COUNCIL OF PRESIDENTS OF MEDICAL COLLEGES

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

REPORT 3: POLICY RECOMMENDATIONS

JUNE 2021

ACKNOWLEDGEMENTS

Effecting Reforms to Australia's Specialist Medical Training and Accreditation System Post COVID-19 is a joint project of the Council of Presidents of Medical Colleges (CPMC) and the Australian Medical Council (AMC). The project is funded by the Australian Government Department of Health.

The CPMC established the Education and Medical Workforce Subcommittee in 2020 to oversee their work on the project. CPMC wishes to thank the members:

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1. EXECUTIVE SUMMARY

The COVID-19 pandemic has had substantial effects on postgraduate medical education in Australia. The Department of Health has funded a joint project by the Council of Presidents of Medical Colleges (CPMC) and the Australian Medical Council (AMC) on *Effecting Reforms in Australia's Medical Training and Accreditation System Post COVID-19*.

CPMC investigated challenges, responses and key learnings from the pandemic to inform enduring educational reform through three outputs:

- Literature Review: Impacts of COVID-19 on postgraduate medical education
- Report 1: Training impacts, responses and opportunities
- Report 2: Determination of training places

These outputs form the evidence base for this final document, Report 3: Policy Recommendations.

CPMC makes the following 12 recommendations under six themes to deliver an adequately skilled and trained GP and non-GP specialist medical workforce with appropriate support:

Education

1. Maintain and improve hybrid online and face-to-face models for educational events
2. Increase training and evaluation of telehealth for clinical care and education

Assessment

3. Increase flexibility in the conduct of assessment and improve assessment experiences

Accreditation

4. Increase the responsiveness and adaptability of accreditation systems and processes

Medical Workforce

5. Coordinate on the process of determining training places
6. Recognise, increase and improve exposure to regional, rural and remote practice early in training
7. Increase support for supervision and decrease barriers to accreditation in regional, rural and remote workplaces
8. Support, enhance and develop generalist specialist training programs including the National Rural Generalist Pathway

Wellbeing

9. Ensure training positions have accreditation standards that effectively support trainee wellbeing
10. Review and improve wellbeing policies and supports
11. Implement and improve programs to support trainees when relocating for work

Risk planning

12. Review risk assessment, mitigation and contingency plans

Health departments, medical schools, membership groups, regulators and specialist medical colleges have all generously contributed to this project. Similarly, cooperation between all stakeholders in specialist medical training is needed to effectively implement these recommendations.

2. INTRODUCTION

Australia has so far been relatively spared from the health impacts of the COVID-19 pandemic with 30,004 cases and 910 deaths recorded to May 2021 (1). Yet, the impacts on how Australians live and work, particularly in healthcare, have been substantial.

These disruptions have significantly affected postgraduate specialist medical education. In response, the CPMC and the AMC established the joint *Effecting Reforms in Australia's Medical Training and Accreditation System Post COVID-19* project (the Project) with funding from the Australian Government Department of Health.

Through this project, CPMC has examined the challenges, responses and key learnings from the pandemic to inform enduring educational reform. A key outcome is to inform the implementation of the National Medical Workforce Strategy 2021 - 2031, which is currently under development by the Australian Government through the Medical Workforce Reform Advisory Committee (MWRAC).

CPMC has four main project deliverables, as outlined in *Table 1.*

Deliverable	Input
Literature Review: Impacts of COVID-19 on postgraduate medical education	Literature review to identify impacts of the pandemic on specialist medical education worldwide.
Report 1: Training impacts, responses and opportunities	Stakeholder consultation survey on issues faced during the pandemic, how they have responded, and what can be taken forward to provide a more flexible and responsive system.
Report 2: Determination of training places	Stakeholder consultation survey to specialist medical colleges and additional research on how training places and numbers are determined.
Report 3: Policy recommendations	All previous deliverables and additional relevant information.

Table 1: *CPMC project outputs.*

This report is the fourth deliverable. It includes policy recommendations, based on the previous outputs and other relevant research, to ensure that Australia has an appropriately trained and supported medical workforce into the future. It includes a consideration of the long-term impacts of the pandemic and high-value, innovative practices in specialist medical training.

Throughout this report, the term 'specialists' refers to both general practitioners (GPs) and non-GP medical specialists.

3. METHODS AND FINDINGS

3.1 LITERATURE REVIEW

The purpose of the literature review was to provide background information for the project, so the search strategy was deliberately broad, as depicted in *Figure 1*.

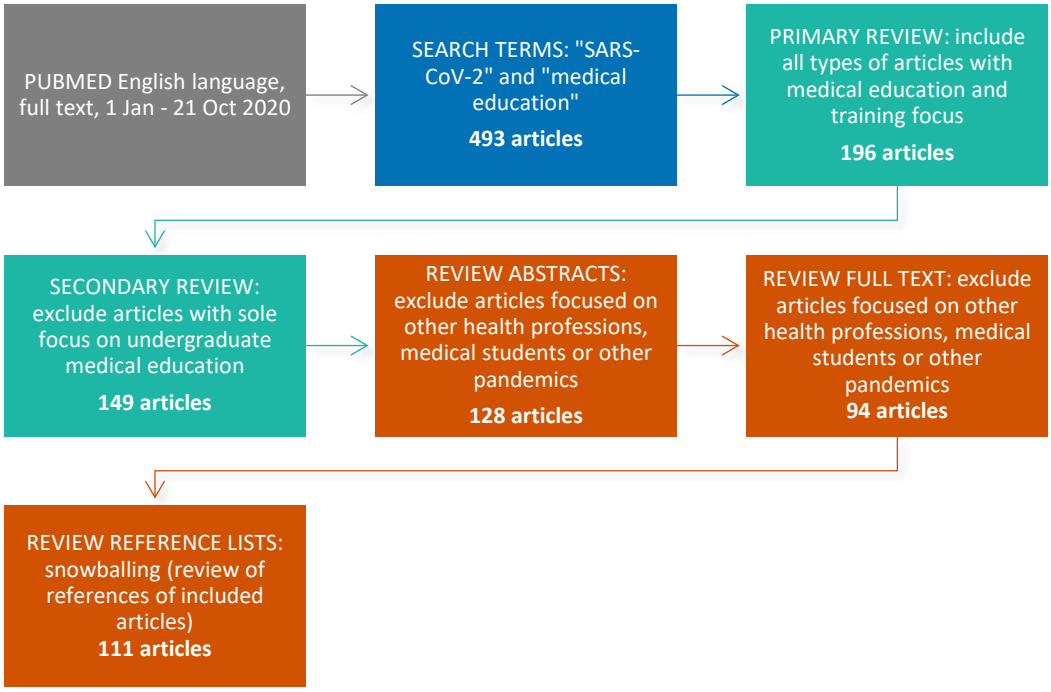

Figure 1: *Summary of search strategy for literature review.*

Additionally, the websites of Australian and New Zealand specialist medical colleges as well as several other relevant domestic and international organisations were searched, seeking information about actions taken in response to impacts of the pandemic on postgraduate medical education.

Findings were grouped under four key themes and 37 subthemes, as shown in *Figure 2.*

It was clear from the literature that the pandemic has had a significant and far-reaching impact on postgraduate medical training programs across the globe. Many changes have been made within health services and hospitals including outpatient clinics, a move to telehealth consultations, and cancellation of elective surgery and meetings. In parallel with these service changes, the delivery of postgraduate medical education transformed rapidly in response to public health measures. To maintain the integrity of training, many programs moved education online. By the latter stages of 2020, postgraduate training requirements had been relaxed, postponed or extended in many countries. The literature review also found that the anticipated impact of the pandemic and training changes on trainee wellbeing required more resources for mental health support.

The literature review had several limitations. Due to project timelines, it only included literature published before 21 October 2020. Secondly, there was a comparatively large focus on procedural specialties, and the majority of articles were from North America, particularly the United States (n=63, 56.8%). Most articles identified could be categorised as Level 3 evidence. However, it was not the goal of the literature review to conduct a systematic review or meta-analysis of the literature itself, as the review functioned as an informative guide for subsequent phases of the Project.

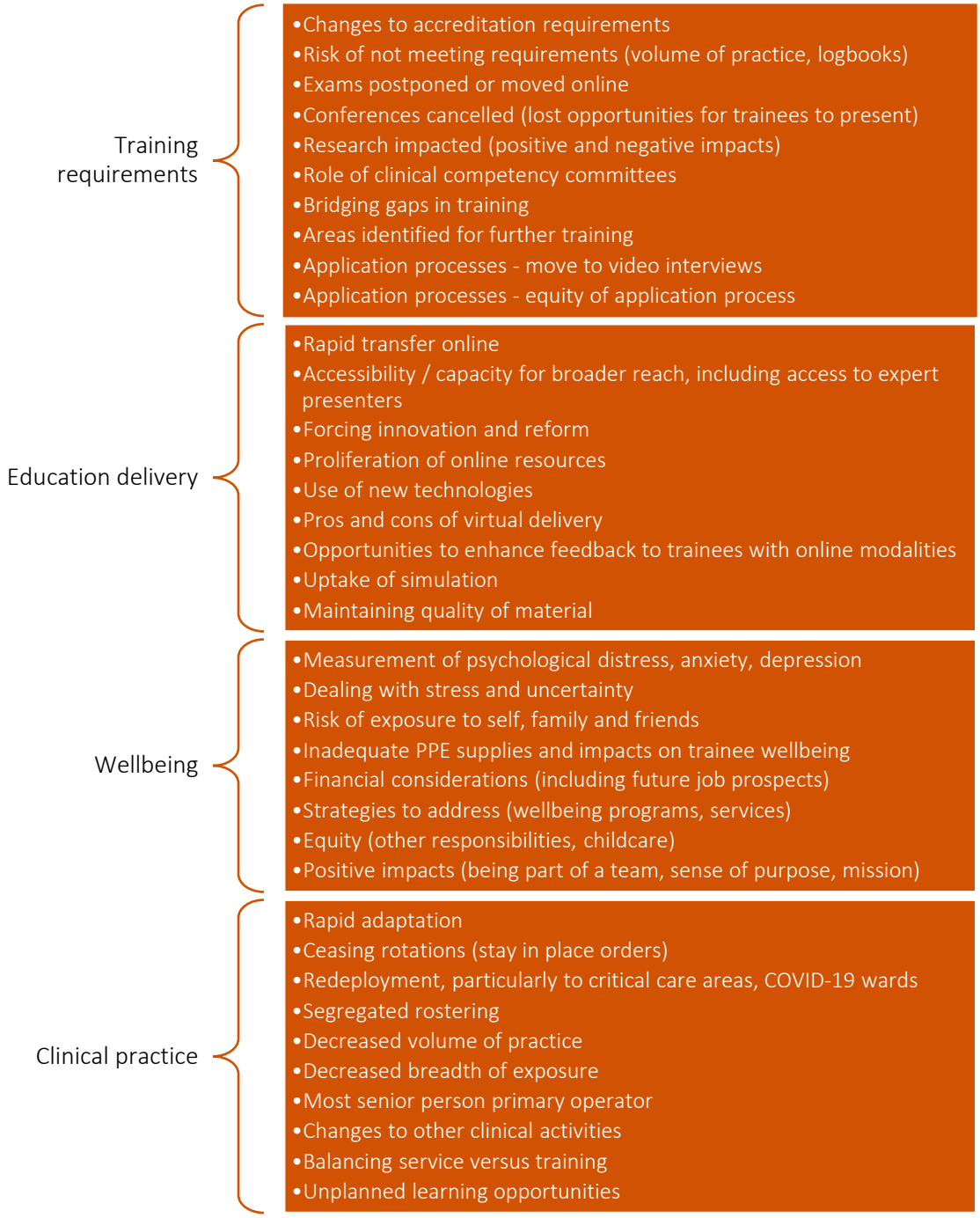

***Figure 2**: Themes and sub-themes identified by the literature review.*

3.2. TRAINING IMPACTS, RESPONSES AND OPPORTUNITIES

The purpose of the first stakeholder consultation (Report 1) was to understand issues faced by key stakeholders during the pandemic, how they responded, and what can be taken forward to provide a more flexible and responsive system.

Key stakeholders were initially proposed by the CPMC project team. This list was reviewed and added to by the AMC project team and the CPMC Education and Medical Workforce Subcommittee (EMWS). The sampling frame comprised organisations from the breadth of the medical training pathway (a full list of key stakeholders is included in Appendix A):

- Colleges (Australian and New Zealand)
- Medical schools
- Membership organisations (including trainee membership organisations)
- Regulators (Australian and New Zealand)
- State and national health departments

Survey questions were developed by the project team and reviewed by the AMC project team and CPMC EMWS. The survey was sent to stakeholders via email, with instructions that responses would be de-identified and aggregated to provide confidentiality. Those who did not respond were sent a follow-up email five weeks later, which included an offer to conduct the survey over the phone. The survey can be seen in *Appendix B*.

Completed written or phone surveys were received from 33 of the 43 stakeholders, a response rate of 76.7%. Respondents represented the whole training pathway, including medical schools, membership organisations, regulators, colleges and health departments.

Survey responses were coded in iterative stages using NVivo (a qualitative research software package), using a codebook drawn from themes and subthemes identified in the literature review. New themes or sub-themes that emerged from the data were discussed by two members of the project team, and then applied to all survey responses where appropriate.

While the Australasian experience overlapped with that of the mainly international literature, there were some important differences. The impacts on clinical practice were not widely mentioned. Conversely, some novel and notable subthemes emerged as shown in *Figure 3*:

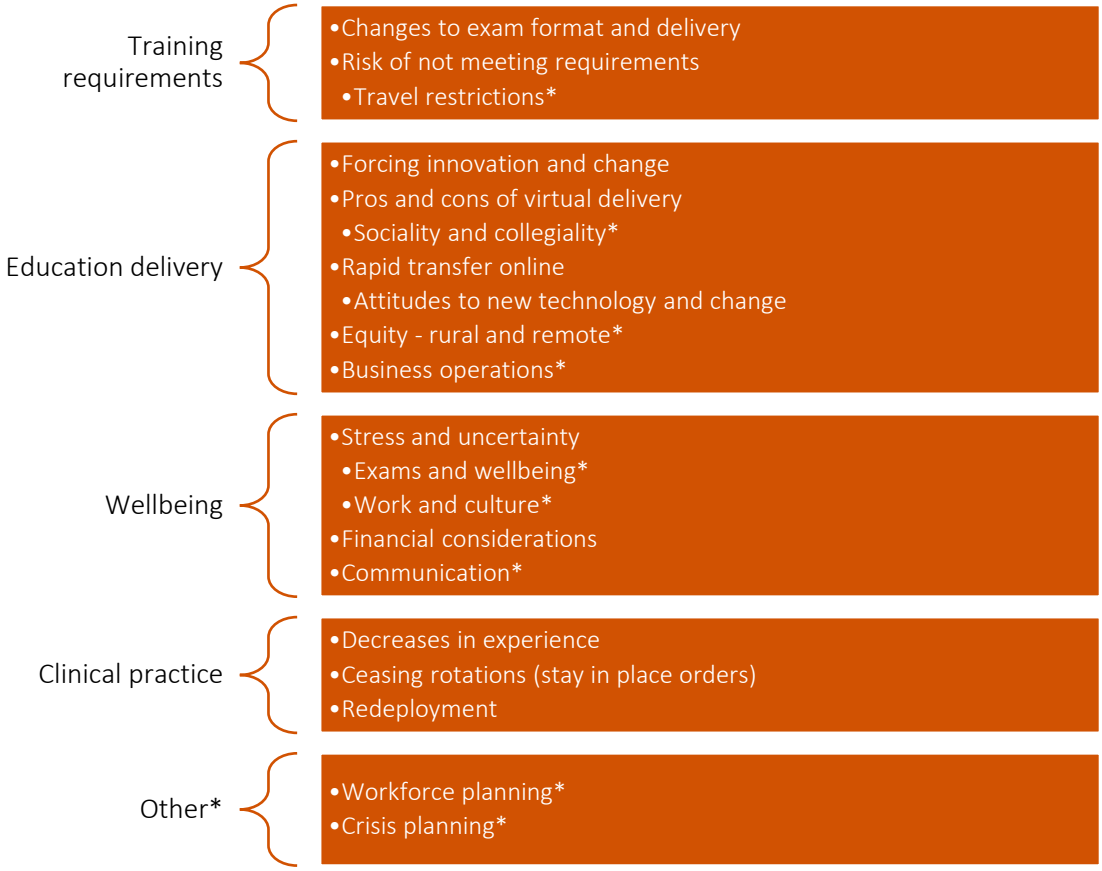

***Figure 3**: Themes and sub-themes as identified by survey analysis - new areas indicated with *.*

Several of the issues identified in the stakeholder consultation have existed in the specialist medical training system for some time, with the pandemic bringing them into prominence or highlighting flow-on effects. Respondents also reported implementing positive solutions and adaptations such as:

- De-centralised, modular exams
- More flexibility for exam deferrals, attempts, and fees
- Temporary waivers on training requirements and consideration for provisional progression
- Reducing or waiving training fees
- Increased teaching, training time, and monitoring
- Use of telehealth
- Use of tele/videoconferencing for education and meetings
- Centralised and frequent communication initiatives

However, some outstanding issues remain:

- Exam timing, format and delivery including the role of high-stakes barrier exams
- Trainees not fulfilling requirements/progressing and the resulting backlog of trainees, workforce shortages or inadequately prepared workforce
- The lack of evaluation of virtual systems for clinical care (telehealth), exam delivery and education delivery, including the potential loss of bedside knowledge, peer support and collegiality
- Workforce maldistribution and the reliance on IMGs/fly-in-fly-out staff in rural and remote areas
- Trainee wellbeing and the underlying issues of high workloads, high stakes assessments and negative workplace cultures
- The lack of risk planning to account for the possibility of future pandemics, natural disasters or other national/global disruptions.

3.3 DETERMINATION OF TRAINING PLACES

The purpose of the second stakeholder consultation (Report 2) was to better understand the processes for determining what training places are available, in what locations, and for what medical specialties.

Initial guiding information was gathered through videoconference discussions with the EMWS as a whole, as well as individual members. This was followed by emailing a short, informal survey to the 15 specialist medical colleges in Australia who form the membership of CPMC, seeking to understand their different approaches to the determination of training places. See *Appendix C* for the survey.

Responses were received from all 15 colleges. Follow-up discussions to clarify or expand on the information provided were conducted with 6 respondents.

Further material was gathered by searching the literature and grey literature for information about specialist medical training places in Australia. Additionally, the colleges' accreditation standards, available through their websites, were reviewed.

This report revealed that there appears to be no coordinated decision-making about the number and distribution of training places, nor a mechanism to achieve this. Instead, multiple stakeholders influence training places directly and indirectly, through decisions on factors including funding, accreditation and models of care, as shown in *Figure 4.*

Training places are funded through multiple levels of government as well as privately, and the balance of funding differs across specialties and jurisdictions. Apart from GP training, most of this funding flows through workplaces which have significant control over the number and type of training places they offer.

Colleges may influence training numbers and distribution through their accreditation standards and processes. They still rely on funding being available and there are tenuous links to jurisdictional or national workforce planning.

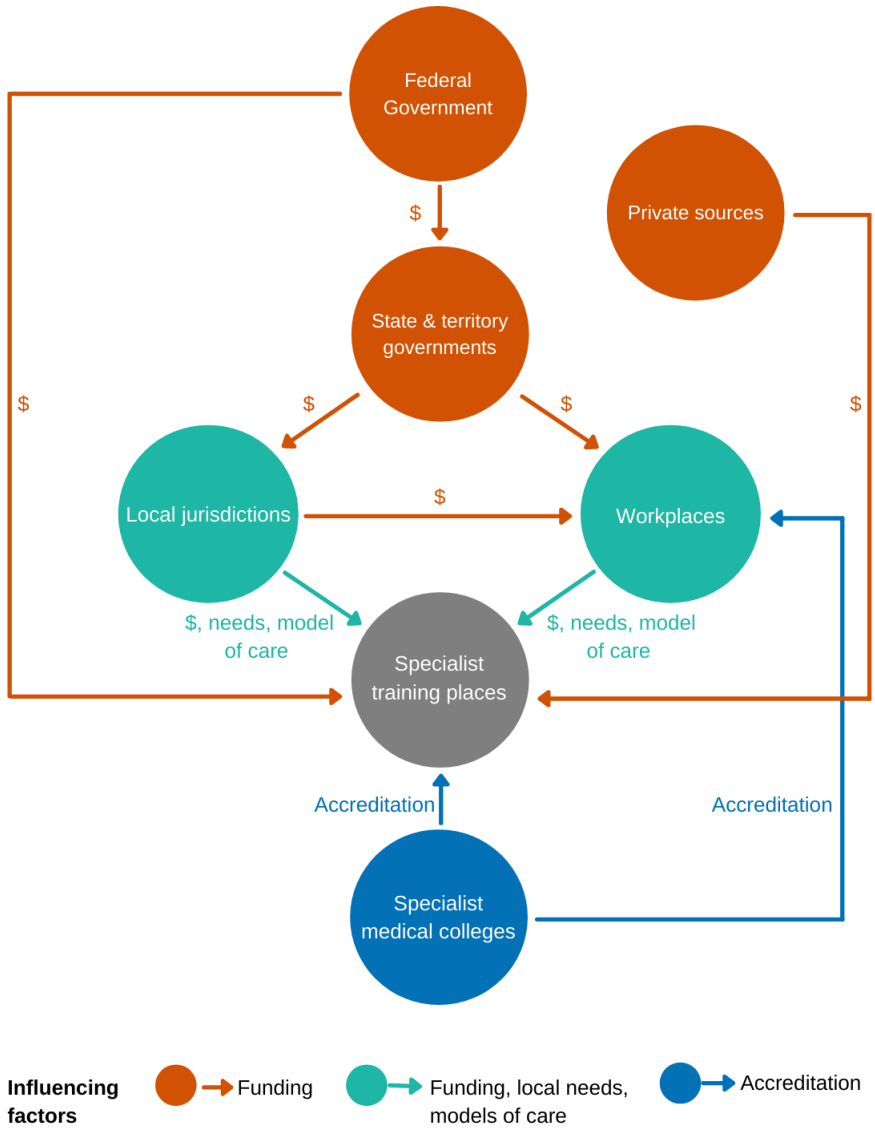

Figure 4: Influences on the number and location of specialist medical training places.

The majority of colleges investigate future workforce needs for their specialty. Some use their findings to influence training places through accreditation and lobbying government. However, according to survey responses, others feel they have no meaningful way to action the information they gather.

Additionally, there is no clear mechanism for combining and acting on workforce information from colleges, workplace and government that involves all these stakeholders. More comprehensive research into how training places are determined is needed, including comprehensive consultation with government, workplaces, colleges, trainees and other stakeholders.

3.4 DEVELOPING POLICY RECOMMENDATIONS

To develop policy recommendations, the project team sent all previous Project outputs (Literature review, Report 1 and Report 2) to the EMWS along with a summary of findings, outstanding issues, and actions taken by stakeholders in response to the pandemic.

The actions were categorised through a schema of need: whether they should be ended, amplified, let go or restarted (*Figure 5*). The EMWS were asked to suggest policies and provide other relevant feedback. The policy suggestions could connect to, build upon or diverge from the actions listed through the schema.

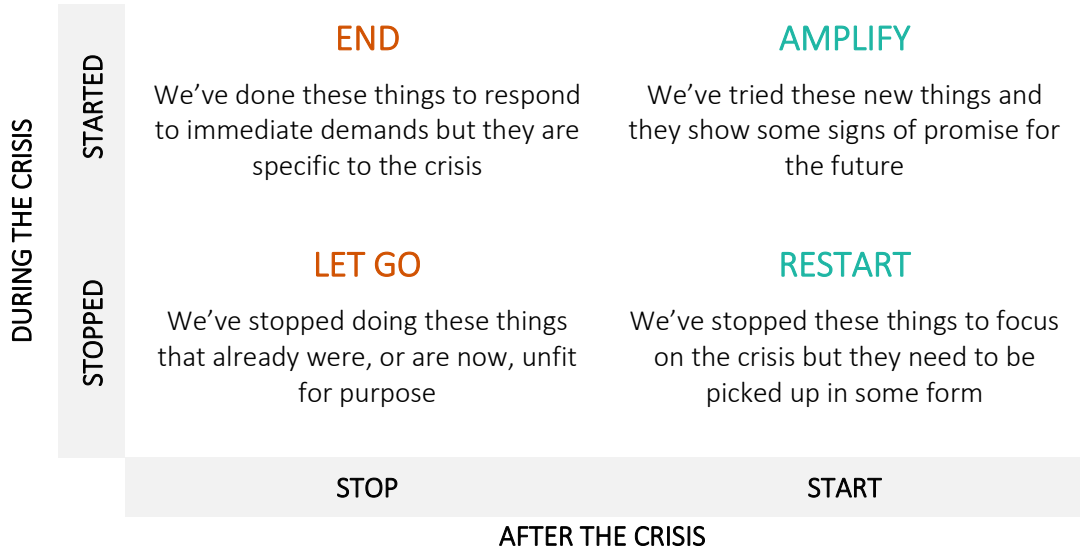

***Figure 5**: Understanding crisis-response measures, adapted from Fuller et al.(2)*

The project team reviewed and added to the policy suggestions provided by the EMWS. During this process, they consulted additional resources (see *Appendix D*), particularly from the trainee perspective.

The project team grouped the resulting draft policy recommendations under education, assessment, accreditation, medical workforce, wellbeing and risk planning. These categories connect to the four themes running throughout the project (training requirements, education delivery, wellbeing and clinical practice) plus additional key ideas that emerged during the development of the recommendations. The project team considered what would be an achievable timeframe for each recommendation and who would need to be involved in implementation to achieve comprehensive progress across the health system.

The project team provided a draft Policy Recommendations report to the EMWS via email for review and incorporated their feedback. The project team and EMWS then discussed and finalised the updated report via videoconference.

4. POLICY RECOMMENDATIONS

CPMC makes the following 12 recommendations under six themes to deliver an adequately skilled and trained GP and non-GP specialist medical workforce with appropriate support. Recommendations are not listed in order of importance, as they are interconnected and strengthen each other.

4.1 EDUCATION

Recommendation 1: Maintain and improve hybrid online and face-to-face models for educational events.

Who: Colleges, workplaces, universities, private companies and other specialist education providers

When: 1-2 years

The increasing move to online education during the pandemic has made it available to a wider audience and facilitated cross-institutional sharing of resources and expertise. However, the rapidity of this transition has left little time for evaluation. There is also concern that online alternatives do not offer the same opportunities to build communities of learning as face-to-face events.

CPMC recommends that education providers maintain and improve hybrid online and face-to-face models, including comprehensive evaluation in line with rigorous quality improvement processes:

- To ensure that attendees using both modalities achieve equivalent educational outcomes
- For cost effectiveness of particular models

This will necessitate ongoing investment in staff and systems, as running hybrid events can be complex and resource intensive. The benefits to people who are unable to attend face-to-face, for example those based in rural areas or with caring responsibilities may justify this investment.

Recommendation 2: Increase training and evaluation of telehealth for clinical care and education.

Who: Colleges, workplaces and health departments (state and territory)

When: 2-5 years

Some training providers, clinicians and consumers have expressed that the use of telehealth during the pandemic has been valuable and should continue post-pandemic. This accelerated move to telehealth has precluded a comprehensive evaluation of its teaching efficacy and determination of clinical best practice. Up-skilling professionals in the clinical uses of telehealth is also needed.

CPMC recommends that more training and evaluation of telehealth use and delivery is developed, particularly as it relates to trainees. For example, trainees suffer from reduced exposure and experience if only seeing telehealth consultations, so policies should be enacted to ensure diverse training experiences.

Telehealth must be evaluated across medical specialties and settings to inform updated and comprehensive best practice guidelines about how and when it should be used. Additionally, training is needed for both senior medical practitioners and trainees so the guidelines are effectively implemented. Policies and practices should be reviewed to reflect the guidelines and allow for ongoing feedback into decision-making from trainees and Fellows. The appropriate agency to provide upskilling in telehealth needs to be determined.

4.2 ASSESSMENT

Recommendation 3: Increase flexibility in the conduct of assessment and improve assessment experiences.

Who: Colleges, supported by regulators and workplaces

When: 2-3 years

The pandemic's most significant short-term impact on specialist medical training has been disruption to the format and delivery of examinations. Most college exams have traditionally followed a centralised, in-person model. Significant changes were required to adapt these systems to virtual and COVID-safe formats, resulting in delays, training backlogs and negative impacts on trainee well-being. However, many of the core issues of exam reform such as pressurised environments, logistics of online exams, and rigidity of processes predate COVID-19. As well as reviewing the role and conduct of exams, this reflects a need to address the balance of formative and summative assessment.

CPMC recommends that colleges increase flexibility in the conduct of assessment. The positive outcomes from adapting to online assessment during the pandemic should be maintained and built upon, including:

- Developing and/or publishing policies on what would trigger changes to exams and the subsequent impact on timing, format and progression
- Continuing to improve risk management strategies around exams
- Increasing methods for completing exams (e.g., remote/online, decentralised)
- Providing relevant and timely feedback to trainees
- Increasing examiner pool, including considering remuneration and professional recognition
- Sharing learnings and resources between colleges

Many of these actions may lead to an improved experience for trainees. Additionally, positive assessment experiences should also be promoted, for example through:

- Modulating elements of high stakes barrier exams to enable distribution of effort across the training program
- Maintaining or increasing trainee input into assessment design and representation on relevant decision-making committees
- Holding additional mock exams for preparation and improvement
- Minimising avoidable barriers to success through contingency plans for illness and flexible deferral rules
- Exploring and evaluating strategies for addressing borderline pass results such as carrying over pass marks in multicomponent exams and supplementary exams for borderline results - whilst retaining reliability and validity of exams
- Establishing processes for addressing the educational and professional needs of candidates who have failed to progress after multiple attempts at significant exams

To effect these changes, workplaces need to support examiner training, including through protected time. To facilitate online or local delivery of exams for rural and remote candidates, funding could potentially be drawn from the Flexible Approach to Training in Expanded Settings (FATES) budget measure.

4.3 ACCREDITATION

Recommendation 4: Increase the responsiveness and adaptability of accreditation systems and processes.

Who: Regulators, colleges, workplaces and other organisations involved in accreditation

When: 1-2 years

In response to travel and social distancing requirements imposed by the pandemic, organisations involved in accreditation have moved towards hybrid and virtual site visits and assessments. These changes have generally been favourably received. Virtual accreditation has the potential of offering time and cost savings for accrediting organisations and freeing staff capacity to focus on additional training priorities.

CPMC recommends that regulators, colleges and other organisations involved in accreditation continue to adapt accreditation processes to include more virtual and/or hybrid components. Additional technological infrastructure, including secure tele- and video-conferencing platforms, will also be required.

The cost will likely be borne by colleges and employers to ensure that accreditation standards are optimised and enforceable. Quality assurance systems will need to be developed to accompany any new virtual or hybrid models.

4.4 MEDICAL WORKFORCE

Recommendation 5: Coordinate on the process of determining training places.

Who: Health departments (all), regulators, workplaces, colleges and medical schools

When: 3-7 years

Evidence-based workforce planning and coordinated implementation are essential for preparing Australia for future needs, including disruptive events like pandemics. Currently, the determination of the number and distribution of training places is highly decentralised with little uniformity across locations and specialties. It is influenced by many stakeholders directly and indirectly through decisions on factors including funding, accreditation and models of care. There are inadequate means for them to discuss and coordinate on workforce needs.

CPMC recommends that all organisations involved in specialist medical training increase coordination and reform the way they determine training places. Establishment of mechanisms to discuss and make decisions about the number and location of training places should account for current and future workforce needs on regional and national levels. Coordination between all organisations involved in this process is needed to reduce congestion in training and over/under-supply issues along training pathways.

This highly complex work will need to be implemented incrementally, leveraging the National Medical Workforce Data Strategy.

Recommendation 6: Recognise, increase and improve exposure to regional, rural and remote practice early in training.

Who: Colleges

When: 2-3 years

The maldistribution of specialists between rural and urban areas is a longstanding issue. Border closures during the pandemic exacerbated workforce problems due to the reliance of rural areas on locums and fly-in-fly-out staff.

Important predictors of future rural practice include trainees having:

- Previous experience and connections with regional, rural and remote areas
- Positive exposure to rural practice early in their training

CPMC recommends that colleges adapt their training program selection criteria to acknowledge rural experience and strong connections to rural areas. Each college will have their own means of weighting these features.

Additionally, CPMC recommends that colleges offer regional, rural and remote rotations/placements early in training and implement initiatives to support this, such as:

- Ensuring there is adequate and well supported supervision
- Increasing rural training events and networking opportunities
- Providing online alternatives to metro-based assessment, events and education

Colleges should actively seek ongoing feedback from trainees and Fellows about enablers and barriers to regional, rural and remote practice.

Recommendation 7: Increase support for supervision and decrease barriers to accreditation in regional, rural and remote workplaces.

Who: Colleges and workplaces with the support of health departments (state and territory)

When: 2-3 years

Having sufficient accredited training places and access to supervisors are core enablers of regional, rural and remote training capacity. Increasing rural training can lead to more specialists continuing their careers in these areas, thereby building local workforces who can respond to a community's specific needs, including in times of crisis.

Resource limitations, case mix, workload volume, and the urban-centric nature of accreditation requirements and processes may make it challenging for rural workplaces to gain and maintain accreditation. Fellows working in rural areas often have high workloads and fewer resources than their metropolitan counterparts, which can reduce incentives and capacity to act as supervisors.

CPMC recommends that colleges review their accreditation standards and processes to remove any unnecessary barriers to regional, rural and remote workplaces gaining and maintaining accreditation both for workplaces and individual training places.

Such adjustments must not result in a lowering of standards for workplaces, which must provide high quality training experiences no matter where they are located. Review of accreditation standards and

credentialling processes must be done carefully, in close consultation with rural Fellows, rural workplaces and other relevant experts.

Additionally, CPMC recommends that workplaces and colleges increase support and incentives for supervision in regional, rural and remote areas including:

- Implementing supported and protected time for supervision and supervisor training
- Increasing rates for supervisors (particularly for GPs)
- Establishing rural supervisor networks
- Adapting supervisor training so it is accessible and useful for rural and remote Fellows
- Making it easy to claim CPD points/credits for supervision

This will necessitate the assistance of state and territory health departments, particularly in making financial and other resources available for workplaces to support and incentivise supervision.

Colleges should share and co-develop resources to make use of existing, high-quality content and reduce the cost of implementing this recommendation. Where appropriate, these efforts could also draw upon the FATES budget measure.

Recommendation 8: Support, enhance and develop generalist specialist training programs including the National Rural Generalist Pathway.

Who: Colleges with the support of health departments (all), regulators and workplaces

When: 2-5 years

Outside of metropolitan centres Australia is a large and sparsely populated country. Providing access to high-quality medical care in these areas can be challenging given the geographic maldistribution and increasing subspecialisation of Australia's medical workforce. Rural practice requires specialists to function at the full scope of their practice.

CPMC supports the development of the National Rural Generalist Pathway and recognises the extra requirements and skills of rural generalists. CPMC recommends that colleges develop generalist specialist training programs including:

- Rural streams to develop specialists who can better meet the needs of rural communities
- Research streams to develop clinician-researchers who can respond to emerging issues (such as pandemics) and support impactful translational research more widely

CPMC supports colleges in strengthening existing training programs, promoting them widely and developing new programs in areas of future need. For example, general physicians with respiratory or public health subspecialty areas have been required during the pandemic.

Fully realising the benefits of such programs will only be possible with the support of:

- Regulators, so that standards and accreditation are maintained
- The Australian Government Department of Health, so that:
    - The Medicare Benefits Schedule structure works for generalist specialists
    - Existing programs, such as the Specialist Training Program (STP), fund generalist training and that of other key specialties
- State and territory health departments and workplaces, so that remuneration recognises and rewards generalist specialists

4.5 WELLBEING

Recommendation 9: Ensure training positions have accreditation standards that effectively support trainee wellbeing.

Who: Colleges, regulators, workplaces and health departments (state and territory)

When: 1-2 years

The high stress levels experienced in medical training programs are well recognised. Some of the underlying causes include high workloads, unpaid overtime, and inability to gain entry to accredited programs. Bullying and harassment are identified as serious issues in the Medical Board of Australia annual Medical Training Survey. During the pandemic, trainees reported magnification of stress and poor wellbeing, particularly regarding exams and program progression.

CPMC recommends that all colleges review their accreditation standards to ensure they effectively support trainee wellbeing, help address underlying causes of poor wellbeing and are in accord with occupational health requirements.

This should be done in consultation with trainees, Fellows and workplaces and include ongoing feedback. Data sources that can be used as benchmarks and guide college-level and cross-organisational actions include:

- College surveys at key points in training
- College training exit surveys
- Medical Training Survey

The AMC should review the impact of wellbeing efforts through their accreditation processes. Workplaces and health departments should consider further actions that they could take to complement and strengthen these efforts, in their roles as employers and funding bodies.

Recommendation 10: Review and improve wellbeing policies and supports.

Who: Colleges and workplaces

When: 1-2 years

The pandemic impacted the mental health of many trainees, supervisors and staff. Serious ongoing concerns around doctors' mental health demonstrate more needs to be done beyond the existing wellbeing policies and supports of colleges and workplaces.

CPMC recommends that colleges and workplaces review and improve internal wellbeing policies and supports, including evaluating the effectiveness of Employee Assistance Programs (EAPs) for specialist trainees and Fellows. Where possible, increased support should be given for doctor-specific wellbeing services.

Colleges should apply a wellbeing lens to all major decisions involving trainees, supervisors and staff.

Recommendation 11: Implement and improve programs to support trainees when relocating for work.

Who: Colleges and health departments (all)

When: 1-3 years

Relocating for clinical rotations is a common feature of specialist medical training. While this provides important educational experiences, it can also result in trainees losing personal and professional

support systems. This has implications for trainee wellbeing, particularly in the face of major disruptions.

CPMC recommends that colleges and health departments implement complementary programs to support trainees relocating for work, with due consideration of family circumstances. This is particularly important for rural and remote areas.

Trainees should be widely consulted about the challenges they face when relocating and ways to mitigate them. Possible actions include:

- Building face-to-face and virtual support networks (mentoring, trainee groups)
- Providing stipends / discounted fees to help rural trainees access education and events
- Considering the support needs of family members

4.6 RISK PLANNING

Recommendation 12: Review risk assessment, mitigation and contingency plans.

Who: Health departments (all), regulators, workplaces, colleges and medical schools

When: 1-2 years

Organisations across the specialist medical training pathway have been able to adapt to the unique circumstances arising from the pandemic and continue delivering their core responsibilities during the crisis. However, few of these adaptations were based on pre-existing risk plans. In the absence of such plans, organisations and their staff were frequently placed under strain. In some cases, adaptations were not delivered early enough to mitigate negative impacts. Had Australia experienced the same COVID-19 case numbers as many other countries, it is not clear that specialist medical training systems would have coped.

CPMC recommends that all organisations involved in specialist medical training review their risk management plans to assure for mitigation and contingency and are updated to future proof the system against critical incidents and public health concerns. These interruptions might result from:

- Natural disasters
- Pandemics or other major public health concerns
- Geopolitical instability
- Border closures/travel restrictions
- Power outages
- Cyber and biosecurity threats
- Economic downturn

It is recommended that organisations consult to ensure their plans are interconnected and complementary to those of related organisations. They should draw upon the work of international health agencies.

For colleges specifically, this planning involves review of the knowledge, skills and attitudes that future Fellows will need when critical incidents and public health concerns occur. Where required, these should be incorporated into training curricula and continuing professional development resources. This is a significant piece of work which may not be possible until the crisis of the COVID-19 pandemic has subsided.

5. CONCLUSION

Cooperation between all stakeholders in specialist medical training is needed to effectively implement these recommendations. This includes health departments, medical schools, membership groups, regulators, colleges and workplaces across Australia. This cooperation will entail broad agreement on the current and future needs of the Australian specialist medical workforce, as well as commitment to provide the resources to meet these needs.

CPMC recognises that achieving these recommendations will be challenging. The experience of the COVID-19 pandemic has demonstrated that these organisations can cooperate, adapt and innovate to achieve positive change.

Further research may be required, for example on:

- Which actions and supports are most effective for promoting trainee wellbeing
- The long-term educational outcomes of the rapid pivot to online learning
- The use and balance of formative and summative assessment to maintain high standards and trainee wellbeing
- How specialist training places are determined, including each stakeholder's processes and priorities
- Which incentives, supports and other programs are most effective for building and retaining rural, regional and remote specialist workforce
- How potential future risks might impact specialist medical training and related organisations

These recommendations feed into the finalisation and implementation of the National Medical Workforce Strategy. Connections between the recommendations and actions in the Strategy are listed in *Appendix E*.

The CPMC thanks the Australian Government Department of Health for enabling this project to occur.

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2. Fuller R, Joynes V, Cooper J, Boursicot K, Roberts T. Could COVID-19 be our 'There is no alternative' (TINA) opportunity to enhance assessment? *Medical Teacher*, 2020; 42(7): 781-786.

APPENDIX A: KEY STAKEHOLDERS

Organisation	Role(s)	Survey 1 response	Survey 2 response
Specialist Medical Colleges			
Australian and New Zealand College of Anaesthetists	President, CEO	Yes	Yes
Australasian College of Dermatologists	President, CEO	Yes	Yes
Australasian College for Emergency Medicine	President, CEO	Yes[1]	Yes
Australasian College of Sport and Exercise Physicians	President, CEO	Yes	Yes
Australian College of Rural and Remote Medicine	President, CEO	Yes	Yes
College of Intensive Care Medicine of Australia and New Zealand	President, CEO	Yes	Yes
Royal Australasian College of Dental Surgeons	President, CEO	No	Yes
Royal Australasian College of Medical Administrators	President, CEO	Yes	Yes
Royal Australian and New Zealand College of Obstetricians and Gynaecologists	President, CEO	Yes	Yes
Royal Australasian College of Physicians	President, CEO	Yes[1]	Yes
Royal Australian and New Zealand College of Radiologists	President, CEO	Yes	Yes
Royal Australasian College of Surgeons	President, CEO	Yes[6]	Yes
Royal Australian and New Zealand College of Ophthalmologists	President, CEO	Yes	Yes
Royal Australian and New Zealand College of Psychiatrists	President, CEO	Yes	Yes
Royal Australian College of General Practitioners	President, CEO	Yes	Yes
Royal College of Pathologists of Australia	President, CEO	Yes	Yes
New Zealand College of Public Health Medicine	President	Yes	Yes
Royal New Zealand College of General Practitioners	President	No	Yes
Royal New Zealand College of Urgent Care	President, CEO	Yes	Yes
Membership groups			
Council of Medical Colleges New Zealand	CEO	No[2]	N/A
Australian Indigenous Doctors' Association	President	No	N/A
Australian Medical Association	President, Sec. General	No	N/A
Australian Medical Association Council of Doctors in Training	Chair	Yes (phone)	N/A
Australian Medical Student's Association	President	No	N/A
Confederation of Post-graduate Medical Education Councils	Chair	Yes	N/A
Medical Deans of Australia and New Zealand	President, CEO	Yes[3]	N/A

Regulatory bodies and other government			
Australian Commission on Safety and Quality in Health Care	Chief Medical Officer	No	N/A
Australian Health Practitioner Regulation Agency	CEO	Yes	N/A
Australian Medical Council	CEO, President	Yes (phone)	N/A
Medical Board of Australia	Chair	Yes	N/A
Medical Council of New Zealand	CEO, Chair	No[2]	N/A
Health departments and other government			
ACT Health	Covid-19 Interjurisdictional Medical Workforce Group members	Yes[1]	N/A
NSW Health	As above	Yes	N/A
NT Health	As above	No[4]	N/A
QLD Health	As above	Yes[1]	N/A
SA Health	As above	Yes	N/A
TAS Health	As above	No	N/A
VIC Department of Health and Human Services	As above	Yes	N/A
WA Department of Health Jurisdictional Working Group	As above	Yes	N/A
Australian Department of Health	Acting Chief Medical Officer	Yes[5]	N/A
Australian Department of Health	Principal Medical Advisor	Yes[5]	N/A
Australian Department of Health	Senior Medical Advisor	Yes[5]	N/A
National Rural Health Commissioner		Yes (phone)	N/A

[1] Sent multiple responses.

[2] Agreed was not necessary as the New Zealand based colleges responded individually.

[3] Included input from rural clinical schools.

[4] Unable to deliver survey due to spam filter.

[5] Sent a combined response.

[6] Fax Mentis.

APPENDIX B: STAKEHOLDER SURVEY 1

COUNCIL OF PRESIDENTS OF MEDICAL COLLEGES

Australian Medical Council Limited

STAKEHOLDER CONSULTATION SURVEY

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

The Council of Presidents of Medical Colleges, in collaboration with the Australian Medical Council, is conducting a review into the impact of the COVID-19 pandemic on Australia's medical training system.

Findings from this survey will inform our recommendations report. The report will aggregate themes from this data, so as not to identity individual responses or stakeholders.

If you have any questions about the survey, or how data will be used, please contact us on (02) 9256 5496 or TrainingReview@cpmc.edu.au.

Q1: What pre-existing issues has the pandemic **highlighted / exacerbated** in medical training pathways?

Q2: What issues has the pandemic **created** in medical training pathways?

Q3: What **solutions** to these issues has your organisation implemented?

1

Q4: In what ways were the solutions effective and/or ineffective?

Q5: Are there issues which have **not yet been addressed**? If so, what are they?

Q6: Has the pandemic **reduced** any issues in medical training pathways?

Q7: What challenges has your organisation faced in **managing change**?

Q8: What are your organisation's **priority areas** for reform?

When complete, please email this to: TrainingReview@cpmc.edu.au.

APPENDIX C: STAKEHOLDER SURVEY 2

1. Are training places for your college determined by:

    a) The college

    b) Workplaces

    c) Consultation between the college and workplaces

    d) Other process (please specify):

2. How does your college consider future workforce need in determining training places (a short summary is fine, e.g. 'based on projected population growth at current service levels using Dept of Health data')

APPENDIX D: ADDITIONAL SOURCES

Australian Health Practitioner Regulation Agency (Ahpra) and the Medical Board of Australia. Medical training survey 2020: results and reports [Internet]. Melbourne, VIC: Ahpra, 2021. Available from: https://medicaltrainingsurvey.gov.au/Results/Reports-and-results

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APPENDIX E: LINKS WITH NMWS

CPMC recommendation(s)	Related NMWS action(s)
Recommendation 1: Maintain and improve hybrid online and face-to-face models for educational events. **Recommendation 2:** Increase training and evaluation of telehealth provision for both clinical care and education.	**22.2** Embed positive changes to selection of trainees and workforce, supervision, teaching and assessments into normal practice. **22.3** Identify and implement changes to embed digital health service delivery as a component of medical practice, and for providing clinical support and supervision to colleagues and trainees.
Recommendation 3: Increase flexibility in the conduct of assessment and improve assessment experiences **Recommendation 4:** Increase the responsiveness and adaptability of accreditation systems and processes.	**14.1** The Australian Medical Council (AMC) and specialist medical colleges to continue to strengthen their focus on learning outcomes, including by reviewing assessment tools and promoting flexibility, quality and safety, while rewarding rural practice and experience. **14.2** AMC and specialist medical colleges to continue to review and reform accreditation process and requirements to enable flexibility in accreditation to consider local contexts and promote more regional and rural training.
Recommendation 5: Discuss and reform the determination of training places.	**12.2** Consider establishing a national 'pool' of training places and an associated process to oversee training numbers and pathways, including distribution in regional, rural and remote locations, based on workforce supply needs. Aboriginal and Torres Strait Islander applicants will be prioritised in this pool and process.
Recommendation 6: Recognise, increase and improve exposure to regional, rural and remote practice early in training.	**11.1** Re-shape training programs to increase the number of training pathways and posts available in regional rural and remote areas. **11.3** Rural and remote training posts to be prioritised, followed by regional positions and then metropolitan-based positions. **11.5** Establish, expand and formalise networked training (inreach and outreach) models that coordinate trainee distribution and create connections between metropolitan and regional health services, so that trainees can be based in regional and rural areas.
Recommendation 7: Increase support for supervision and decrease barriers to accreditation in regional, rural and remote workplaces.	**11.4** Supervision models to better support rural training by: providing supervisors with tailored support (such as education opportunities or financial support) to deliver quality training

	supporting quality remote supervision to trainees in locations where there is limited specialist availability on-site and a need for that specialty funding additional training places and supervision in Aboriginal Community Controlled Health Services. 22.2 Embed positive changes [from COVID-19] to selection of trainees and workforce, supervision, teaching and assessments into normal practice.
Recommendation 8: Support, enhance and develop generalist specialist training programs including the National Rural Generalist Pathway.	20.1 Continue to implement the National Rural Generalist Pathway, while supporting shared learning and generalist networks to increase communities of practice. 20.2 Leverage innovations from the National Rural Generalist Pathway that can be adapted to other medical specialties where appropriate. 20.3 Explore and implement meaningful ways of recognising high-performing generalist practitioners across the medical workforce.
Recommendation 9: Ensure training positions have accreditation standards that support trainee wellbeing.	25.1 Review environments with high staff turnover to determine common factors that lead to unsustainable services including bullying and harassment. 25.2 Provide a framework for high turnover contexts to ensure sustainable and positive employment practices. 25.3 Provide supports for trainees and doctors to enable help seeking behaviour.
Recommendation 10: Review and improve wellbeing policies and supports.	24.1 Investigate and develop innovative employment model trials that provide greater equity in employment conditions and accrued benefits between GP registrars and hospital-based registrars as they move between hospital and primary care settings. 25.1, 25.2 and 25.3 as above
Recommendation 11: Implement and improve programs to support trainees when relocating for work.	Potentially within 25.1, 25.2 and 25.3 as above
Recommendation 12: Review risk assessment, mitigation and contingency plans.	Nil