trainee exposure to rural and regional locations. Contributing factors include specialist pain medicine physician undersupply and mal-distribution. Regional centres with accredited units are Geelong (two), Newcastle (two), Nambour and Townsville. There are some accredited private pain units which provide trainees with a breadth of experience. Satellite accreditation also expands trainee exposure to more diverse settings.

Provision of healthcare to Aboriginal and Torres Strait Islander and Māori peoples

Anaesthesia training

ANZCA trainees provide healthcare to Aboriginal and Torres Strait Islander and Māori peoples in Australia and Aotearoa New Zealand as part of their work, including for elective and emergency surgical procedures, perioperative medicine, pain medicine, care of pregnant patients, and in intensive care medicine. Trainees at some sites, for example in Darwin and the Northern Territory, gain greater experience in healthcare for Aboriginal and Torres Strait Islander peoples, because of the local population. There is no minimum training requirement, and trainee exposure to Aboriginal and Torres Strait Islander and Māori peoples and training in cultural competence is not specifically evaluated at accreditation. Some sites, for example Counties Manukau Health, Aotearoa New Zealand, provide specific training in cultural competence for their staff, and this has been commended at ANZCA accreditation.

Pain medicine training

Provision of pain medicine services to Aboriginal and Torres Strait Islander and Māori peoples in accredited units, primarily in metropolitan centres, is not specifically evaluated at accreditation, so exposure of trainees is unknown. In 2015, FPM implemented an accreditation criterion on cultural competency. In 2021, the criterion was revised to address cultural safety. All FPM accreditation visits investigate how each unit addresses cultural safety.

This is an area for improvement in both disciplines. See *'Improvement opportunities and future plans'* at the end of this standard.

Accreditation of environments for high quality clinical care

Quality of clinical care is standard 1 for both anaesthesia and pain medicine training accreditation.

Anaesthesia accreditation

ANZCA accreditation standard 1 (quality patient care) requires sites to demonstrate that they deliver safe and high quality patient care, primarily assessed against a range of ANZCA professional documents. Under standard 7 (clinical governance), sites must demonstrate that they have the governance structures to deliver and monitor safe patient care in a safe workplace. These standards are evaluated at accreditation through site self-assessment, TPS reports, audits, and during accreditation visits. Trainee involvement in a variety of clinical roles is expected at all sites, including pre-anaesthesia consultation and provision of acute pain services. Trainees are expected to be actively involved in departmental quality assurance activities.

Pain medicine accreditation

High quality clinical care is challenging to define in pain medicine, with few established benchmarks. Units report on their participation in outcome data collection (such as the electronic Persistent Pain Outcomes Collaboration) and benchmarking against similar units. They are also evaluated against FPM professional documents which include clinical standards and guidelines. Units with relevant casemix must be accredited by the Royal Australasian College of Physicians (RACP) Chapter of Palliative Medicine.

Accreditation of educational infrastructure and resources

Anaesthesia training

ANZCA accreditation standard 6 (facilities) ensures that trainees have access to appropriate educational facilities and systems required for training. These include access to a suitable conference room for quality assurance, clinical review and educational activities, and that supervisors and trainees have ready access to computer and internet facilities for TPS access, including WBA documentation. Sites must also provide a private study space for trainees, as well as access to office space to enable private conversations between supervisors and trainees.

Pain medicine training

Pain medicine training infrastructure is evaluated also under accreditation standard 6 (facilities). This includes office space, internet access, electronic record system, and procedural and consulting rooms.

Accreditation-related data

On 1 January 2022, the college has 160 accredited anaesthesia training sites (including satellites and additional campuses) (table 8.11) and 38 accredited pain medicine sites, excluding those accredited for individual practice development training (table 8.12). One accredited pain medicine site lost accreditation from the commencement of the 2022 hospital employment year, with timing managed so trainees were not disadvantaged. Tables 8.15 to 8.19 show accreditation data for the past five years, including the impact of the pandemic.

Table 8.15 Anaesthesia and pain medicine site accreditation activities 2017

2017 site and unit accreditation activities										
	ACT	**Qld**	**NSW**	**NT**	**SA**	**Tas**	**Vic**	**WA**	**NZ**	**Total**
Anaesthesia										
Sites visited	0	4	8	0	10	2	7	3	0	34
Sites accredited and reaccredited	0	4	7	0	9	2	7	3	0	32
New sites accredited	0	0	1	0	1	0	0	0	0	2
Pain medicine *										
Units visited	0	0	3	0	1	0	2	2	0	8
Units accredited and reaccredited	0	0	3	0	1	0	2	2	0	8
New units accredited	0	0	0	0	0	0	0	0	0	0

** FPM data in all these tables do not include accredited units in Hong Kong and Singapore*

Table 8.16 Anaesthesia and pain medicine site unit and site accreditation activities 2018

2018 site and unit accreditation activities										
	ACT	**Qld**	**NSW**	**NT**	**SA**	**Tas**	**Vic**	**WA**	**NZ**	**Total**
Anaesthesia										
Sites visited	0	0	19	0	2	2	6	0	0	30
Sites accredited and reaccredited	0	0	18	0	2	2	6	0	0	29
New sites accredited	0	0	1 *	0	0	0	0	0	0	1
Pain medicine										
Units visited	0	1	4	1	1	0	4	1	1	13
Units accredited and reaccredited	0	1	3	1	1	0	3	1	1	11
New units accredited	0	0	1	0	0	0	1	0	0	2

**The NSW hospital that was not accredited was a new application that did not yet meet the accreditation requirements.*

Table 8.17 Anaesthesia and pain medicine site unit and site accreditation activities 2019

2019 site and unit accreditation activities										
	ACT	**Qld**	**NSW**	**NT**	**SA**	**Tas**	**Vic**	**WA**	**NZ**	**Total**
Anaesthesia										
Sites visited	0	2	12	0	0	2	8	7	6	37
Sites accredited and reaccredited	0	2	12	0	0	2	8	7	5	36
New sites accredited	0	0	0	0	0	0	0	0	1	1

2019 site and unit accreditation activities										
	ACT	Qld	NSW	NT	SA	Tas	Vic	WA	NZ	Total
Pain medicine										
Units visited	0	0	2	0	0	0	3	2	3	10
Units accredited and reaccredited	0	0	1	0	0	0	3	2	2	8
New units accredited	0	0	1	0	0	0	0	0	1	2

Table 8.18 Anaesthesia and pain medicine site unit and site accreditation activities 2020

2020 site and unit accreditation activities										
	ACT	Qld	NSW	NT	SA	Tas	Vic	WA	NZ	Total
Anaesthesia										
Sites visited	0	2	0	0	0	0	2	0	8	12
Sites accredited and reaccredited	0	1	0	0	0	0	2	0	8	11
New sites accredited	0	1	0	0	0	0	0	0	0	1
Pain medicine										
Units visited	0	0	1 (virtual)	0	1	0	2 (virtual)	0	0	4
Units accredited and reaccredited	0	0	1	0	1	0	2	0	0	4
New units accredited	0	0	0	0	0	0	0	0	0	0

Table 8.19 Anaesthesia and pain medicine site unit and site accreditation activities 2021

2021 site and unit accreditation activities										
	ACT	**Qld**	**NSW**	**NT**	**SA**	**Tas**	**Vic**	**WA**	**NZ**	**Total**
Anaesthesia										
Sites visited	0	16	7	2	2	0	2	3	7	39
Sites accredited and reaccredited	0	16	7	2	2	0	1	3	7	38
New sites accredited	0	0	0	0	0	0	1	0	0	1
Pain medicine										
Units visited	0	2	7	0	0	1	6	2	2	20
Units accredited and reaccredited	0	2	7	0	0	0	6	1	2	18
New units accredited	0	0	0	0	0	0	0	1	0	1

Reasons and outcomes for unscheduled or unplanned reviews over the past five years

Anaesthesia

One training site had numerous significant concerns, including significant interpersonal conflicts, which were significantly impacting the training environment. Council considered withdrawal of accreditation, however with the input of the jurisdictional health department and local leadership, revisits and regular written reports led to improvements at the training site within 12 months of the original visit, and hence accreditation was maintained.

Another training site had successfully applied for an increased accreditation duration. However, subsequent monitoring of SSU and VOP data identified that the site was unlikely to provide training requirements commensurate with the new accreditation duration. This was confirmed at an out-of-cycle visit which also identified other factors impacting the learning environment. Accreditation duration was reduced to the previous duration.

Pain medicine

Securing ongoing hospital funding for staffing put the delivery of the FPM training program in one hospital at risk. Following an unscheduled review, a number of strict conditions to

maintain accreditation were drawn up. Working with hospital management, this was addressed over a 12-month period allowing the unit to rebuild and remain accredited.

Reports of interpersonal conflicts and issues with the training environment resulted in an unscheduled review of another unit. This unit had its accreditation suspended for a 12-month period to allow it to address issues without a trainee in the unit. Once this period has elapsed, another visit will occur which will result in either the unit achieving accreditation standards or having their accreditation withdrawn.

Most recent accreditation policy and criteria review, changes and impact

Anaesthesia accreditation

The most recent anaesthesia accreditation policy and criteria review was the accreditation handbook review by TAC in October 2019. The main change was to the minimum requirements for a site approved for 104 weeks accreditation, reducing the number of completed specialised study units that each trainee can achieve at such sites from six to five. The impact of these changes was some regional training sites are now eligible for increased accreditation duration, from 52 to 104 weeks. A potential benefit of this is growth in the regional specialist anaesthesia workforce, aligned with the ANZCA 2018-2022 Strategic Plan.

Pain medicine accreditation

In 2015, following the launch of the revised FPM training program, the FPM accreditation by-law was reviewed and the FPM accreditation handbook introduced. Over 2020 and 2021 these documents were updated, with revised versions published ahead of the 2022 hospital employment year.

Consistent approaches to accreditation across specialties

While the anaesthesia and pain medicine accreditation processes use the same accreditation standards, they are separately run and managed with limited interaction and collaboration. This and the development of new programs at the college create an opportunity for greater collaboration. This was a major focus of the ANZCA and FPM accreditation and learning environment project which is described in more detail under *Improvement opportunities and future plans* at the end of this standard.

Informing MCNZ of intention to withdraw or limit accreditation

Anaesthesia training sites

Following an accreditation visit, a decision about the outcome is made by TAC. A letter is sent to the site informing them of this outcome and requiring them to respond to any mandatory corrective actions within a defined timeframe. At a subsequent meeting, TAC considers these responses. If at any point, TAC identifies deficiencies that significantly impact training or the trainees and specialists who work at a site, ongoing accreditation is at risk. If this is the case in Aotearoa New Zealand, the site is warned in writing that if TAC is not satisfied with progress in their next response, then TAC will notify the MCNZ of the intention to limit or withdraw accreditation. At the same time ANZCA Council is notified, as only council has the authority to withdraw site accreditation.

No hospitals have lost their ANZCA accreditation since this notification requirement was introduced by the MCNZ. The college finds that advising sites that this is a potential outcome is associated with increased attention paid to compliance with corrective actions.

Pain medicine training units

Should a decision be made to withdraw or limit accreditation for a pain medicine unit in Aotearoa New Zealand, the FPM documented process is that TUAC advises the MCNZ in writing. FPM most recently undertook this notification process in 2021.

The college works with jurisdictions and the private health system to effectively use health system capacity

In Australia, specialist training program (STP) funding has promoted pain medicine accreditation, particularly in the private sector, and anaesthesia accreditation in rural, regional and private sectors (standard 1.6). In Aotearoa New Zealand, a greater proportion of secondary and tertiary care is delivered in the public sector, and all rotations already have provincial (rural) hospitals with their rotations. In some rotations, such as central New Zealand, almost all anaesthesia trainees spend time in a provincial hospital.

Additional campus accreditation (anaesthesia)

In 2017, additional campus accreditation was developed to allow accreditation of smaller training sites without a formal visit. These sites, sometimes in the private sector and rural and regional areas, provide specific and valuable training experience not available at the parent hospital (the linked hospital). Time spent at the additional campus (satellite) counts towards the maximum time each trainee can accrue at the parent hospital. Approved satellites are re-reviewed when the routine visit is conducted at the associated main training site but not at an out-of-sequence review.

A paper-based application is submitted for a TAC decision, with approval criteria as follows:

- Individual trainees spend less than 10 per cent of their training time at the site.
- Level one supervision is provided at all times.
- The site has confirmed compliance with Australian Council of Healthcare Standards (Australia) or HealthCert (Aotearoa New Zealand).
- There is appropriate trainee indemnity (for a private hospital).

Accreditation is withdrawn automatically from satellite hospitals which anaesthesia trainees have not worked at for two or more years. If it planned to re-rotate trainees there, a new application must be submitted. This reduces unnecessary accreditation visits to satellites and ensures that satellites resuming trainee placements remain compliant with required training standards.

Engagement with other providers to support common accreditation approaches and information sharing

Intensive care and retrieval medicine accreditation for anaesthesia training

ANZCA indirectly accredits intensive care units (ICUs). Training sites with ICUs accredited by the CICM for general or limited general training are considered appropriate for the mandatory intensive care medicine experience required in anaesthesia training.

ANZCA indirectly accredits retrieval services. Units accredited by the ACEM and CICM are considered appropriate for anaesthesia training. Trainees must apply to the DPA assessor for prospective approval for time spent in retrieval services (regulation 37.8.7). Such experience is not mandated but may be undertaken, for example in provisional fellowship training.

Acute pain services and pain medicine accreditation

FPM accredits acute pain services which provide experience for pain medicine training. These services may also be ANZCA-accredited (if located at anaesthesia training sites). Under by-law 19.3.3, acute pain services must comply with ANZCA professional document *PG41 Guideline on acute pain management*, so FPM recognises ANZCA accreditation of these services.

Changes since last accreditation (2012)

Anaesthesia accreditation changes

In 2015, ANZCA completed a training site accreditation project, with launch of a new online accreditation management system, revised datasheet and comprehensive reporting from the TPS (replacing trainee surveys prior to site visits). In the same year, the first annual department-level WBA report, generated from the TPS was shared with accredited anaesthesia departments to demonstrate their performance in this important training function.

In 2016, in response to the Australian Health Ministers Advisory Council and the Council of Presidents of Medical Colleges Accreditation Project, the ANZCA accreditation cycle was reduced from seven to five years. Advantages include better oversight of developing issues and engagement of sites by visitors (who include ANZCA councillors). The faculty has always had a five-year accreditation cycle.

In 2017, the online TSA was updated with standardised wording for 70 potential accreditation recommendations, based on relevant policies. This supports consistent application of accreditation standards. In 2018, ANZCA participated in a workshop with the UNSW Border Regional Training Hub, on the NSW-Victorian border, on accreditation, selection and trainee placements.

Pain medicine accreditation changes

In 2013, annual surveys of FPM accredited units were implemented and trainee exit survey summaries were used for accreditation. In 2016, FPM commenced a comprehensive review of pain medicine accreditation following 2015 curriculum implementation. This included introduction of the current seven overarching standards, new accreditation criteria and the handbook. These developments included consultation with heads of department, SOTs, committees, fellows and trainees.

In 2019 and 2020, the pain medicine accreditation by-law and handbook were reviewed and updated with the following key changes:

- Introducing a formal accreditation status and accreditation criteria for PDS units.
- Retiring level two units consequent to the new accreditation of PDS units.
- Retiring the nomenclature ‘satellite sites’, as many pain medicine units now comprise multiple sites.

- Amending accreditation standard 7, clinical governance to include that units must demonstrate cultural safety for Aboriginal and Torres Strait Islander and Māori and culturally and linguistically diverse populations.
- Updates to many criteria across all standards.

In 2021, FPM piloted the clinical experience pathway of the Procedures Endorsement Program (PEP). Several FPM trainees participated in this pilot as their PDS training. It is anticipated that the PEP will develop into a clear pipeline for those trainees who wish to include pain medicine procedures as part of their practice.

Impacts of COVID-19

Selection, appointment and reappointment of SOTs

Current processes for selection, appointment and reappointment of SOTs are outlined in ANZCA handbook for training; and these have been minimally impacted by COVID-19 pandemic responses.

SOT training

Usually a face-to-face workshop specifically targeting newly appointed SOTs is offered at each ANZCA ASM. This is run by the training and education experts such as the DPA assessor responsible for supervisors and other experienced facilitators. In 2020 and 2022, this new SOT workshop was cancelled due to COVID-19 restrictions.

EOs coordinate SOT meetings for their region which include delivery of educational activities. Many face-to-face meetings have been cancelled due to the pandemic, although not in all regions. Some have been held virtually.

Existing online resources remain available to support SOTs, with work underway to increase these offerings (e.g. SOT e-induction module and SOT hub). This recognises that remote learning plays a significant role in continuing supervisory professional development.

Assessment of SOTs

Fellows with an education portfolio at an accredited training site will have this aspect of their work evaluated at their annual performance review with heads of department.

ANZCA accreditation team at inspection of training sites will assess teaching and supervision provided to trainees against accreditation standards:

- Standard 3 – Supervision.
- Standard 4 – Supervisory roles and assessment.
- Standard 5 – Education.

Details of these standards can be found in the ANZCA handbook for accreditation.

COVID-19 pandemic responses restrict ANZCA‘s ability to conduct accreditation visits and so reduce opportunities to formally assess supervisory performance in the workplace.

However, any concerns raised will be acknowledged and managed as per existing college procedures and policies.

Pain medicine training units

While FPM continued to recruit fellows into supervisory and assessment roles during COVID-19 there were no in-person training opportunities. New examiners participated in the written examination but not the oral examination.

FPM reached out to supervisors and unit directors early in the pandemic to offer support and to understand how it was impacting different training units. The feedback from supervisors and unit directors was pivotal to the development of the general exemptions that were included on the website. Anecdotal feedback from FPM SOTs is that it has been challenging to provide effective supervision during COVID-19 when telehealth was the primary method of interacting with patients. While most units transitioned to telehealth consultations, pain medicine trainees were able to continue their training. When in person consultations commenced again, a few more trainees than usual received borderline ITAs and were given additional support by their units to bring their level of performance up to the level expected.

Anaesthesia accreditation visits

Training sites due for an accreditation visit after 10 April 2020 were automatically granted an extra 12 months accreditation and were visited in 2021. A number of visits due in late 2021 were deferred to 2022 due to COVID-19 outbreaks and associated interstate travel and hospital visitor restrictions in Sydney and Melbourne. There is a plan to visit all these sites in the first half of the 2022 HEY.

As public hospitals began to focus on the care of patients with COVID-19 and those requiring emergency surgery, elective surgery at those sites significantly reduced. This reduced the range and volumes of practice available to trainees, potentially impacting their ability to complete training requirements. Many public hospitals moved patients requiring elective surgery to sites that trainees would not normally work in, including local private hospitals.

To support trainees and their training progression, in 2020 ANZCA Council approved the standards for a new accreditation level – temporary additional campus accreditation. A number of sites in Victoria and New South Wales have been approved under this new standard, supporting training in expanded settings during the pandemic. This required a paper-based evaluation and was approved by the relevant regional or national accreditation officer and the chair of TAC. All approvals of temporary additional campus accreditation were noted at the next TAC meeting and were for 12 months only.

If a trainee could not relocate within rotations due to restrictions, training time was automatically increased at the hospital for that trainee. This provision was maintained as the pandemic continued in 2021.

Pain medicine accreditation visits

For most of 2020 accreditation visits for pain medicine units were postponed. Towards the end of that year, an accreditation visit via videoconference was trialed successfully. In 2021, 19 accreditation reviews were undertaken via videoconference and two were undertaken in person. Units prioritised for onsite reviews in 2021 either had unresolved conditions from a previous accreditation review or were the subject of trainee complaints.

FPM Procedures Endorsement Program

Unlike other college programs, the Procedures Endorsement Program accredits the procedural supervisors and not the training sites/units. This reflects the apprenticeship model approach and that procedures are often undertaken in multiple units.

The supervised clinical experience pathway of the Procedures Endorsement Program is entirely workplace-based, where learning is overseen by the accredited procedural supervisor. Appointed co-supervisors are involved in providing clinical experience and in giving feedback to endorsees. All accredited procedural supervisors and co-supervisors must themselves be endorsed in procedures in pain medicine by FPM.

At least one workshop a year has been held for accredited procedural supervisors via Zoom. These supervisors also participate in the first part of meetings for the Procedures in Pain Medicine Committee to give feedback, address any concerns and discuss areas of interest with other supervisors.

There are no current mechanisms for evaluation of individual supervisors.

Other training programs

Joint Consultative Committee on Anaesthesia (JCCA)

Supervisors and assessors

The clinical supervision framework is determined by individual hospitals, with most using the four-level model used for anaesthesia training (standard 8.1.1). Some hospitals use an IAAC-like signoff before allowing more distant supervision, although this is not required. Each trainee has two nominated supervisors, a FANZCA and an RGA or GPA, who volunteer for the role. Where a GPA is not available, a GP mentor is strongly advised. There are no role descriptions. The same supervisors undertake the local exam. The resources available for supervisors and assessors are those provided by their primary college. There is no current mechanism for evaluation of individual supervisor and examiner performance.

Accreditation

Most JCCA training occurs at sites accredited by ANZCA for specialist (FANZCA) anaesthesia training. If a site is not accredited by ANZCA, it may apply for accreditation, and a visit by a JCCA accreditation team is arranged. This follows the RACGP criteria for special skills accreditation. The governance group approves accreditation or not, based on findings of the site visit. A list of accredited sites is on the JCCA website; inactive sites are those without a current trainee and combined sites have trainees across two hospitals.

Diploma of Rural Generalist Anaesthesia (DRGA)

Supervisors and assessors

The clinical supervision framework for the DRGA will be based on the four-level model used for anaesthesia training (section 8.1.1). Resources to support DRGA supervisors will be developed throughout 2022 to support 2023 DRGA implementation. Supervisors will be provided opportunities in Q3 and Q4 2022 to attend information and education activities regarding WBA completion, using the TPS, initiating the trainee support process and other key supervisor responsibilities. StAMPS examiners and the process for implementing the

MCQ exam are in development and expected to be presented to the Tripartite Committee of Rural Generalist Anaesthesia (TC-RGA) in March 2022 for further consideration.

Accreditation

The standards and procedures for accreditation of DRGA training sites are yet to be determined. The ALEP project recommendations provide scope for standardisation of all college accreditation standards and procedures.

Diploma of Advanced Diving and Hyperbaric Medicine (DHM)

Supervisors and assessors

All clinical work towards the diploma must be supervised. The clinical supervision framework for DHM training is one-to-one supervision (unfamiliar areas, as required by patient condition, at trainee request), on-site supervision and distant supervision (off-site, consultation available at all times, able to attend within reasonable timeframe).

The supervisors of the DHM diploma are DHM clinical supervisors (supervise clinical work and complete WBAs, sign a supervisor agreement) and DHM SOTs. The SOT is the college representative at the accredited training unit and is responsible for coordinating training activities in the unit, including clinical and educational supervision. The SOT is nominated by the unit director and completes an SOT agreement, and is appointed by the DHM Sub-committee (DHMSC) for three-year terms up to a maximum of 12 years. Professional development resources for DHM supervisors are those available to all ANZCA supervisors, including the ANZCA Educators Program. There is no current mechanism for evaluation of individual supervisor performance.

WBAs within DHM training are undertaken by DHM clinical supervisors and SOTs. DHM examiners are knowledgeable and experienced specialists in the discipline appointed by the DHMSC for three-year terms to a total of 12 years, according to the criteria in section 14.4 of the handbook. The DHM community is a small one and conflicts of interest are carefully managed. For example, no trainee is examined by their current SOT. There is no current mechanism for evaluation of individual examiner and WBA assessor performance.

WBA assessors and SOTs have access to all the training and resources of ANZCA that relate to other supervisor training. The expectation is that such resources are useful to define and train assessors and SOTs in their roles, with the individuals concerned able to apply their learning to their roles in DHM training. DHM diploma examiners are expected to have attended formal examiner training for either the ANZCA primary or final exams.

Accreditation

Currently, there are six accredited DHM training sites, one in Aotearoa New Zealand and five in Australia. Accreditation is undertaken by experienced DHM SC members using a paper-based process on a five-yearly cycle with two application periods per annum. Sites (rather than posts) are accredited for a maximum of 22 or 44 weeks FTE training time. The routine paper-based process may be supplemented by a site visit with review of documentation, a physical tour of the facility, and interviews with trainees and other staff.

The standards and procedures for accreditation of training sites for the DHM diploma are in the handbook for advanced DHM accreditation. Standards relate to safe facilities (aligned

with AS/NZS 4774.2), staffing and supervision, profile of work, teaching and learning, and clinical governance. Feedback from trainees is collected as part of the accreditation process. There is an opportunity with the accreditation and learning environment project and online accreditation management system (lifelong learning project, standard 4) to align and improve accreditation processes.

Diploma of Perioperative Medicine (POM)

The facilitation model for the DipPOM is being finalised. The following delivery roles are provisionally identified:

- **Topic area lead**: oversees participant progression and ensures all assessments are completed for each module.
- **Facilitator:** supports delivery of teaching and learning activities (face-to-face workshops and online).
- **Clinical supervisor**: oversees clinical learning environment and completes workplace based assessments.
- **Assessor**: supports assessment activities.
- **Director of professional affairs (assessor)**: reconsideration, reviews and appeals processes (standard 1.3) and sign-off participant training completion.

Development of a dedicated facilitator and supervisor training program is planned. A facilitator manual will be produced that will include guidelines and resources to support facilitators and supervisors.

Grandparenting

A critical mass of qualified and committed supervisors is required to deliver the qualification. This requires a legacy process, commonly called grandparenting, which needs to be finalised and publicised ahead of delivering the diploma. A structured pathway and process was drafted by a sub-group of the Perioperative Medicine Steering Committee (POMSC) in late 2021 and a period of consultation and feedback was undertaken with all medical colleges represented on the POMSC. From that process, a working group was established with members from ANZCA, RACP and CICM to identify the points and evidence required from their respective colleges to achieve the DipPOM via the legacy pathway. Refer to the *Pathways for Recognition of the ANZCA Perioperative Medicine Diploma* document approved by POMSC in February 2022 (appendix 8.17).

Dual FANZCA-FCICM pathway

Supervisors and assessors

The clinical supervision framework for training experience in each discipline will be identical to those of the primary college, individualised to trainee performance and experience. Supervisors will be those who currently provide clinical and educational supervision for ANZCA and CICM trainees. They will continue to access relevant supervisory resources, but will require pathway orientation, specific pathway guidance and clear avenues for information and support. It is anticipated that mechanisms for supervisor performance evaluation, examiner and WBA selection, support and performance evaluation will be those of the primary college.

Accreditation

It is anticipated that this will remain as per current processes. However, closer collaboration between ANZCA and CICM creates opportunities for better information sharing and potential efficiencies in rural and regional centre accreditation.

Strengths

Clinical supervision framework (standard 8.1)

The college has well established and widely understood frameworks for clinical supervision in all disciplines supported by supervisors (and tutors in the case of anaesthesia training) who can access professional development resources for their roles.

Senior supervisory and assessor roles (standard 8.1)

There are clearly defined senior supervisory and assessor roles to support newer supervisors and assessors and to provide a conduit for communication between training sites and units, and the college. Supervisor examples are the EO and ROT roles in the anaesthesia training program and the SOT advisor in the pain medicine training program. Assessor examples include examiner trainer assessors for the anaesthesia exams and accreditation officers for evaluation of training sites against accreditation standards and criteria. While FPM does not have nominated roles to train new examiners or accreditation reviewers, shadowing experienced fellows is standard practice.

Peer review process (standard 8.2)

The college has a well-established peer review process in both disciplines that promotes training in environments, ensuring broad exposures and appropriate training infrastructure, supervision and workplace-based assessment.

Improvement opportunities and future plans

The ANZCA Educator Skills Project Group

The ANZCA Educator Competency Framework (appendix 8.18) was developed in the ANZCA educator skills project, part of training evolution. The framework will be published on the college website in mid-2022 and included in the supervisor support hub. It informed the curriculum review of the ANZCA Educators Program underway in 2021 and 2022 (standard 4).

The ANZCA Educator Competency Framework resulted from an analysis of educator roles and responsibilities in specialty training, a scoping review and thematic analysis of published competency frameworks, a survey of educators, expert group discussion, and stakeholder feedback. Its broad design covers all the competencies required of educators for specialty training, from the basic competencies expected of all clinical specialists to the more advanced competencies required of oversight education committee members. It may be used by institutions involved in medical specialty training to map the competencies required of different educator roles.

After a scoping review and thematic analysis of the literature, six competency domains were identified:

- **Domain 1:** Teaching and facilitating learning.
- **Domain 2:** Assessment of learning.

- **Domain 3:** Designing and planning learning.
- **Domain 4:** Educational leadership and management.
- **Domain 5:** Educational research and scholarship.
- **Domain 6:** Educational environment, quality, and safety.

The final report of the educator skills project (November 2020) included recommendations to create pathways for ANZCA and FPM educators to gain competence required for their roles.

The outcomes of the educator skills project also include plans for an ANZCA and FPM Educators Academy. An academy working group formed in late 2021 to develop a model of delivery of this academy. The group is reporting its findings to EEMC in late 2022 (appendix 8.19).

Supervisor and assessor training (standards 8.1.3 and 8.1.5)

While the college provides training for supervisors and assessors, uptake is variable and is not formally monitored (standard 6). While some roles have mandated training there are gaps, particularly for anaesthesia training program supervisors, WBA assessors and WBPF assessors. No supervisor or assessor roles have mandatory training in cultural safety. There is an inconsistent approach to on boarding training. Given the crucial role that supervisors play in providing feedback on trainee performance to achieve graduate outcomes, known issues with training culture in health (standard 7) and the role of high-stakes assessments (standard 5), the college must review the need for mandatory training for these significant training roles.

College-wide supervisor and assessor performance feedback (standards 8.1.4 and 8.1.6)

The college has no systematic processes for individual supervisor and assessor performance feedback that involves input from trainees. As the AMC and MCNZ expect that supervisors and assessors receive robust individual performance assessment that includes feedback from trainees, this is an area for future development.

College-wide accreditation management through the lifelong learning project (standard 8.2)

The lifelong learning project (standard 4) will create opportunities for all training programs with an electronic accreditation and training recording system providing streamlined accreditation processes and training data as supporting evidence. Currently the pain medicine accreditation process is managed using paper submission forms and limited database functionality. Once accreditation and trainee systems are introduced it is planned that data access will facilitate monitoring of units between accreditation visits. Identification of issues at present is based primarily around individuals raising issues directly with FPM.

College-wide Accreditation and Learning Environment Project Group (ALEPG) (standard 8.2)

In 2019, the ALEPG was established as part of training program evolution (TPE) project to:

- Evaluate current anaesthesia and pain medicine training accreditation standards and procedures.
- Benchmark the college against accreditation best practice to set a strategic direction for evolution of accreditation.
- Improve evaluation of the clinical learning environment through accreditation.

Project group members brought anesthesia and pain medicine educational and accreditation expertise and included fellows, a trainee and staff, including the chairs of ANZCA TAC and FPM TUAC. Mixed methodology included literature reviews, surveys and consultations with selected Australian and New Zealand colleges and international accrediting bodies. The project completed its work in mid-2021, identifying diverse opportunities for improvement across training accreditation practices. The key recommendation was that the college convene an accreditation renewal project, with a cross-program approach that is scalable for current and future training programs. The final report has 15 recommendations for the short (2022-2023), medium (2024-2027) and longer-term (2028-2032).

Implementation of the cross-program accreditation renewal project will be established in mid-2022 with the engagement of governance and working groups to address the following short-term recommendations:

1. Introduce annual monitoring of accredited sites to include bi-directional data flow between the college and accredited sites, and an annual college-wide state of accreditation report that is available to internal and external stakeholders.
2. Strengthen support for the volunteer accreditor workforce by reviewing and redesigning recruitment, orientation, training and performance evaluation processes.

A challenge for all programs is ensuring trainees, particularly at sites with small numbers of trainees, feel safe to provide feedback on their training experiences. This is a particular difficulty in pain medicine where most units have only one or two trainees. This will be addressed in accreditation redesign.

This project sets the strategic direction for evolution of accreditation and provides an opportunity to address identified gaps between current and best practice in accreditation and to improve evaluation of the clinical learning environment through accreditation. It also promotes collaboration between the anaesthesia and pain medicine training programs, allowing shared learning, creating efficiencies and ensures both programs are evolving towards best practice.

Standard 9

Continuing professional development, further training and remediation

ANZCA
FPM

Standard 9: Continuing professional development, further training and remediation

Overview

The ANZCA and FPM continuing professional development (CPD) standard and program are governed by the ANZCA and FPM CPD Committee (standard 1.2), reporting to the ANZCA Professional Affairs Executive Committee (PAEC) and hence ANZCA Council. Changes affecting pain medicine require FPM Board endorsement. Staffing is via the CPD team within the Education and Research unit (standard 1.5). The standard and program address requirements for both specialist anaesthetists and specialist pain medicine physicians in three categories – practice evaluation, knowledge and skills, and emergency response. Requirements are on the college website with recording via a bespoke CPD online portfolio including uploading of evidence, a dashboard to show progress, and automatic generation of compliance certificates. A randomly selected seven per cent of participants are audited annually, with non-compliant participants supported to meet requirements. Requirements have evolved to meet requirements of the Medical Board of Australia (MBA) and the Medical Council of New Zealand (MCNZ), with a CPD redesign underway to meet requirements due 2023 and mid-2022, respectively.

Most requests for further training are in the context of return to work for specialists who have been absent from practice. Occasionally, such requests are from regulatory bodies. Professional document PG50(A) *Guideline on return to anaesthesia practice for anaesthetists* 2018 provides the framework for return to practice programs for anaesthetists (key resources below). Based on the ANZCA roles in practice, it includes components of the CPD program such as emergency responses, a period of one-to-one supervision followed by oversight and practice evaluation such as multisource feedback. A similar process for specialist pain medicine physicians (SPMPs) is in development.

Pathways for addressing requests for remediation of specialists involve the directors of professional affairs (DPAs), regulation 26, the guideline *promoting good practice and managing performance in anaesthesia and pain medicine*, and a professionalism guide. The scope of the latter is being updated to encompass pain medicine. Fortunately, such requests are rare.

Key resources:

- Continuing professional development program handbook.
- Continuing professional development standard.
- Peer review of performance.
- Multisource feedback.
- Regulation 27 Performance assessment of anaesthetists and pain medicine physicians.
- Regulation 28 Removal of role holders, committee subcommittee and working group members and representatives.
- Promoting good practice and managing poor performance in anaesthesia and pain medicine.
- Supporting anaesthetists' professionalism and performance. A guide for clinicians.

- Guideline on return to anaesthesia practice for anaesthetists. PG50(A) 2018.

See also: standard 2 (educational purpose, program and graduate outcomes), standard 3 (ANZCA provisional fellowship training) and (standard 10 SIMG assessment).

9.1 Continuing professional development

The AMC accreditation standards are as follows:	
9.1 Continuing professional development	
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.

Overview

The purpose of the ANZCA and FPM CPD program is to maintain and advance each individual doctor's knowledge, skills and professional behaviour to ensure the highest standards of patient care throughout their working lives. The framework for the ANZCA and FPM CPD program is articulated in the CPD standard, which is publically available on the college website. The CPD program is further supported by the handbook and online CPD portfolio. The program is based on the ANZCA roles in practice with CPD requirements

mapped to these roles. Information on CPD for DHM practitioners is under *Other training programs* at the end of this standard.

The CPD team includes a CPD administrator and CPD lead from the Learning and Innovation team of the Education and Research unit. As an important source of support for CPD participants, the team resolve numerous enquiries per week, in addition to managing key operations such as the end of triennium and verification audit process. The learning and innovation manager, executive director of education and research and FPM operations manager provide oversight of CPD activities. More information on staffing is in standard 1.5.

Requirements determined by stakeholder consultation and MBA and MCNZ requirements

The Continuing Professional Development Committee (CPDC) regularly evaluates the CPD program structure for currency and accuracy, and to ensure it meets MBA and MCNZ requirements. Evaluation uses many sources, including member enquiries, committees and sub-group enquiries, regulatory updates and cycle reviews (standard 6). Key amendments to the current CPD program since its introduction in 2014 are in table 9.1.

Table 9.1 Changes to the ANZCA and FPM CPD program since 2014

Year	Changes
2015	Inclusion of new knowledge and skills activity '*Review of ANZCA or FPM fellows or trainees'.*
2018	Review of emergency responses and updating of activity guidelines. Inclusion of new emergency response activity 'Acute severe behavioral disturbance (ASBD) in the adult'.
2019	Cultural safety CPD activities relocated from knowledge and skills to practice evaluation category with value increased from one to two credits per hour. Inclusion of new practice evaluation activity for '*Examiners of final exams'.* Inclusion of new emergency response activity and guidelines '*Cardiac Arrest – Specialist Pain Medicine Physicians (SPMP)'.*
2020	Inclusion of wellbeing question in CPD plan. Inclusion of new emergency response activity '*COVID-19 airway management'.*
2021	Inclusion of new emergency response activity '*Central Nervous System oxygen toxicity (CNS-OT)'* for those practising Diving and Hyperbaric Medicine (DHM). Inclusion of new knowledge and skills activity '*Wellbeing CPD education sessions'.* Developed requirements for maintaining FPM endorsement in procedural pain medicine.

In Aotearoa New Zealand, the ANZCA and FPM CPD program is approved as the recertification program for Aotearoa New Zealand anaesthetists and specialist pain medicine physicians. It is noted that 'recertification' is the term used in section 41 of the *HPCA Act 2003*. MCNZ requirements are addressed including providing processes for multisource feedback (under practice evaluation) and collegial practice visits (under practice evaluation). This includes reporting to the MCNZ (standard 9.3). To date, the college has not had any Aotearoa New Zealand participants not meet CPD requirements (recertification) or withdraw from the program, unless also retiring from practice.

ANZCA and FPM CPD Program requirements for safe contemporary practice

Introduced on 1 January 2014, the current CPD program operates on a three-year cycle, commencing on 1 January of the first year and concluding on 31 December of the third year. There are three active CPD trienniums (cohorts) at any given time, involving over 6600 participants. Table 9.2 shows the spread of participants across the current trienniums.

Table 9.2 Participant numbers in current trienniums at 26 January 2022

Triennium	Participant no.
2020 – 2022	3561
2021 – 2023	1867
2022 – 2024	1200

CPD program structure

The ANZCA and FPM CPD program includes three categories:

1. Practice evaluation.
2. Knowledge and skills.
3. Emergency responses.

Requirements by participant type are in table 9.3. At present, most CPD participants must accrue a minimum of 30 credits each year. During each triennium, they must achieve 180 credits with at least 100 credits in practice evaluation and 80 credits in knowledge and skills. While there is flexibility for 'clinical' participants to claim activities relevant to their individual scopes of practice, all are required to complete a minimum of two mandatory activities each from the practice evaluation and emergency responses categories, noting the ER categories do not accrue credits. Non-interventional practice type is catered for, as are participants who are not directly involved in patient care (under the non-clinical practice type). Full details on the CPD program structure and CPD requirements for various participant types is in the CPD handbook, page 9.

Table 9.3 CPD requirements by practice type

Practice type	Triennial minimum requirements					Annual minimum requirement
	CPD plan	Practice evaluation	Knowledge and skills	Emergency responses	Triennial evaluation	
Clinical [1]	Yes	100 credits*	80 credits	2 activities	Yes	Plan plus 30 credits
Non-interventional [2]	Yes	100 credits*	80 credits	N/A	Yes	Plan plus 30 credits
Non-clinical [3]	Yes	N/A	80 credits	N/A	Yes	Plan plus 15 credits

Notes to table:
** including two of the mandated activities*

1. *Contact with patients for the purpose of assessment, diagnosis or treatment, or where any procedures are performed. This is inclusive of FANZCA and FFPM practitioners.*
2. *Neither a) administer anaesthesia and/or sedation; nor b) work in a practice environment where it would be expected that the practitioner would respond to an emergency situation (for example, a vasavagal event during an interventional pain procedure).*
3. *Not involved in direct patient care.*

All FPM fellows can fully participate in the program due to pain medicine specific emergency response standards on ASBD and cardiac arrest for the SPMP, and practice evaluation activities tailored for pain medicine practice, including for procedural endorsement (see 'FPM Procedures endorsement program' at the end of this standard).

Quality professional development: Beyond continuing medical education (CME) for knowledge and skills

Development of the emergency response category

The 2014 CPD program introduced a unique category tailored specifically to the emergency response (ER) needs of CPD participants and their patients. This category was originally developed to facilitate regular education in those emergency responses considered 'core' to safe anaesthesia and sedation practice. Criteria for the emergency response category were developed for the purpose of defining what constitutes an emergency response activity, supporting consideration for inclusion in the CPD program. Subsequently, FPM recognised a role for ER activities and developed two pain medicine emergency response activities to support safe pain medicine practice. Emergency response guidelines and activity details are in the CPD handbook pages 23- 25. The number of activities in this category has doubled since implementation in 2014 (table 9.4).

Table 9.4 Emergency response activities developed from 2014 to 2021

Year	Emergency response activities
2014	Can't Intubate, Can't Oxygenate (CICO) Cardiac Arrest Anaphylaxis Major Haemorrhage
2018	ASBD in an adult patient
2019	Cardiac Arrest – Specialist Pain Medicine Physicians (SPMP)
2020	COVID-19 airway management
2021	Central Nervous System oxygen toxicity (CNS-OT)

During 2017 and 2018, the CPDC comprehensively reviewed the four anaesthesia emergency response guidelines available since 2014 (CICO, cardiac arrest, major haemorrhage and anaphylaxis) for currency. Changes included updated references, participant-to-facilitator ratio and structured time durations enhancing consistency across all ER activities. Full details were made available in the 2018 summer *ANZCA Bulletin* (page 62) 'CPD Emergency Response Standards Review completed'.

Introduction of mandatory practice evaluation requirements

The 2014 CPD redesign introduced a new practice evaluation category which included mandatory own practice activities and optional practice evaluation activities. The mandatory activities includes four CPD activities that evaluate each participant's own practice for quality assurance and improvement. These are:

1. Patient experience survey.
2. Peer review of practice.
3. Multi-source feedback (MSF).
4. Clinical audit.

Participants are required to complete two of the four practice evaluation activities each triennium. The same activity may be completed twice to satisfy this requirement, aiding all participants to consider ones relevant to their scope of practice. Practice evaluation activity sample forms, guidelines and activity details are in the CPD handbook pages 13-15. These include clinical audit templates for both anaesthesia and pain medicine practice, including perioperative management of chronic medication and medical conditions; efficacy of epidural analgesia for labour; postoperative complications prevention, incidence and management; patient outcomes from pain management programs; and outcomes from interventional pain procedures. The templates include guidelines on audit objectives; suggested indicators; standards and criteria for best practice; methodology and references; data collection forms; and summaries of own results against suggested benchmarks.

Appendix 9.1 shows how these four practice evaluation activities have been taken up by participants. These data will support further consideration of current triennial requirements

as part of the CPD review project (see *'Improvement opportunities and future plans'* at the end of this standard).

Optional activities within the practice evaluation category

Other activities that can be credited to the practice evaluation category include morbidity and mortality meetings, case conferencing, report of clinical audit findings, review of patient care pathways, incident monitoring and reporting, team training scenarios in own workplace, root cause analysis, hospital accreditation, specialist international medical graduates (SIMG) assessment visits (standard 10), medico-legal reports, annual performance appraisal, and cultural safety activities (CPD handbook pages 16-18).

From cultural competency to cultural safety

In 2020, the CPD activity cultural competency was re-located from knowledge and skills to the practice evaluation category and increased from one to two credits per hour as 'Cultural safety'. The activity is described as follows: "*Participants explore culturally different expectations for clinical communication/behaviour, to develop strategies for responding effectively when expectations differ between colleagues, patients and their family members/carers. Being able to identify these diverse cultural perspectives will allow practitioners to understand medical beliefs and behaviours that relate to their own and others' cultures, and, where necessary, guide others in adapting to the Australian or New Zealand context*". These changes reflect the importance of strengthening cultural proficiency resources and competencies across Australia and Aotearoa New Zealand.

In the first 12 months of its relocation, this activity was recorded over 500 times by program participants. This is a three-fold rise from previous years. The committee and team continue discussions on embedding cultural safety and health equity across the whole CPD framework, in line with the MCNZ's foundational recertification requirement.

Recognition of wellbeing CPD education guidelines and activity

In April 2021, the college approved a new *wellbeing CPD education sessions* activity in the knowledge and skills category. This new activity acknowledges the importance of participant development in this area, supporting a sustainable workforce with healthy doctors who can provide the best in patient care. This need was heightened by the demands of the COVID-19 pandemic, requiring specific attention for CPD participants and all healthcare personnel. This activity and related guidelines draw inspiration from the Royal College of Physicians and Surgeons of Canada (RCPSC) draft CanMEDS professional key competency on physician health and wellbeing, currently in development.

In the first six months, 431 participants recorded 746 wellbeing education session activities in their CPD portfolios. Communication on changes was via the website news item 'New wellbeing CPD education sessions activity', with an update in the 2021 summer *ANZCA Bulletin* article 'Self matters' page 20-21.

Mandatory CPD planning and triennial evaluation

CPD participants must complete a **CPD plan** at the start of each triennium. The online CPD portfolio prevents access to CPD statements, certificates and recording of activities until planning is documented. This ensures that planning is completed at the start of each cycle.

Participants must complete a **triennial evaluation** at the end of each three-year cycle, which they can't access until their final year. Once it is completed, participants can obtain a

compliance certificate and commence a new triennium. Full details on the CPD plan are available in CPD Handbook, Appendix 17 CPD Plan, and in the triennial evaluation in the CPD Handbook, Appendix 18 CPD Evaluation.

Since 2014 and at 18 December 2021, 6824 participants have completed 15,863 CPD plans and 11,440 triennial evaluations in their online CPD portfolios. Further evaluation of CPD planning is anticipated during the CPD review project, specifically considering regulatory authority requirements for an annual planning process (see '*Improvement opportunities and future plans*' at the end of this standard).

CPD program and activities available to all specialists in the specialties

The CPD program caters to ANZCA fellows, FPM fellows, dual fellows, anaesthesia and pain SIMGs, anaesthesia provisional fellowship trainees (PFTs), and non-fellows including general practitioner anaesthetists and DHM practitioners, from hereon referred to as 'CPD participants'. Non-fellows are a growing cohort, potentially including all doctors practising anaesthesia and pain medicine in Australia and Aotearoa New Zealand who are not college fellows. General practitioners and rural generalist anaesthetists are only one category within this CPD membership type.

Registered medical practitioners can choose to join the ANZCA and FPM CPD Program through the application process on the college website. The program is included in fees for annual membership, SIMG assessment and training for ANZCA provisional fellows. It is also available to non-fellows for an annual fee which provides access to the CPD portfolio system, the ANZCA Library and Networks. Non-fellows must meet the same CPD requirements as fellows. This latter fee applies to DHM diploma holders who are not fellows.

College criteria for assessing and crediting educational activities

College educational activities

The college develops and delivers educational resources as described in standard 4. All are developed considering sound educational principles of adult learning.

Externally provided activities

The CPD program has a recognition of suitability process for the emergency response category. Providers of such education sessions (courses and workshops) apply for these to be recognised as suitable by the college. Each application form mirrors the relevant emergency response activity guidelines and their learning objectives. There is no fee for this process. The aim is that emergency response activities meet the criteria within the ER guidelines. It includes a declaration that the provider will advise the college of changes to activity content or duration (which might require reapplication).

Applications are processed by the CPD team and approved (or not) by the CPD chair or a CPD committee member. Approved applications receive either once-off event recognition or on-going recognition for three years. They are provided with a 'recognition of suitability code' which participants must use when recording emergency response activities in their online CPD portfolios. The process, application forms, and emergency response guidelines are located on the college website here.

While emergency response activities have a recognition process, this is not a formal accreditation process. Furthermore, this does not extend to the *practice evaluation* or *knowledge and skills* activities. Activities in these categories do not require prior recognition

from the college. Discussion about recognition of externally-produced educational resources has occurred at the CPD committee since 2018. Criteria based on educational quality that considers governance, implementation and evaluation will be formally considered during the CPD review project (see *'Improvement opportunities and future plans'* at the end of this standard).

Online CPD portfolio

The online CPD portfolio system enhances participant recording, monitoring and uploading of evidence on their CPD activities from a variety of devices, as it is mobile-responsive. Current integration with college-run events and training activities is a strength that is valued by many participants. These are auto-populated to the CPD portfolio system by the Events team, automatically from the ANZCA training portfolio system (TPS) and from the online learning management system, Networks. The CPD team actively supports enquiries on mastering the online CPD portfolio. *CPD portfolio – support document 2020* (appendix 9.2) is a step-by-step guide to portfolio navigation, including a checklist to ensure requirements are met.

Anaesthesia provisional fellowship trainees (PFT) access the online CPD portfolio towards the end of their training. This familiarises them with using the online CPD portfolio in anticipation for their admission to fellowship. Building on the support document for fellows, tailored PFT support is in *PFT CPD portfolio – support document 2021* (appendix 9.3).

Monitoring participation and dealing with non-compliance

Participation in other CPD programs

To provide flexibility to FPM fellows who are not also FANZCAs, the ANZCA and FPM CPD Program includes provision for them to elect to participate in the CPD program of their primary specialist college, providing that they also meet the ANZCA and FPM CPD standard. These fellows are included in the annual audit process. To encourage FPM fellows who do not hold FANZCA as their primary specialist qualification to participate in the ANZCA and FPM CPD Program, one of the FPM fellow members of the CPD committee is a non-anaesthetist specialist pain medicine physician.

Annual end-of-triennium process and reporting

The CPD end of triennium process (late August to early April annually) is administered by the CPD team with involvement of CPDC members. The process identifies, monitors and provides support to participants in each triennial cohort with the final submission date of 31 December in the third year.

Reminders include regular individualised emails with specific data on outstanding triennial requirements. Support calls from the CPD team and CPD Committee members, and in-person sessions (when applicable) are also conducted. A tracker is used to monitor impact of communications, and provide progress updates to the committee, including comparative results with prior trienniums. This tracker was first implemented for the 2017-2019 triennium and 2019 verification providing a benchmark for future CPD progress (appendix 9.4). An example of the tracker used for the recently completed 2019-2021 CPD triennium is in appendix 9.5. It shows tracking above average towards submission completion on 31 December 2021. Details are in the website news item '2019-2021 CPD end of triennium'.

The college has a proud record of end-of-triennium process completion rates between 98.9% and 100% over the past five years (further details in section *9.3 Remediation*). The

latest 2018-2020 CPD triennium achieved 100% completion. Details are in the website item 2018-2020 CPD end of triennium results. End-of-triennium results for 2018-2020 are available in the completion report produced in April 2021 (appendix 9.6).

The monitoring of CPD participation via online CPD portfolio records and end-of-triennium results support a proactive approach to avoid remediation processes. This has included tracking triennial cohorts in comparison to previous years and includes multiple communication methods (such as email, phone, college publications and social media). Through the online CPD portfolio functions and reports, staff can view CPD records in real time. This allows direct targeting of key areas and requirements such as tailored communication to support and manage CPD participants to meeting requirements.

Evidence to support this strength is in table 9.5, which shows 98.9% to 100% of participants in each triennium since 2014 entering complete requirements. Those CPD participants with 'requirements not met' are selected for verification of CPD activities (audit).

Table 9.5 Results from each end-of-triennium process since 2014

Triennium cohort	No. participants	Requirements met	Requirements not met	Result
2014 - 2016	2962	2950	12	99.6%
2015 - 2017	1528	1512	16	98.9%
2016 - 2018	916	915	1	99.8%
2017 - 2019	3149	3147	2	99.9%
2018 - 2020	1687	1687	0	100%
2019 - 2021	1113	1113	0	100%

Annual verification of CPD activities (audit) process

Each year the college randomly selects a minimum 7% of all participants for CPD records (CPD portfolio entries) verification. This represents 7% of FANZCA and ANZCA non-fellow participants and 7% of FFPMANZCA and FPM non-fellow participants. Full details on the verification process are available in the website news item 'Annual CPD verification: your questions answered' and the CPD handbook Appendix 19, Verification of CPD activities.

The verification of CPD activities (audit) process has been strengthened through the online CPD portfolio introduced in 2014. Participants selected for verification and college staff both benefit from streamlined access to CPD evidence through this tailored online platform. Participants directly upload evidence showing completion of CPD activities, and the CPD team can readily access and check it. This electronic information transfer reduces the need for sending paper evidence to the college. Evidence uploaded to the CPD portfolio also functions as a data repository for other purposes (e.g. so participants can provide hospitals with evidence of advanced life support currency).

The college has a proud record of accuracy and completion, with annual verification results between 98.3% and 99.5% since 2016 (table 9.6). Additionally, almost all of the very small percentage (0.5-1.7%) of participants who are not successfully verified are subsequently

supported and achieve requirements. Further details and data are in standard 9.3 Remediation. Appendix 9.5 (above) displays the tracking and monitoring used for the 2021 verification process.

Table 9.6 Results from verification of CPD activities process since 2016

Verification	No. participants	Requirements met	Requirements not met	Result	Repeat non-compliance
2016	415	408	7	98.3%	0
2017	415	409	5	98.5%	1
2018	447	443	4	98.8%	2
2019	450	448	2	99.5%	2
2020	No verification due to COVID-19 pandemic				
2021	462	462	0	100%	0

Participants selected for verification are notified of their CPD status at the end of the process in late March of the following year. CPD participants found to have repeat CPD non-compliance are reported to the DPAs in line with regulation 26 (standard 9.3). From the 2012 reaccreditation until 2016, no CPD participants were reported to the DPA for repeated CPD non-compliance. There have been five CPD participants who have been reported to the DPA for repeated CPD non-compliance since 2017 (table 9.7).

Table 9.7 Number of participants reported to the DPA for repeat non-compliance

Year	Reported to DPA	Continued CPD participation
2017	1	1
2018	2	2
2019	2	2

Each participant in table 9.7 has been supported through the remediation process, with no interruption to their fellowship/membership. All are now actively participating in the CPD program. They remain under college monitoring and have been re-selected in the 2021 verification of CPD activities process.

CPD non-compliance

The CPD non-compliance remediation process is similar to at the last reaccreditation, with enhanced monitoring and data collection made possible by the online CPD portfolio. The CPD team processes for end of triennium and annual verification of CPD activities provide opportunities to identify not-yet-compliant participants prior to submission deadlines. Furthermore, a few months grace period with increased communication and support is provided to members in an effort to assist, prior to DPA notification or audit selection.

9.2 Further training of individual specialists

The AMC accreditation standards are as follows:	
9.2 Further training of individual specialists	
9.2.1	The education provider has processes to respond to requests for further training of individual specialists in its specialty(s).

Further training of individual specialists

Anaesthesia

In 2017, the professional document PS50 *Guidelines on return to anaesthesia practice for anaesthetists* was updated to advise anaesthetists whose absence from clinical anaesthesia practice has been sufficient to warrant a formal return to practice program. It guides anaesthetists and those assisting them to develop, monitor and successfully complete such a program. The overall aim is that the returning anaesthetist provides safe and up-to-date care. While PS50 provides a template for this, each program is individualised so that it is appropriate for that fellow, in their practice, takes into account their reason for absence, and monitors and supports an individualised rate of return to full independent practice. This approach includes all MBA or MCNZ requirements, as relevant, for return to practice.

The process is voluntary, although highly recommended and promoted via mandatory requirements for trainees returning to practice (standard 3.4). The college is only involved on fellow or their employer's request. The executive director of professional affairs responds to queries, discusses return to work plans with the fellow and their department director, as relevant, approves plans prospectively, and ratifies the supervisor decision that the plan has been completed successfully. In 2021, the executive director of professional affairs assisted 16 fellows across Australia and Aotearoa New Zealand with this process.

Pain medicine

FPM fellows who have a break from pain medicine practice are required to undertake a re-entry program that meets the Australian Medical Council (AMC) or MCNZ requirements, as relevant. In 2021, a document development group was established to define a pain medicine-specific return to practice program, adapted from the anaesthesia policy and templates. It is anticipated that the FPM document will be drafted by late 2022 for piloting.

In 2021, FPM piloted a new training pathway for FPM fellows to become proficient in various pain medicine procedures leading to endorsement. FPM fellows and FPM trainees in the practice development stage may enrol in the program and select the procedures for which they wish to train. Endorsees work under the supervision of an FPM-accredited procedural supervisor. This provides a pathway for expanded scopes of pain medicine practice. FPM fellows who are endorsed in procedures in pain medicine have specific CPD requirements that are outlined in the CPD Handbook.

9.3 Remediation

The AMC accreditation standards are as follows:	
9.3 Remediation	
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.

Remediation of specialists

Remediation requests of the college are extremely rare, with none received in recent years. Performance review requests are infrequent, with the last in Aotearoa New Zealand in 2019 and the last in Australia in 2021. On average, the college receives one to two performance review requests per year.

Mechanisms for detecting underperformance are primarily the reports of others (e.g. regulators, institutions, colleagues or patients). There may be a request from an employer or regulator. These are referred to the directors of professional affairs (DPAs) in accordance with Regulation 26. Matters of continued CPD non-compliance are reported via this pathway in accordance with the ANZCA CPD mandatory compliance policy, including the end of triennium and verification of CPD activities processes (standard 9.1).

Developed in 2017, the document Supporting anaesthetists' professionalism and performance: A guide for clinicians was based on similar guidelines of the RACS and RACP and the ANZCA roles in practice. This guideline supports anaesthetists' professionalism and performance by providing advice to managers, leaders, mentors and colleagues on promoting an environment that supports excellent professionalism. It also assists in identifying and managing practitioners performing below acceptable standards. It lists behavioural markers for good and poor behaviours in all roles including non-medical expert ones, applies the more general guidance within the MBA and MCNZ Codes of Conduct to the practice of anaesthesia, and has a list of useful resources. Along with ANZCA standards, professional documents and the MBA/MCNZ Codes of Conduct, the professionalism guide is used in assessment of whether an anaesthetist is practising at an appropriate standard.

Promoting good practice and managing poor performance in anaesthesia and pain medicine was also developed in 2017. It includes four sections:

1. Methods available in departments and for fellows in solo or group practice for maintaining excellence in professional practice.
2. Advice for the individual practitioner on maintaining high standards throughout a professional career, including the role of appraisal and personal activities to support excellence.
3. How to identify poor performance.
4. Guidance on how clinical directors or colleagues should proceed when concerns arise about a fellow's performance.

After initial notification to the college of matters other than CPD noncompliance, the executive director of professional affairs discusses the concerns leading to such notification with the practice or institution in which the fellow or CPD participant is practicing, to agree

on an appropriate process. If there is significant risk to patient safety, this may include referral to the regulatory authority by the practice or institution (assuming mandatory notification has occurred as required under law).

Other options include an institution-based formal competence review. For this, fellows are nominated by the college under regulation 27 which also guides the process to be followed. If there is referral of the fellow from the regulator consequent to their assessment, the executive director of professional affairs discusses this with the practice or institution within which the fellow is working to agree a plan of supervised practice. Performance assessments are based on practice evaluation components of the ANZCA and FPM CPD Program (standard 9.1). There are also specific pathways for management of particular areas of professional performance such as bullying, discrimination and sexual harassment (standard 7.4). The college has a process for removal of college role holders, committee, sub-committee and working group members, as relevant, under regulation 28.

Following initial remediation outcomes, matters may then be reported directly by the college to the regulatory authorities, AHPRA or the Medical Council of New Zealand, respectively, as required. Very few such requests are received; approximately one every one or two years across all of Australia and Aotearoa New Zealand.

Impacts of COVID-19

CPD (standard 9.1)

Monitoring and risk analysis

Following the early 2020 COVID-19 pandemic announcement, the CPD team and CPD Committee received numerous enquiries from participants concerned about meeting CPD requirements. Concerns included leave restrictions, cancelled conferences and workshops, and significant demands from growing clinical workloads.

Given the CPD program's triennial design, a considered data-driven approach was taken. This included ongoing monitoring of CPD portfolio entries to understand nuanced impacts. For example, cancellation of the ANZCA Annual Scientific Meeting (ASM) (standard 4) significantly reduced documentation in the knowledge and skills category. Initial analysis of CPD portfolio entries in March 2020, with possible solutions and risks is in appendix 9.7. The committee and CPD team continue to actively monitor portfolio records for the effects of pandemic-related restrictions. The evolution of this analysis with results for 2020 and 2021 are in appendices 9.8 and 9.9, respectively.

Engagement with other colleges

The college CPD team actively participates in and hosts the CPD Managers Network. This network provides opportunities for CPD managers and other college representatives to discuss approaches and processes for their respective programs. The importance of the network was strengthened during the pandemic, with enhanced sharing of experiences and resources. All 16 specialist medical colleges were regularly represented, along with representatives from the regulatory bodies who provided regular updates.

CPD requirements unchanged

In June 2020, the college decided not to change annual and triennial requirements, stressing the importance of professional development during this time of need. The analysis

of context, data and options is available in an internal paper to ANZCA Council (appendix 9.10). Efforts were made to ensure CPD participants were able to correctly map pandemic-related activities (e.g. airway management, team training) to CPD program categories.

In recognising new learning opportunities and difficulties accessing usual CPD activities, the college implemented:

- A new 'COVID-19 airway management' emergency response guidelines activity. Since its April 2021 introduction, this activity has been recorded in the CPD portfolio by over 3200 participants.
- A COVID-19 and CPD webpage with key resources for CPD participants.

No 2020 verification of CPD activities

In line with regulatory decisions about CPD, the college did not verify CPD activities in 2020. This decision acknowledged the disruption to usual CPD, especially the decreased availability of face-to-face activities, and challenges obtaining evidence for activities undertaken online (e.g. webinars and podcasts). A letter was sent to the AMC in September 2020 reporting on this decision (appendix 9.11). While annual and triennial CPD requirements remain the same, 2020 evidence will not be requested from audited participants during verification of the 2019-2021 and 2020-2022 trienniums in 2021 and 2022, respectively. The college focused on sharing resources and participants deriving value from activities able to be completed, supporting requirements completion.

Virtual (online) emergency response activities

In September 2020, the college introduced flexibility for all emergency response activities to be recognised for virtual (online) format. This is specifically for the hands-on requirements of emergency response activities can't intubate, can't oxygenate (CICO), cardiac arrest and cardiac arrest – SPMP. Face-to-face format continues to be accepted through the recognition of suitability process available on the college website here. This decision allows for COVID-19 pandemic restrictions including physical distancing by allowing alternative delivery methods to meet learning objectives. It supports participant learning in these core areas, specifically airway management.

The virtual format was used for CICO workshops delivered at the 2021 ANZCA ASM (standard 4). Further information is in the 2021 winter *ANZCA Bulletin* article – *ASM hosts world-first virtual CICO workshop* and a report on these workshops was published in the journal *Anaesthesia and Intensive Care* (appendix 9.12).

Recognition of virtual ER activities has been extended to 1 January 2023. This supports ongoing pandemic-related restrictions and disruption, also aligning with timelines for the CPD review project (see *'Improvement opportunities and future plans'* at the end of this standard). Full details are available through the website news page 'Support for CPD emergency response activities as virtual/online sessions'.

Further training of specialists (standard 9.2)

The main pandemic impact was increased applications for return to practice programs, due to delays extending leave, and fellows needing to leave work because of medical vulnerability to infection. Completing common aspects of return-to-work programs, including emergency response courses and an initial period of fully supervised work, was more difficult. This affected very few fellows, with return to work programs adjusted to ensure

successful completion with equivalent outcomes. The pandemic has led to redeployment of some anaesthetists to other critical care areas, requiring upskilling, handled locally.

Remediation of specialists (standard 9.3)

The pandemic has had no impact on processes for specialist remediation. During lockdowns and because of travel restrictions, there has been more limited access to sites to undertake performance assessment.

FPM Procedures Endorsement Program

FPM fellows who are endorsed in pain medicine procedures are required to meet the ANZCA CPD standard and must maintain a balance of CPD activities encompassing core activities relating to the sociopsychobiomedical framework of pain medicine, alongside specific procedures-related activities. This includes undertaking professional development related to the fellows' procedural scope of practice, to ensure ongoing competence in pain medicine procedures and adherence to PS11 (PM): Procedures in Pain Medicine Clinical Care Standard.

Specific CPD requirements to maintain endorsement in procedural pain medicine are in the CPD handbook. These include:

- A clinical audit per triennium.
- At least 30 credits per triennium/10 credits per annum on knowledge and skills activities related to procedures.
- A limit of 10 credits per triennium for industry events under knowledge and skills activities.

Other training programs

Joint Consultative Committee on Anaesthesia (JCCA)

CPD requirements for JCCA graduates are determined by their primary colleges. The JCCA offers a specific anaesthesia CPD program, including to those who are not college members. Requirements are consistent with aspects of the ANZCA and FPM CPD standard, including practice evaluation and emergency response activities. In 2017, the JCCA recommended that credentialing authorities ensure all medical practitioners delivering anaesthesia services are compliant with the JCCA CPD standard. The process is not audited. Some general practice anaesthetists participate in the ANZCA and FPM CPD program. GPAs are included as part of the 7% of CPD participants audited.

In 2017, the JCCA developed a *return to work/upskilling policy*. Requests for remediation would be referred to the primary college.

Diploma of Rural Generalist Anaesthesia (DRGA)

The CPD requirements, audit processes and remediation for DRGA graduates are yet to be determined.

Diploma of Advanced Diving and Hyperbaric Medicine (DHM)

The ANZCA and FPM CPD Program is open to all DHM practitioners with no separate program or additional activities and requirements. DHM practitioners who do not hold FANZCA or FFPMANZCA may choose to do CPD at their primary college or join the ANZCA

and FPM CPD program. Under guidance of the DHM Sub-committee (DHMSC), supporting tools have been developed for DHM practitioners in the program, including:

- In June 2019, nine DHM-tailored forms and guidelines for the patient experience survey, multi-source feedback (MSF) and peer review of practice activity (see appendices marked 'DHM' in *ANZCA CPD program handbook*).
- In September 2019, a clinical audit sample (appendix 9.13) on 'Prevention of Middle Ear Barotrauma (MEBT) during compression for hyperbaric oxygen therapy (HBOT)'.
- In April 2021, a new emergency response activity on 'Central Nervous System oxygen toxicity (CNS-OT)'. Full details are in the 2021 winter *ANZCA Bulletin* (page 39).
- The CPD for DHM diplomates is audited within the ANZCA CPD audit framework.

The DHMSC is responsible for assessing DHM diplomates and defining any necessary remediation should such a situation arise. The process would be developed within the sub-committee and would be based on wider college processes.

Diploma of Perioperative Medicine (POM)

CPD activities for those with the DipPOM are yet to be finalised.

Dual FANZCA-FCICM pathway

Details of CPD and changes in scopes of practice and specialist remediation are yet to be determined. While these will likely remain as per each college, closer collaboration between ANZCA and the College of Intensive Care Medicine (CICM) creates opportunities for better information sharing and potential efficiencies in CPD provision for dual specialists working in rural and regional centres.

Strengths

ANZCA and FPM CPD program valued by fellows (standard 9.1)

An overarching strength of the CPD program is the value fellows and other CPD participants place on their professional development. This is best indicated through the 2021 ANZCA and FPM fellowship survey results where CPD was one of the four most highly-rated priorities.

Mandatory ANZCA and FPM practice evaluation activities (standard 9.1)

The 2014 introduction of mandatory own practice evaluation activities (MSF, patient experience survey, audit, peer review of practice) supports participants measuring and reflecting on patient outcomes in their practice, a mission-aligned process to support high quality and safe care. This ANZCA and FPM CPD program category also puts the college in a strong position for forthcoming regulatory body CPD standard changes.

ANZCA and FPM emergency response activities (standard 9.1)

Inclusion of emergency response activities supports time-critical decision-making in all specialities (including DHM) for best patient care. The college continues to explore opportunities to develop specific emergency response activities for all disciplines. Areas identified for future emergency response activities include major neurological complications associated with pain procedures, malignant hyperthermia and paediatric cardiac arrest. This ANZCA and FPM CPD program category also puts the college in a strong position for

forthcoming regulatory body CPD standard changes. An example of an analysis of emergency response activity providers is in appendix 9.14.

Professional documents, guidelines and statements (standard 9.1)

Professional documents, guidelines and statements focus on broader issues associated with anaesthesia and pain medicine beyond clinical considerations. They recognise the challenges faced by clinicians with regard to wellbeing as well as those issues impacting on communities, both socially and environmentally. They also provide valuable promotion of professionalism to members and the medical community. The results of the 2021 fellowship survey include professional documents, guidelines and statements as one of four most highly rated priorities of ANZCA and FPM fellows.

Real-time information from online CPD portfolio (standard 9.1)

During the COVID-19 pandemic, regular channels for participants to complete CPD requirements (such as conferences and scientific meetings) were cancelled or delayed. The CPD team used real-time information from the online CPD portfolio to identify recorded activities. This facilitated the provision of targeted support for participants to assist in meeting requirements in a changed environment. This evidence-based approach ensured a sound empirical basis specific to CPD participants, rather than applying a set of contingencies, such as reduce all requirements.

Return to work following time away from anaesthesia practice (standard 9.2)

The current return to work process is individualised for each fellow and includes components of the ANZCA and FPM CPD program, such as planning and practice evaluation tools.

Remediation of specialists (standard 9.3)

Practice evaluation components of the ANZCA and FPM CPD program provide measurement tools for individual specialist performance assessment. Peer review of practice, MSF and clinical audit ‘recipes’ have particular utility, depending on circumstances. The college also has a professionalism guide which describes behaviour markers of acceptable and poor performance. This is being updated for relevance for pain medicine specialists.

Improvement opportunities and future plans

CPD review project (standard 9.1)

The ANZCA and FPM CPD standard and program are due for review to maintain alignment with the Medical Board of Australia’s (MBA) proposed Professional Performance Framework and revised CPD registration standard (effective January 2023), and Medical Council New Zealand’s (MCNZ) recertification document (effective mid-2022). The college submitted responses to public consultations on these changes in 2019 and 2020.

The ANZCA and FPM CPD review will also align with a planned review five years from implementation of the 2014 program, delayed by COVID-19. The online CPD portfolio is also in scope for the strategic lifelong learning project (standard 4). A CPD review project group is established and first met in October 2021. Full details on the project were publicised to members through the website news item ‘New CPD review project group’ with ongoing communication reflected in the project group’s own webpage. In 2022, the CPD review

project group will provide recommendations to ANZCA Council and the FPM Board to ensure the ANZCA and FPM CPD program addresses new regulatory standards.

Both regulatory bodies have requested new amendments to reports from CPD homes on CPD compliance, with further consultation required on the duration and type of reports required. Further direction is anticipated from the regulators in early 2022, with conversations thus far requiring a change to an annual submission date to comply. This is in scope for the CPD review project.

Embedment of cultural safety and a focus on health equity in the CPD program (standard 9.1)

As part of the CPD review project, the group are evaluating best-practice direction to meet the MCNZ requirement to *embed cultural safety and a focus on health equity across the recertification programme.* This includes analysis of CPD participant data on current completion of cultural safety activities under the practice evaluation category, and consultation with cultural safety/competency training providers, regulatory bodies and other education providers. The topic has been broadly discussed at CPD managers' network meetings. Work will continue throughout 2022, with proposed implementation on 1 January 2023.

An enhanced CPD portfolio (standard 9.1)

While many CPD participants view the online CPD portfolio as a strength in achieving CPD compliance (including seamless verification), further improvements are being explored. The CPD team encounters numerous enquiries from CPD participants about access to statements, completion of their CPD plan and evaluation, and confusion about incomplete requirements. Increasingly, CPD participants expect enhanced technology. Transitioning existing paper-based patient experience surveys and multi-source feedback online is a regular request.

Future enhancements and support through a new online CPD portfolio are planned in the lifelong learning project (standard 4). This is informed by detailed analysis into the critical high-level user requirements, including improved support for compliance, useability, more advanced technology and streamlined processes (such as internal automation of CPD records). These areas have been included as critical requirements during the lifelong learning project, for which the CPD portfolio is in scope. Enhancement also includes portfolio orientation for new participants and better portfolio navigation to confirm requirements are met. The CPD team have produced documents to support participants (appendix 9.2 and 9.3), which will be updated to reflect changes in the online CPD portfolio.

Identifying quality CPD activities (standard 9.1.6)

While the college recognises CPD providers, its process does not currently include identifying quality CPD resources according to educational quality (9.1.6). This is an area for future improvement in the CPD redesign project.

Pain medicine specialist return to practice (standard 9.2)

A policy and process for return to work for FPM specialists is in development and is expected to be piloted at the end of 2022.

Expected individual performance in anaesthesia and pain medicine (standard 9.3)

An area for improvement is defining standards for anaesthesia, pain medicine, and perioperative medicine. This also facilitates CPD practice evaluation activities by providing benchmarks against which performance can be measured. Overarching principles for this type of work are guided by the 2021 introduction of the college's Document Framework Policy (standard 1). A standards working project is developing standards applicable to anaesthesia, pain medicine, and perioperative medicine.

Standard 10

Assessment of specialist international medical graduates

Standard 10: Assessment of specialist international medical graduates

Overview

Since 2013, specialist international medical graduate (SIMG) assessment is a joint process for anaesthesia and pain medicine. Within an overarching bi-national and bi-specialty process, there are specialty-specific and country-specific modifications to meet the differing requirements of the Medical Board of Australia (MBA) and Medical Council of New Zealand (MCNZ). Information on the process is available publicly on the college website.

The SIMG Committee oversees this process, reporting to both anaesthesia and pain medicine governing committees and to the New Zealand National Committee (NZNC). Staff support is through the Melbourne office, New Zealand national office and the SIMG director of professional affairs. Recent recruitment has focused on increased involvement of former SIMGs and pain medicine fellows. The committee, interview and performance assessment panels now reflect most of the countries from which SIMG applicants originate.

Assessment conforms to MBA and MCNZ requirements and has improved in response to major external reviews. Progressively, there has been reduced reliance on examination and greater use of workplace-based performance assessment. From 2022, all SIMGs undergo multisource feedback (MSF). Areas for improvement include monitoring and pass rates in the SIMG examination.

Key resources:

- Regulation 23.
- Handbook for specialist international medical graduates.

See also: Standard 1.3 (reconsideration, review and appeals processes).

10.1 Assessment framework

The AMC accreditation standards are as follows:	
10.1	**Assessment framework**
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.

Governance

The SIMG committee oversees SIMG assessment for both anaesthesia and pain medicine, guided by regulation 23 and supported by the SIMG director of professional affairs (DPA), staff within the education and research unit, and a staff member in the New Zealand national office. For anaesthesia, the committee reports to the Education Executive Management Committee (EEMC) and hence to ANZCA Council. For pain medicine, the committee liaises with the FPM Training and Assessment Executive Committee (TAEC), with recommendations approved by FPM TAEC and the FPM Board.

Recent recruitment has focused on involving more pain medicine fellows and fellows who have completed the ANZCA and FPM SIMG assessment process. Anaesthesia SIMG applications most often originate from the United Kingdom, South Africa, India and Germany. For pain medicine, most applications are from the United Kingdom. Fellows whose primary specialist training was in these countries are involved on the committee, interview panels and as performance assessment (PA) assessors. The committee and panels also include those with college training program and assessment expertise.

Assessment framework is consistent with MBA and MCNC guidelines

Australia

The SIMG assessment process evaluates the ability of each SIMG to practise as an unsupervised specialist anaesthetist or specialist pain medicine physician at a standard comparable to that of a recently graduated ANZCA or FPM fellow, respectively. The process conforms to the MBA good practice guidelines and is regularly reviewed for consistency with regulatory changes. A revised regulation 23 was implemented in 2021 in accordance with *specialist medical college assessment of specialist international medical graduates*, MBA, 2021.

Aotearoa New Zealand

As the Vocational Education and Advisory Body for anaesthesia and pain medicine, the college maintains an ongoing collaborative and communicative relationship with the MCNZ to ensure the process aligns with their requirements, providing the MCNZ with an assessment of SIMG training, qualifications and experience. The college provides advice to the MCNZ which makes the decision on vocational registration. In accordance with MCNZ policy, regulation 23 specifies that fellowship is not a pre-requisite for recommendation for full vocational registration. Aotearoa New Zealand-based staff and fellows regularly attend MCNZ meetings at which SIMG processes are discussed.

Area of need process

The area of need (AON) process applies to Australia only. It addresses medical workforce shortages in designated areas and doesn't lead to fellowship or specialist registration by the MBA. The relevant government jurisdiction, not the college, declares that a position is AON. College support is site-specific and cannot be transferred to another position.

The process assesses suitability for the specific position, rather than comparability to an Australia-trained specialist. However, to determine SIMG suitability for a specific position, the college requires combined assessment for specialist recognition and AON. Following interview, the college issues a “combined report” to the SIMG and uploads this to the AMC portal confirming that the SIMG “is” or “is not” suitable for the position and including details of the comparability assessment.

Process determines comparability with Australian or New Zealand-trained specialists

The SIMG assessment process compares training qualifications, specialist practice and CPD with that of locally-trained specialists. In Australia, the outcome is whether the SIMG is substantially, partially or not comparable. In Aotearoa New Zealand, it is whether they are equivalent to, as satisfactory as or neither equivalent to nor as satisfactory as a locally-trained specialist. The college never requires more from SIMGs than it does from locally-trained specialists. SIMG requirements are based on those of the relevant training program and the ANZCA and FPM CPD program (standard 9).

The comparison considers:

- Basic medical training and experience prior to specialist training, ensuring a good general medical foundation for specialist training.
- The specialist training program duration, structure, content (including subspecialty experience and practice domains), supervision, assessment, governance, and progression.
- Specialist qualifications including their governance.
- Specialist experience, especially in the previous 36 months. This includes case mix, credentialing, compliance with international and national standards of practice and practice across the ANZCA or FPM specialist roles in practice (standard 2).
- CPD, especially participation in practice evaluation activities (e.g. audit), and emergency response activities (standard 9).
- The comparability of the health system in the country of origin and Australia or Aotearoa New Zealand, as relevant.
- Understanding of the context of specialist practice including community, cultural and professional expectations.

Outcomes of assessment of these components forms the individual SIMG assessment program.

This pathway is not a specialist training program. In Australia, SIMGs assessed as needing significant training to reach the standard of a locally-trained specialist are referred back to the AMC. In Aotearoa New Zealand, the college advises the MCNZ for their final decision. Successful completion of the SIMG pathway allows practice as an unsupervised specialist anaesthetist and/or specialist pain medicine physician and application for ANZCA and/or FPM fellowship, as relevant.

The college reports outcomes of all phases of assessment to relevant stakeholders within required timeframes (usually within 10-14 business days of the assessment). An annual report is provided to the AMC. While there are common elements to pathways in Australia and Aotearoa New Zealand, the processes accommodate regulatory differences.

Application

Since 2014, SIMGs in Australia apply directly to the college. In Aotearoa New Zealand application is to the MCNZ. Forms for Australian applications are available on the college website.

Preliminary review

In Australia, the preliminary review determines whether the application is complete and if the applicant satisfies criteria for an interview (Regulation 23.8.5). College staff confirm the application is complete. The DPA SIMG completes the summary of preliminary review (SPR, appendix 10.1) which is sent to the applicant with 21 calendar days for a response and provision of additional information.

In Aotearoa New Zealand, preliminary review is undertaken following request by the MCNZ which provides all SIMG documentation. The college provides preliminary advice about the applicant's qualifications, training and experience and recommended pathway requirements. This advice is documented using the MCNZ RGR 6 form.

Interview panels

The structured interview is described in the handbook for specialist international medical graduates. The interview panel assesses SIMG training, qualifications, specialist experience and CPD.

Interview panels in Australia and Aotearoa New Zealand include a minimum of three (preferably four) interviewers for each interview day. The panel **must** contain mixed gender, one community representative and a chair.

SIMG staff ensure each panel member is scheduled for at least two interview days per year. Once applicants are assigned interview dates, staff check for any potential conflict of interests (i.e. if an applicant is currently working in Australia those working in the same hospital are not invited as panel members).

Training for SIMG panel members includes observing their first interview day and participating in the panel on their second interview day. The panel chair completes a performance report at the end of the second day which the DPA SIMG reviews prior to approving their appointment. Any issues raised in the report are escalated to the SIMG Committee for review.

This apprentice-style training completed at the start of the role is supplemented by regular workshops. Aotearoa New Zealand-based members of the SIMG PA assessor and interview panels have bi-annual two or three-hour training sessions convened at the time of NZNC meetings. These cover specific skills, such as interviewing, the legal basis for SIMG decisions and discussion of the process and challenges faced by members. The most recent training session, held in October 2021, included interviewing skills training by an external facilitator. Prior to the pandemic, Australian-based members of the SIMG PA assessor and interview panels had annual training days covering similar topics. However, following significant staff turnover and the onset of the pandemic, these have been postponed. It is hoped to re-start them in 2022.

Specialist recognition and fellowship

SIMGs are recommended for specialist recognition following satisfactory completion of all requirements specified by the college. They are eligible to apply for admission to ANZCA or FPM fellowship by assessment under Regulation 6.2 for anaesthesia or By-law 3.4 for pain medicine.

Requirements are documented and published

Requirements are documented in regulation 23 and the handbook for specialist international medical graduates, both publicly available on the college website. The process is supported by a self-assessment tool, also publicly available for prospective SIMGs.

Regulation 23 undergoes regular review for consistency with evolving Australian and Aotearoa New Zealand training regulations, CPD standards and AMC, MBA/AHPRA and MCNZ standards and guidelines. The most recent version of the regulation, implemented in January 2022, is rewritten in plain English, enhancing readability.

The handbook for specialist international medical graduates was introduced in January 2022, streamlining regulation 23 to the 'rules' and providing greater explanation of the assessment processes. With a format and structure based on the ANZCA handbook for training, the handbook for specialist international medical graduates is a reference for SIMGs as they proceed through the process.

10.2 Assessment methods

The AMC accreditation standards are as follows:	
10.2	**Assessment methods**
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.

Assessment methods are fit for purpose

The SIMG assessment process includes assessment methods recommended by the MBA guidelines which have been chosen for their reliability, validity and feasibility.

The clinical practice assessment period (CPA)

The CPA period familiarises the applicant with anaesthesia or pain medicine practice in Australia or Aotearoa New Zealand, and facilitates practice performance assessment. The SIMG process is not a training program, however, the CPA period may address specific deficiencies in training or experience. Each SIMG's performance is assessed every three months by their supervisor using the CPA report form (appendix 10.2). All anaesthesia and pain medicine reports are reviewed by the DPA SIMG, and any concerns dealt with as detailed below. The supervisor role is clearly outlined by both regulatory authorities and the application to anaesthesia and pain medicine is described in the SIMG supervisor agreement.

College CPD participation

Payment of the SIMG annual fee provides access to the online ANZCA and FPM CPD portfolio. All SIMGs must actively participate in the ANZCA and FPM CPD program and submit a participation certificate for each year that they are in the SIMG assessment process. Certificates are reviewed by the DPA SIMG to determine whether minimum CPD requirements are met. Failure to actively participate in the CPD program may result in a review of the SIMG's application under regulation 23.14.

Effective Management of Anaesthetic Crises for anaesthesia SIMGs only

As part of the SIMG assessment process, anaesthesia SIMGs are required to successfully complete an Effective Management of Anaesthetic Crises (EMAC) course which is also a compulsory component of ANZCA anaesthesia training (standard 4). The EMAC course involves interactive learning for emergency responses, including underlying human factors. It provides excellent learning on the non-hierarchical nature of the medical workforce in Australia and Aotearoa New Zealand, which may be different from some SIMGs' experiences. It also teaches the common language, protocols and checklists used in emergencies.

External assessment

Depending on the interview outcome, SIMGs must complete either the SIMG performance assessment (SIMG PA) or the SIMG examination.

SIMG performance assessment (SIMG PA)

The SIMG PA is a comprehensive peer review assessment undertaken by two trained fellows. It is held over one day in the hospital or unit in which the SIMG is employed. The SIMG PA assesses professional performance against the standard that is expected of a FANZCA or FFPMANZCA and covers all ANZCA or FPM roles in practice, respectively. Information on the PA is in the SIMG Handbook and specific information is given to the SIMGs in advance of their assessment. The SIMG PA assessor manual is at appendix 10.3.

SIMG examination

The anaesthesia SIMG examination is conducted by the Final Examination Sub-committee, and consists of the anaesthesia and medical oral components of the ANZCA final fellowship exam (standard 5). The FPM SIMG examination is conducted by the FPM Examination Committee, and consists of the viva component of the FPM fellowship exam. Relevant exam reports are available to all SIMGs (appendix 5.7).

Criteria for success

- Successful progression through the SIMG assessment process: It is anticipated that this will improve with the 2022 introduction of regular meetings to review those SIMGs whose progress is causing concern.
- Successful SIMG program completion: Most SIMGs complete the process successfully. Up to one per year (but not every year) fails the SIMG PA. Most of these successfully complete a repeat assessment, after a remediation program lasting at least six months. Table 10.3 shows SIMG examination pass rates which remain concerning.

Procedures for notifying safety concerns to employers and regulators

All reports about SIMG performance are reviewed by the DPA SIMG. These include regular clinical practice assessment (CPA) reports, the PA report (signed off by the two peer reviewers), and any other notifications by the employer or SIMG supervisor.

If there are concerns about any assessment, the DPA SIMG contacts the supervisor to discuss the SIMG's performance and clarify their assessment of the SIMG, the steps that the supervisor and employer will take or has taken to prevent any harm to the public and a remediation plan, if this is considered feasible. This discussion includes whether the performance observed requires notification to the regulator, or whether the preceding

measures will ensure patient safety while remediation occurs. The draft remediation plan is submitted for approval to the DPA SIMG, and then follow-up assessments are submitted as required until remediation is successful or re-interview to assess ongoing participation in the SIMG assessment process is required. Concerns about SIMGs are reported to the SIMG committee for review of their progress in the pathway.

The college has not detected any risks to patient safety that have required notification to the regulator in either country, but is always alert to the possibility. There have been a few anaesthesia SIMGs in Australia who have been assessed as requiring one-on-one supervision at all times. This has been instituted pro-actively by the relevant anaesthesia department and a remediation plan put in place following approval by the DPA SIMG. Anaesthesia departments are familiar with closer supervision for trainees to ensure patient safety. This process is usually successful as the SIMGs acculturates to local practice.

If concerns are not addressed successfully, then SIMGs are invited to a re-assessment interview. This occurs for one or two anaesthesia SIMGs each year. In 2018, in a re-interview of an Australian SIMG it became apparent that the initial assessment should have been 'not comparable', and so this doctor was removed from the SIMG process with a Report 2 sent to the AMC. This is the only SIMG removed from the SIMG process for performance concerns. There have been no major concerns with Aotearoa New Zealand anaesthesia or pain medicine SIMGs.

The process used for SIMGs notification to the regulators is similar to that used for trainees (standard 5). Regulation 23.19 outlines how SIMGS with conditions, limitations and restrictions on medical registration are managed. SIMGs are required to advise the college of any changes to their registration.

10.3 Assessment decision

The AMC accreditation standards are as follows:	
10.3	**Assessment decision**
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.

Assessment decisions are in line with requirements

The SIMG Committee chair is a member of the Education Executive Management Committee (EEMC) and committee minutes are tabled at EEMC meetings. For pain medicine SIMGs, the committee liaises with the FPM Training and Assessment Executive Committee (TAEC), with recommendations approved by FPM TAEC and Board. All assessment decisions are in line with those acceptable to the regulators; e.g. all those

SIMGs assessed as substantially comparable in Australia are asked to undertake 12 months or shorter CPA, and don't sit the SIMG exam. The requirements for those assessed as substantially and partially comparable are summarised below.

Substantially comparable requirements: anaesthesia and pain medicine

- Complete a period of up to 12 calendar months full-time equivalent (FTE) clinical practice in the relevant specialty (anaesthesia or pain medicine).This period may be reduced if the applicant:
    - Has suitable previous experience in the Australian or Aotearoa New Zealand healthcare system, of at least 12 months duration.
    - At the time of interview, has been working in an approved post for at least six months.
- Successfully complete the SIMG performance assessment.
- Complete a multisource feedback.
- Actively participate in the ANZCA and FPM CPD program.
- For anaesthesia, complete an EMAC course (see 'Exemptions or credits based on program outcomes' below).
- Partially comparable requirements: anaesthesia
- Complete a period of between 12 and 24 months FTE of clinical practice in anaesthesia, normally in an ANZCA-accredited hospital department. ANZCA accredited departments are categorised by duration of allowable training time each trainee may spend at that site and this information is available on the college website. Individual SIMG requirements are in the interview outcome report. This period may be reduced if the applicant:
    - Has suitable previous experience in the Australian or Aotearoa New Zealand healthcare systems of at least 12 months duration.
    - At the time of interview, has been working in an approved post for at least 12 months.
- Successfully complete the SIMG examination or SIMG PA, as determined by the interview panel.
- Complete a multisource feedback.
- Actively participate in the ANZCA and FPM CPD program.
- Complete an EMAC course (see 'Exemptions or credits based on program outcomes' below).

Partially comparable requirements: pain medicine

- Complete a period of 12 months FTE clinical practice in pain medicine. This must be completed in a level 1 FPM accredited training unit.
- Complete a multisource feedback.
- Successfully complete the viva component of the FPM fellowship examination or the SIMG PA.
- Actively participate in the ANZCA and FPM CPD program.

Not comparable

These applicants are not eligible to continue in the SIMG pathway and must contact the AMC and MBA or MCNZ, as relevant, to discuss assessment options via the general pathway and then, if relevant, the college training pathway. These applicants may be eligible for limited or provisional registration through another pathway that will enable general registration; subsequently, they can apply for entry into a college specialist training program. Applicants are advised to contact AHPRA or the MCNZ, as relevant, for further guidance on their options for practising in Australia or Aotearoa New Zealand.

Cultural safety

The SIMG interview assesses in detail comparability to an Australian or Aotearoa New Zealand trained specialist anaesthetist or specialist pain medicine physician. The interview expands on the information provided in the application and focuses on the following areas:

- Training.
- Qualification.
- Specialist practice.
- CPD.
- Cultural safety and community awareness.

The community representative listens to the answers given by the SIMG applicant regarding their training, qualifications and experience. This helps to form questions for the community awareness component of the interview. The panel explores the applicant's understanding, attitudes and skills in non-technical areas of anaesthesia or pain medicine practice at a specialist level. Questions may include understanding of the meaning and application of patient-centred care with particular focus on cultural safety and its impact on the care provision and patient outcomes. The applicant is also asked about professional behaviours and ethical standards and may be asked to describe a personal experience detailing their role in handling a challenging situation.

The SIMG's initial job description is checked to ensure that cultural safety is part of their orientation program. As a result of their interview performance, a few SIMGs have been advised to undertake extra cultural safety training.

Exemptions or credits based on program outcomes

Anaesthesia SIMGs may be exempted from the EMAC course if they have previously completed a course with a similar curriculum and assessments in their specialist training or CPD in their country of origin. SIMGs who have already spent time practicing in Australia or Aotearoa New Zealand are given credit for that, and their CPA time reduced by up to six months.

In Aotearoa New Zealand, MCNZ makes decisions on required time under supervision. They have notified all colleges that those assessed 'as satisfactory as' (partially comparable) can have their time shortened to up to six months if they are already in a post in Aotearoa New Zealand that will be approved for supervised practice, will continue with the same supervisor, and should complete requirements within that time frame.

Clear documentation of additional requirements and timelines for completion

Following interview, each applicant receives Report 1 (Australia) or an assessment outcome report (Aotearoa New Zealand) outlining the requirements they must successfully complete to be eligible to apply for fellowship (the SIMG's individual program). Applicants are provided with an "agreement to continue in the SIMG process" form, which they must complete, as well as pay an annual fee, to commence their individual program. Once this occurs they become active in the SIMG pathway.

The purpose of the individual program is to:

- Assist the SIMG with their transition to the Australian or Aotearoa New Zealand health system.
- Ensure SIMG performance is at the standard of an Australian or Aotearoa New Zealand trained specialist commencing practice.
- Provide the SIMG with professional support.
- Support the SIMG to assess and maintain their professional development.

The individual program is generally made up of five components:

1. Internal assessment: a defined period of supervised practice, the clinical practice assessment (CPA).
2. External assessment: anaesthesia examination, pain medicine examination or SIMG performance assessment (SIMG PA).
3. The EMAC course (anaesthesia SIMGs only).
4. A multisource feedback assessment.
5. ANZCA and FPM CPD program participation and compliance.

The timelines for completing SIMG individual programs are consistent with regulatory authority guidelines and standards. In Australia, this is two years for those assessed as substantially comparable, and four years for those assessed as partially comparable. In Aotearoa New Zealand, this is determined and managed by the MCNZ.

Communication with applicants and registration authorities

In Australia, a copy of the Report 1/college report is emailed to the applicant and uploaded to the AMC/AHPRA portal, within 14 calendar days of interview.

In Aotearoa New Zealand, the recommendations of the interview panel are sent to the MCNZ which determines the outcome of the vocational registration pathway assessment. The MCNZ emails this outcome to the applicant. If the applicant has also requested an ANZCA/FPM fellowship pathway assessment, the outcome of that assessment is emailed after the MCNZ assessment outcome has been provided. This is usually four to eight weeks after the interview.

SIMG assessment data 2017-2021

Tables 10.1 and 10.2 show the numbers of SIMG applications and their outcomes for the past five years for anaesthesia and pain medicine, respectively. Figures are provided for each country and for Australian AON applications.

Table 10.1 Applications of the SIMG assessment and AON processes for anaesthesia applicants 2017-2021

Anaesthesia **Applications and outcomes for specialist recognition**										
	2017		**2018**		**2019**		**2020**		**2021**	
	AUS	**NZ**	**AUS**	**NZ**	**AUS**	**NZ**	**AUS**	**NZ**	**AUS**	**NZ**
Total applications received	68	14	39	9	67	15	53	24	55	30
Specialist/vocational registration	65	14	37	9	66	15	51	24	53	30
Area of need	3	N/A	2	N/A	1	N/A	2	N/A	2	N/A
Total initial assessments completed	68	14	39	9	67	15	53	24	55	13
Suitable	47	14	28	9	55	15	40	24	41	13
Not suitable	20	0	10	0	10	0	11	0	10	0
Withdrawn	1	0	1	0	2	0	2	0	4	0
Total interviews completed	57	12	36	9	45	12	56	16	43	28
Not comparable	9	1	2	1	4	2	6	1	2	0
Partially comparable	26	3	16	3	19	7	23	11	19	17
Substantially comparable	22	8	18	5	22	3	17	4	22	11
Completed requirements and admitted to fellowship	49	9	47	14	40	12	26	6	51	12

Table 10.2 Applications of the SIMG assessment process for pain medicine applicants 2017-2021

Pain Medicine **Applications and outcomes for specialist recognition**										
	2017		**2018**		**2019**		**2020**		**2021**	
	AUS	**NZ**	**AUS**	**NZ**	**AUS**	**NZ**	**AUS**	**NZ**	**AUS**	**NZ**
Total applications received	2	0	2	1	10	0	7	0	5	0
Specialist/vocational registration	2	0	2	1	8	0	6	0	4	0
Area of need	0	0	0	0	2	0	1	0	1	0
Total initial assessments completed	2	0	2	1	10	0	7	0	5	0
Suitable	0	0	1	1	9	0	6	0	2	0
Not suitable	2	0	1	0	1	0	1	0	2	0
In progress	0	0	0	0	0	0	0	0	1	0
Total interviews completed	0	0	1	0	2	1	11	0	5	0
Not comparable	0	0	0	0	0	0	1	0	0	0
Partially comparable	0	0	0	0	1	0	8	0	1	0
Substantially comparable	0	0	1	0	1	1	2	0	4	0
Completed requirements and admitted to fellowship	1	0	0	0	1	0	0	2	2	0

10.4 Communication with specialist international medical graduate applicants

The AMC accreditation standards are as follows:	
10.4	**Communication with specialist international medical graduate applicants**
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.

Clear and accessible information about requirements, fees and changes

Any SIMG applicant or prospective applicant wanting information, is encouraged to contact simg@anzca.edu.au (Australia) or assessments@anzca.org.nz (Aotearoa New Zealand).

A table of indicative fees was developed in response to the findings of the Deloitte review. This table allows prospective applicants to understand likely costs of the process.

All SIMGs receive a regular newsletter updating them on any changes to the SIMG assessment process and any other matters of interest. A sample newsletter is at appendix 10.4.

Whenever requirements change (regulation 23 revision), the files of all SIMGs who may be affected are viewed by the SIMG manager and DPA SIMG. Those who might be advantaged by the changes are invited to apply for re-assessment under the revised regulation.

In 2021, an operational SIMG review and watch list group was established with membership including the DPA SIMG, DPA assessor, DPA policy, SIMG manager and training and assessments manager. At its first meeting in December 2021, it agreed to identify existing supports to ensure SIMGs are aware of these. This includes exam preparation courses, as relevant.

Previously, a group of SIMGs and college fellows established the overseas trained specialist anaesthetist network (OTSAN) to support SIMGs, primarily those presenting for the SIMG exam. However, with the decrease in numbers of SIMGs presenting for the exam and the passage of time, enthusiasm waned. College support for OTSAN ceased in 2014, with the group disbanding several years later.

Timely and correct information to SIMGs on their progress

The progress of SIMG applicants is tracked centrally in the SIMG office and Aotearoa New Zealand national office, respectively, using performance assessments and three-monthly CPA reports. A small number of SIMGs experience difficulty in maintaining progress along their pathway. This is identified by poor performance in the clinical setting or at the examination, sometimes both. At the time of each CPA report approval, the SIMG is notified of outstanding requirements to complete their SIMG process.

Failure to maintain satisfactory individual progress results in a review by the SIMG Committee, which includes inviting the SIMG to a review interview with an SIMG interview panel. The purpose of the review process is to identify barriers to completion of the SIMG

assessment process and to provide advice, assist with overcoming barriers, and identify possible solutions. The review may be initiated on advice from the chair of the Final Examination Sub-Committee or FPM Examination Committee, the applicant's authorised clinical practice assessment supervisor or the SIMG Committee.

The review may result in one or more of the following outcomes:

- More frequent clinical practice assessment reports.
- Remedial activities to address areas of weakness.
- Extension of the required clinical practice assessment period.
- Recommendation to the Medical Board of Australia, the Australian Medical Council (in Australia) or the Medical Council of New Zealand (in Aotearoa New Zealand) for withdrawal from the SIMG assessment process.
- Re-categorisation, for example from substantially comparable to partially comparable.

The EEMC (for anaesthesia) and the FPM Board (for pain medicine) are notified of applicants who have been withdrawn from the process

Anaesthesia SIMG examination outcomes

Table 10.3 compares the examination results of anaesthesia SIMGs with those of anaesthesia trainees from 2019 to 2021, inclusive. Note that the SIMGs do not sit the written exam, only the medical clinical viva and the anaesthesia viva ('viva' in the table). SIMGs are allowed a maximum of five attempts at the exam, the same as the number allowed for anaesthesia trainees (standard 5).

These data reveal a systematic difference between pass rates of SIMGs and trainees. SIMG pass rates are concerning. However, SIMGs required to complete the exam are a selected group whose overseas training was not considered to be of the same standard as local training, often due to the lack of an external summative assessment. In general, these SIMGs start from a position of greater difference from the Australian and Aotearoa New Zealand specialist training programs, and so have a larger gap to make up during the assessment process.

However, the college also recognises the need to strengthen support for exam preparation in this cohort. In 2022, a new process of supporting SIMGs will begin with exam pass rates being one of the areas for discussion and development. This process will mirror some aspects of the ANZCA trainee support process (standard 5.3.3). The SIMG watch list group will be chaired by the SIMG DPA and includes the DPA assessors, the training and assessment manager and the SIMG team lead.

Table 10.3 Outcomes of the final examination and the SIMG examination 2019-2021

			MCQ	SAQ	Medical Clinical	VIVA	Overall
Final exam 2019.1	ANZCA trainees	No. Sat	208	208	208	174	208
		No. Passed	153	96	163	163	158
		Pass rate	**73.6%**	**46.2%**	**78.4%**	**93.7%**	**76.0%**
	SIMG – No written	No. Sat	-	-	35	35	35
		No. Passed	-	-	19	15	12
		Pass rate	**-**	**-**	**54.3%**	**42.9%**	**34.3%**
	Both groups	No. Sat	208	208	243	209	243
		No. Passed	153	96	182	178	170
		Pass rate	73.60%	46.20%	74.90%	85.20%	70.00%
Final exam 2019.2	ANZCA trainees	No. Sat	131	131	131	110	131
		No. Passed	102	54	103	81	80
		Pass rate	**77.9%**	**41.2%**	**78.6%**	**73.6%**	**61.1%**
	SIMG – No written	No. Sat	-	-	22	22	22
		No. Passed	-	-	8	6	5
		Pass rate	**-**	**-**	**36.4%**	**27.3%**	**22.7%**
	Both groups	No. Sat	131	131	153	132	153
		No. Passed	102	54	111	87	85
		Pass rate	77.9%	41.2%	72.5%	65.9%	55.6%
Final exam 2020.1	ANZCA trainees	No. Sat	183	183	-	157	183
		No. Passed	136	88	-	141	141
		Pass rate	**74.3%**	**48.1%**	**-**	**89.8%**	**77.0%**
	SIMG – No written	No. Sat	-	-	-	21	21
		No. Passed	-	-	-	8	8
		Pass rate	**-**	**-**	**-**	**38.1%**	**38.1%**
	Both groups	No. Sat	183	183	-	178	204
		No. Passed	136	88	-	149	149
		Pass rate	74.3%	48.1%	-	83.7%	73.0%
Final exam 2020.2	ANZCA trainees	No. Sat	99	99	-	84	99
		No. Passed	68	33	-	76	76
		Pass rate	**68.7%**	**33.3%**	**-**	**90.5%**	**76.8%**
	SIMG – No written	No. Sat	-	-	-	7	7
		No. Passed	-	-	-	2	2

			MCQ	SAQ	Medical Clinical	VIVA	Overall
		Pass rate	**-**	**-**	**-**	**28.6%**	**28.6%**
	Both groups	No. Sat	99	99	-	91	106
		No. Passed	68	33	-	80	78
		Pass rate	68.7%	33.3%	-	87.9%	73.6%
Final exam 2021.1	ANZCA trainees	No. Sat	196	196	196	175	196
		No. Passed	134	121	171	162	160
		Pass rate	**68.4%**	**61.7%**		**92.6%**	**81.6%**
	SIMG – No written	No. Sat	-	-	15	14	15
		No. Passed	-	-	13	7	7
		Pass rate	**-**	**-**	**86.6%**	**50%**	**46.7%**
	Both groups	No. Sat	196	196	211	190	211
		No. Passed	134	121	183	169	167
		Pass rate	68.4%	61.7%	86.7%	88.9%	79.2%
Final exam 2021.2	ANZCA trainees	No. Sat	171	171	-	157	177
		No. Passed	118	106	-	132	133
		Pass rate	**61.1%**	**62.6%**		**84.1%**	**75.1%**
	SIMG – No written	No. Sat	-	-	-	16	16
		No. Passed	-	-	-	6	6
		Pass rate	**-**	**-**	**-**	**37.5%**	**37.5%**
	Both groups	No. Sat	171	171	-	173	193
		No. Passed	118	106	-	138	138
		Pass rate	61.1%	62.6%		79.8%	71.5%

Pain medicine SIMG examination outcomes

Pain medicine SIMGs are also allowed a maximum of five attempts at the exam. Three pain medicine SIMGs have sat the FPM SIMG examination, one in 2015 and two in 2018, with all three passing at their first attempt.

Changes to SIMG assessment since 2012

- Since 2013, EMAC course completion is mandatory for anaesthesia SIMG assessment.
- In 2014, the Australian application process changed following the *Lost in the Labyrinth* report. Applications now come directly to the college, although the AMC still provides primary source verification. There was no change to the Aotearoa New Zealand process.
- In 2017, FPM by-law 16. Recognition as a Specialist in Pain Medicine for International Medical Graduate Specialists (IMGS) and Admission to Fellowship by

Assessment for IMGS was retired and Regulation 23 expanded to include pain medicine.

- In 2017, the Australian AON process was incorporated into the SIMG assessment process.
- In 2017, the first FPM fellow was admitted to fellowship via the SIMG assessment process.
- In 2017, the reporting of the SIMG committee was changed so that it now reports to EEMC, the major anaesthesia-related educational governance committee.
- There has been greater use of the SIMG PA as external assessment for those assessed as having a robust and reliable nationally-delivered training program with external and internal assessments. When the SIMG PA was first introduced, it was only used for applicants trained in the United Kingdom and Ireland, due to their extremely high pass rate in the ANZCA SIMG exam. These countries have exams that are similar to those of the college (e.g. governed nationally, multiple methods of assessment, covers the whole curriculum). In the past, SIMGs perceived that the exam was a barrier for entry into the process. As a result, college work was undertaken to identify and expand eligibility criteria for the SIMG PA.
- In 2017, exam requirements were changed to the viva only. This removed the less relevant barrier to passing of written language skills in a time-limited context. Examiners can now check the SIMG candidate's understanding of the question at the viva exam.
- Credit is now given for medical practice in Australia or Aotearoa New Zealand prior to assessment, allowing the CPA period to be reduced to 6 months in some cases. This minimises barriers to completion and accounts for prior orientation to medical practice in the relevant country.
- Since 2017, participation in the ANZCA FPM CPD program is mandatory for all SIMGs.
- From January 2022, all SIMGs will undergo multisource feedback (MSF). This is already part of the SIMG PA process but was not previously required for those undertaking the SIMG exam as their external assessment. This change ensures the non-technical skills of all SIMGs are assessed in their workplace by a range of other team members. Any issues identified by the SIMG PA are referred to the SIMG committee for consideration including an appropriate remedial pathway and further assessment by the SIMG supervisor.
- From January 2022, the examination requirements for pain medicine SIMGs were changed to just the oral component of the FPM fellowship examination. Prior to 2022, the pain medicine SIMG assessment process included all the summative assessment requirements included in the pain medicine training program.

Impact of COVID-19 on the SIMG assessment pathways and processes

Decision-making

A COVID-19 SIMG Decision Group was delegated authority by the EEMC to make decisions about SIMGs that were an exception to regulation 23 but in line with COVID-19 guidance issued by the MBA in a timely and fair manner. Such exceptions include extensions to SIMG process durations, allowing work in ICM if seconded there for COVID-19 requirements or EMAC completion deferred if courses cancelled due to COVID-19. See standard 1.

Assessment of applications

Assessment of applications was not impacted by COVID-19. The ANZCA SIMG staff team successfully worked from home managing applications and enquiries from current and prospective SIMGs.

Principles

In April 2020, ANZCA agreed the following overarching principles for the FANZCA training program and trainees. These principles were adapted for the SIMG assessment process and relevant decisions:

1. Maintaining high standards of patient care and a healthy workforce are fundamental priorities. SIMG wellbeing, including adequate supervision, is paramount. All SIMGs are able to access ANZCA's wellbeing resources, including Converge International (more information is in standard 7.4).
2. The college recognises that upskilling requirements may be significantly disrupted by COVID-19. Allowances will be made for direct and indirect impacts of the pandemic.
3. Australian Medical Council/Medical Council of New Zealand accreditation of the college requires that SIMGs meet minimum standards. The college seeks to minimise disadvantages to SIMGs, whilst ensuring that those undergoing the assessment process are adequately skilled to serve the community as specialist anaesthetists and/or specialist pain medicine physicians.
4. While the college will endeavour to be flexible in interpreting upskilling requirements, extensions to the SIMG process may be unavoidable in some circumstances.
5. SIMGs must continue to receive supervision and orientation, even/especially if they are deployed to a different clinical area.

Information for SIMGs about the college's support for SIMGs affected by COVID-19 was published on the college website.

SIMG assessment process adaptations

In line with the overarching principles above, the following allowances were made:

Structured interviews

Assessment interviews: Prior to COVID-19, interviews were only undertaken by videoconferencing in exceptional circumstances, such as SIMGs in later stages of pregnancy who were unable to fly to Australia or Aotearoa New Zealand. Since the initial onset of COVID-19, all interviews in Australia have been undertaken via videoconferencing (Zoom), whereas in Aotearoa New Zealand a mix of in-person (applicants already in the country) and videoconferences (applicants from outside the country) took place once domestic travel resumed.

This change was to account for any difficulties with travelling for the applicants and the panel members due to COVID-19 restrictions. A secondary outcome is that it has been less of a financial burden for the SIMG applicant and for the college as panel members come from across Australia and Aotearoa New Zealand.

The college has taken into consideration the time difference for SIMGs based overseas, with interviews scheduled between 6am and 11pm (SIMG local time) so individuals are not disadvantaged.

Table 10.4 SIMG interviews held in Australia and Aotearoa New Zealand 2019 – 2021

Year	Number of SIMG interviews Australia	Number of SIMG interviews Aotearoa New Zealand
2019	43	14
2020	45	18
2021	47	29

The feedback from the panel members has been that they prefer the panel members to be in the one spot to allow for rich discussions between themselves and the candidates. In 2022, the college will monitor government travel advice and may endeavor to bring panels together but allow the candidate to be interviewed via Zoom.

Interviews to review progress were initially postponed until face-to-face interviews could recommence; however, with the increasing duration of COVID-19-related travel limitations, these were also conducted by video conferencing.

Redeployment

SIMGs were able to be redeployed to related areas in medical practice (e.g. intensive care medicine for those in the anaesthesia SIMG pathway) and were not required to submit a “position description variation” as long as: redeployment was within the same hospital and met MBA (for Australia) guidelines, and the same supervisor continued to provide supervision.

However, time spent in redeployment could not be counted towards the minimum Clinical Practice Assessment (CPA) time in clinical anaesthesia or pain medicine.

Performance assessment

COVID-19 restrictions have impacted the management of some PAs as there have been stringent restrictions on travel and access to some hospital sites. The college decided to set up some video interviews for the non-local assessor and the local assessor took the observation of practice components of the assessment. While managing these logistics the feedback from the assessors was that they were able to complete the assessment to enable the SIMG to progress in their assessment program.

2020 SIMG exam attempts did not count towards the maximum allowable because of the significant effect of COVID-19 on exam preparation and performance.

Table 10.5 Number of SIMG performance assessments in Aotearoa New Zealand and Australian regions 2019-2021

Region or country	Year			Comments re: 2021 PA data
	2019	2020	2021	
Total	31	30	40	
ACT	1	1	0	
NSW	3	3	5	
NT	1	1	0	
NZ	10	10	12	
Qld	6	3	9	One PA was conducted via Zoom to include an interstate assessor. SIMG assessment was for both anaesthesia and pain medicine, with time limits approaching
Vic	6	5	9	Two PAs were conducted via Zoom to include an interstate assessor, in the face of border restrictions
Tas	1	0	0	
SA	0	3	1	
WA	3	4	5	

CPD

As for other CPD participants, there was no selection of SIMGs in the process for verification of CPD activities (audit) in 2020 (standard 9).

Process duration

- Individual program duration could be extended more than the maximum of one year until assessments (PA, exams) could be undertaken and results known. This was contingent on delays being due to factors outside the SIMG's control, such as exam postponement or travel restrictions impacting the SIMG PA (external assessment). SIMGs had to continue to submit CPA reports until completion of the SIMG process.
- Requests for interruption to the SIMG process for more than one year were considered in light of COVID-19 impact on travel or health.
- COVID-19 related deployment provided grounds for extension of the duration of SIMG assessment and paused time accrual associated with the SIMG process.
- SIMGs could also apply for an extension to attend interview for up to 12 months.

Flexible hours

Converting from full-time to part-time employment rather than interrupting upskilling and placing SIMG's process "on hold" has been recommended as a better option for some SIMGs. Detailed records of the impact of COVID-19 are requested.

Program commencement

SIMGs unable to commence their individual program due to travel restrictions who experience financial hardship can be charged the administrative portion of the SIMG fee only. This can be remitted in a maximum of three instalments.

Financial hardship

SIMGs experiencing financial hardship after commencing their program can apply to have their SIMG fees charged in instalments.

Effective Management of Anaesthetic Crises course

The EMAC course can be deferred for up to 12 months after conferment of FANZCA if the SIMG who is on the anaesthesia pathway has been prevented from attending a planned course due to lockdown and it is not possible to attend one prior to completing all other requirements for FANZCA. These decisions are made on a case-by-case basis by a group comprising the DPA SIMG along with DPA assessors that considers EMAC deferral requests from both trainees and SIMGs. The SIMG is asked to sign an undertaking that they will complete EMAC in the specified timeframe. If the course is not completed within the ensuing 12 months, then the fellow will be reported to a college professional practice committee as per regulation 26. At 31 January, five SIMGs have received EMAC exemption.

The following standards and requirements remained unchanged despite COVID-19:

- SIMG exam must be passed or SIMG PA must be successfully completed. A few PAs were postponed until travel restrictions were lifted in mid-2020 with fellows then able to travel to undertake PAs. All deferred PAs have been completed subsequently.
- Following detailed consideration, the ANZCA and FPM CPD Committee determined that 2020 annual and triennial CPD requirements for SIMGs would remain unchanged (standard 9).

Strengths

Greater focus on workplace performance assessments (standard 10.2)

Over time, reliance on examination has reduced with greater focus on workplace performance assessment. The SIMG assessment includes structured performance assessment and multisource feedback supporting safe and high-quality care for the Australian and Aotearoa New Zealand communities.

Professional support for the SIMG assessment process (standards 1 and 10)

The college has high-level professional support from experienced directors of professional affairs for the SIMG assessment process.

Improvement opportunities and future plans

Monitoring of SIMG assessment processes (standards 6 and 10)

The college could strengthen monitoring of SIMG assessment processes for continuous quality improvement. Examples include the consistency of PA assessor and panel decisions.

SIMG examination pass rates (standard 10.2)

The low examination pass rates for anaesthesia SIMGs are concerning. Plans to address this include the recent establishment of regular SIMG support process meetings, which will discuss those SIMGs failing to meet process milestones, and advise supervisors on resources and how to improve SIMG support.

Regional SIMG support (standard 10.4)

The college could identify a member of each Australian regional committee who is responsible for SIMG support, noting the chair of the New Zealand panel for vocational registration is a member of the NZNC. This would also improve visibility of the SIMG assessment process and provide links to each region (analogous to accreditation officers and TAC, standard 8.1). This is supported by the SIMG Committee and consultation is underway with Australian regional committees.