ACT Government | Canberra Health Services

Our reference: **FOI20-50**

[redacted]

Dear [redacted]

DECISION ON YOUR ACCESS APPLICATION

I refer to your application under section 30 of the *Freedom of Information Act 2016* (FOI Act), received by Canberra Health Services (CHS) on **Tuesday 29 September 2020.**

This application requested access to:

'The Canberra Hospital "PHYSICIAN TRAINING PROGRAM REVIEW Nov -Jan 2020.'

I am an Information Officer appointed by the Chief Executive Officer of Canberra Health Services (CHS) under section 18 of the FOI Act to deal with access applications made under Part 5 of the Act. CHS was required to provide a decision on your access application by **Wednesday 28 October 2020**.

I have identified the document within scope of your access application.

Decisions
I have decided to grant partial access to the document.

My access decisions are detailed further in the following statement of reasons and the documents released to you are provided as Attachment A to this letter.

In reaching my access decision, I have taken the following into account:

- The FOI Act;
- The contents of the documents that fall within the scope of your request;
- The views of relevant third parties; and
- The *Human Rights Act 2004*.

The identified document contains information that I consider, on balance, to be contrary to the public interest to disclose under the test set out in section 17 of the Act.

Public Interest Factors Favouring Disclosure
The following factors were considered relevant in favour of the disclosure of the documents:

- *Schedule 2.1 (a) (i) promote open discussion of public affairs and enhance the government's accountability;*
- *Schedule 2.1 (a) (ii) contribute to positive and informed debate on important issues or matters of public interest; and*
- *Schedule 2.1 (a) (iv) ensure effective oversight of expenditure of public funds.*

Public Interest Factors Favouring Non-Disclosure

The following factors were considered relevant in favour of the non-disclosure of the documents:

- *Schedule 2.2 (a) (ii) prejudice the protection of an individual's right to privacy or any other right under the Human Rights Act 2004;*
- *Schedule 2.2 (a) (xii) prejudice an agency's ability to obtain confidential information;*
- *Schedule 2.2 (a) (xv) prejudice the management function of an agency or the conduct of industrial relations by an agency; and*
- *Schedule 2.2 (a) (xvii) prejudice the effectiveness of testing or auditing procedures.*

Partial redactions have been made to information contained on pages 25 – 47. Participants in the review were provided an assurance of confidentiality prior to conducting the structured interviews. I have decided that the release of verbatim comments of the participants constituted an unreasonable disclosure of individuals' personal information. The physician trainee community is a small number of staff, and comments could be attributed to an individual based on style and content. On balance, the factors favouring disclosure did not outweigh the factors favouring non-disclosure as the substantive information, findings and recommendations have been provided. The release of this information would or could reasonably be expected to have a detrimental effect for the agency's ability to conduct future surveys within the organisation as it may reduce engagement and diminish the honest and truthful participation of staff members. Therefore, I determined the information identified is contrary to the public interest and I have decided not to disclose this information. Information contained on page 48 is personal information of the participants and is also contrary to the public interest to release.

I would like to note that this was an internally commissioned review, taken as a proactive measure to address known cultural issues. In particular, the aim was to investigate underperformance of CHS in physician exams and understand this in relation to structural and cultural issues.

CHS agrees with the overall sentiment of the report and has given careful consideration to each recommendation. Many of the recommendations have already been addressed through initiatives rolled in out during 2019 and 2020. Others are part of a program in place for action as soon as practicable. Some recommendations require additional resources, and CHS will consider the most appropriate way to fund these recommendations.

CHS has put in place a number of initiatives that meet the Review's recommendations, including:

- Ensuring dedicated teaching time is arranged within working hours for physician trainees – this is to address the burnout experienced by junior doctors;
- Reviewing rostering and leave allocation processes, to ensure training programs are managed in line with leave arrangements that are also important for clinicians' health and wellbeing; and
- Committing comprehensively to improving and implementing trainee wellbeing programs.

Funding has also recently been approved to recruit additional medical registrars for 2021, which will significantly help to reduce overtime per trainee and contribute towards covering annual and study leave.

CHS has been proactive in addressing this issue by recently appointing the ACT Network Director of Physician Education, Dr Ashwin Swaminathan, to the role of Clinical Director of the Division of Medicine at CHS. This appointment creates a valuable link between the training cohort and the senior physician staff and has been well received by trainee physicians as well as senior staff.

I will be working with Dr Swaminathan to support an ambitious program of quality training for CHS's physician trainees and bring about real change in the physician training program and an improved relationship between CHS's trainee physicians and their senior clinical colleagues.

Charges

Processing charges are not applicable to this request.

Disclosure Log

Under section 28 of the FOI Act, CHS maintains an online record of access applications called a disclosure log. The scope of your access application, my decision and documents released to you will be published in the disclosure log not less than three days but not more than 10 days after the date of this decision. Your personal contact details will not be published.
https://www.health.act.gov.au/about_our-health_system/freedom-information/disclosure-log.

Ombudsman review

My decision on your access request is a reviewable decision as identified in Schedule 3 of the FOI Act. You have the right to seek Ombudsman review of this outcome under section 73 of the Act within 20 working days from the day that my decision is published in ACT Health's disclosure log, or a longer period allowed by the Ombudsman.

If you wish to request a review of my decision you may write to the Ombudsman at:

The ACT Ombudsman
GPO Box 442
CANBERRA ACT 2601
Via email: ACTFOI@ombudsman.gov.au
Website: ombudsman.act.gov.au

ACT Civil and Administrative Tribunal (ACAT) review

Under section 84 of the Act, if a decision is made under section 82(1) on an Ombudsman review, you may apply to the ACAT for review of the Ombudsman decision. Further information may be obtained from the ACAT at:

ACT Civil and Administrative Tribunal
Level 4, 1 Moore St
GPO Box 370
Canberra City ACT 2601
Telephone: (02) 6207 1740
http://www.acat.act.gov.au/

Further assistance

Should you have any queries in relation to your request, please do not hesitate to contact the FOI Coordinator on (02) 5124 9829 or email HealthFOI@act.gov.au.

Yours sincerely

Dr Nick Coatsworth
Executive Director of Medical Services
Canberra Health Services

26 October 2020

ACT Health BPT Training Program review

November 2019 – Jan 2020

A/Prof Anne Powell

Dr Bethan Richards

1. BACKGROUND

1. The ACT Physician Training Network is responsible for providing training to Basic Physician Trainees (BPTs).

2. In 2018 and 2019, the ACT Physician Training Network had low pass rates in the RACP clinical examinations (7/19 37% in 2019; 5/14 36% in 2018). These rates were well below the overall Australian (70.6% in 2018 and 69.6% in 2019) and New Zealand (76.7% in 2018 and 80.3% in 2019) pass rates. The factors contributing to these low pass rates were unclear.

3. To investigate the factors contributing to these low pass rates, ACT Health, in conjunction with Canberra Hospital and Health services and the ACT Network Director of Physician Education (NDPE), Dr Ashwin Swaminathan, commissioned this external review.

4. The aims of this review are to:

    i. Identify program, trainee, educator and institutional factors that have led to the Network's low clinical examination pass rates over the past 2 years.
    ii. Recommend culturally acceptable and sustainable changes to the ACT Physician Training Network to improve future clinical examination pass rates.

2. EXECUTIVE SUMMARY

1. <u>Setting.</u>

ACT Health, with its dedicated group of clinicians and administrators, provides an ideal setting for physician training.

2. <u>Challenges.</u>

a. The greatest challenge for ACT health is in the management of competing service provision needs with the ongoing education requirements of its junior medical staff.

b. There is currently an absence of a formalised structure to support the NDPE. The reviewers have recommended that the organisation consider the appointment of additional staff to provide the NDPE with greater support to deliver the education program and pastoral care requirements.

c. Workload was also an issue common across all junior staff groups, with overtime (paid and unpaid) regularly being worked by the Hospital Medical Office (HMO) group.

d. Key points where the program differs from that offered by other metropolitan hospitals with a successful RACP clinical examination program, as judged by a pass

rate at or above the national average, include the provision of a trial examination that mimics the RACP clinical exam and an extensive long case / short case roster within working hours.

e. High rates of Basic Physician Trainee burnout were recorded (78.9%) which is well above the international average of 51%.

3. <u>Recommendations.</u>

The reviewers are of the opinion that consideration should be given to the development of a strategic service plan, which encompasses some of the recommendations in this report.

The reviewers have set out a number of recommendations for the organisation to consider.

a. Governance and Strategic Planning.

A review of the governance is required with increased resources considered towards increased FTE for teaching and supervisory staff.

b. Workplace Culture

Strategies to improve the morale within the hospital are required. High rates of burnout in the network need to be addressed.

c. Medical Workforce – Staff Rosters and leave processes.

There is a need for a review of safe working hours with a balance between training and service delivery.

d. The development of a structured training program for RACP clinical examination.

e. Planning should address senior clinician disengagement.

f. The planning should address improvement to the current junior staff mentoring program.

3. REVIEW METHODOLOGY

1. The Review was carried out in accordance with the Terms of Reference attached in Schedule One.

2. The reviewers analysed a number of documents that were provided by the ACT Physician Training team (Schedule 2). These documents provided detailed information on the current

ACT Physician Training Network program, orientation activities at Canberra and Calvary Hospitals, rosters, leave, overtime and network governance issues. This information was used to guide interviews and was verified during the interview process.

3. An online survey was completed by the basic physician trainees who sat the clinical RACP examination in 2019 prior to the reviewers' site visit (November 2019). The results are set out in Schedule Three.

4. Structured interviews were conducted with administrative and support staff, basic physician trainees, advanced trainees, senior medical staff, directors of physician training, the network director of physician education, Head of the Division of Medicine at The Canberra Hospital on Wednesday 27th November 2019 and Thursday 28th November 2019 respectively.

5. All staff present were informed that their individual responses would remain confidential, with only collated data and themes reported back to the organisation. Consultants unable to attend face to face interviews with the reviewers were given the opportunity to email the reviewers their thoughts on the factors contributing to the low ACT clinical examination pass rates. Any further themes identified in these emails were added to the interview data collected.

6. Following several interviews with basic physician trainees, it became apparent that trainee wellbeing and burnout may be significant factors contributing to the low clinical exam pass rate. To further assess the levels of burnout across the whole cohort of trainees, a second online survey with validated measures of burnout and wellbeing was sent to all basic physician trainees following the reviewers' site visit (December 2019). The results are set out in Schedule Four.

7. The collated responses of all interview, survey and email data were analysed independently by the two reviewers. Each reviewer initially identified independently the major factors felt to be contributing to the low pass rates, as well as recommendations on how to address these. Contributing factors and recommendations were then discussed and collated.

4. RECOMMENDATIONS

4.1 Governance and Strategic Planning

Issues Identified

- Strong relationships, built up over many years, between senior clinicians and the previous NDPE had been a key factor in engaging clinicians at all levels to contribute to the teaching program, despite their hectic schedules. With no succession plan in place, and a delay in appointing a new NDPE, clinician engagement with the training program was significantly reduced. This resulted in a difficult situation for the new incumbent NDPE, who did not have pre-existing relationships with colleagues to engage clinical staff in teaching.
- Lack of engagement/communication between the new training team, the previous training team and other senior clinicians from the Division of Medicine.
- Disengagement of senior clinicians who had traditionally contributed heavily to the program. Possible contributing factors to this include:
    - Excessive senior staff clinical workload
    - Absence of any incentives to teach
    - Lack of protected FTE or recognition of teaching in contracts, policies and procedures,
    - Increasing administrative requirements with RACP processes at both the BPT and AT levels
    - Low morale among senior and junior medical staff
    - An uneven distribution in teaching responsibility and allocation.
    - Turnover of staff in senior positions who had contributed heavily to the teaching program. New appointments have not taken on the same teaching contributions.
- Increasing numbers of trainees sitting the exams without a comparable increase in training team staff.
- Inadequate session allocation for DPE/NDPE roles (total 0.5FTE) compared to other networks to provide the oversight, implementation, supervision and support required for the increasing number of trainees.

Recommendations

1. Institution of regular meetings between the NDPE/DPE (or medical superintendent) and Director of Medical Services at Canberra hospital.
2. Ensuring that ACT Health and the Division of Medicine recognises the importance of a successful BPT training program to trainee wellbeing, organisational culture and the quality and safety of patient care delivered. This could be achieved by setting a clearly articulated, united vision and charter that all departments signed up to. A strategic plan for how to achieve this should also be developed with appropriate resources and oversight process to ensure suggested changes are implemented.
3. Ensuring the Division of Medicine and departmental meetings include “BPT training issues/update” as a regular agenda item.

4. Ensuring that all medical units have accountability for the training of their BPTS. When making new appointments, teaching requirements and expectations to be agreed upon with heads of department and the DMS at each site.
5. To be comparable with other similar sized BPT networks, ensure succession planning, protection of corporate knowledge and on site availability to supervise and support trainees, there needs to be additional positions created. A possible solution is in addition to NDPE 0.5 FTE position:
   - Create a new DPE position (minimum 0.2 FTE) at Canberra Hospital and appoint an existing member of staff from Canberra Hospital.
   - Upgrade the senior fellow position to a staff specialist Medical Superintendent (0.5FTE/0.5FTE clinical)
   - Appoint a Canberra Hospital DPE (0.5FTE) and increase the NDPE FTE to 0.5FTE (rather than combined role with less total FTE).
6. Ensure succession planning for key training oversight positions. Adequate lead time to ensure time for recruitment and handover is suggested.
7. To improve communication and spread the teaching workload, it is recommended that a designated teaching champion in each department is appointed. This position should have some dedicated time for the role (e.g. 0.1 FTE) and act as the link of their department to the BPT training team.
8. Consider other strategies to spread the teaching workload so that it is proportional to the number of clinicians in each department. An example used in other networks is to allocate to heads of department (or departmental teaching champions) a teaching roster, e.g. for long or short cases. The nominated individual is then responsible for liaising with senior staff on the unit to ensure that teaching sessions are allocated. This is a more sustainable model, as it ensures that the teaching program is not reliant on the pre-existing relationships between the NDPE and senior clinicians. It also ensures that all teaching contributions are adequately acknowledged by the clinical unit and that new staff are given the opportunity to contribute to the program.

4.2 Workplace Culture

Issues identified

- Low staff morale and high levels of staff burnout noted during the review.
- Less than half of the BPTs interviewed or who completed the survey would recommend the ACT Physician Training Program to a junior colleague.
- Lack of a regular forum for senior or junior medical staff to have their concerns heard.
- Overwhelming sense that clinical staff do not feel valued by the system.
- Common themes commented on included poor exam results, repeated exam failures and “good” people failing exams.
- Trainees often reported witnessing senior clinician conflict.
- Currently no culture of mentorship at the hospitals. The labeled mentor program operates more as long case supervisor rather than a true mentor role.
- Currently no culture of teaching at the hospitals. Trainees report service provision roles with minimal “teaching on the run” reported on most rotations.
- Lack of team building, community or social events.

- Surveys are completed (i.e. on incivility) however no feedback to trainees that any action was taken to address issues raised.
- Trainees report no good system processes on addressing bullying and harassment complaints by junior staff. Several examples were raised during the discussions that had all been reported to consultants within the health service with no (obvious) action taken. No feedback to the trainee or support mechanisms put in place.
- It is clear from the high rates of survey returns by junior staff and good turnout to face to face interviews by medical and administrative staff that there is an interest and keenness to make improvements to the workplace at all levels if given the opportunity and vision.
- Positive role modeling observed in the actions/ support of Dr Ashwin Swaminathan and Natalie Monkivitch (MESO).

Recommendations

1. NDPE/DPE/or Senior Clinician hold a weekly BPT meeting to facilitate a regular communication channel with BPTs.
2. Consider developing a clinician engagement strategy that includes:
   - Forums with senior staff and Division of medicine
   - A unified vision and goal with buy in from Division
   - Heighten senior and administrative staff awareness on the value to all of a successful BPT training program
   - Implementation of social events such as Division of Medicine / Surgery Welcome drinks, exam celebration
   - Appointment of departmental teaching champions with protected FTE.
   - Engagement with medical administration.
   - Institution of teaching/mentoring awards – Senior medical staff and Advanced trainee levels.
3. Reinstitute a staff lounge to improve sense of community, provide informal opportunities for social connection, mentorship, and debriefing.
4. Institute mentoring programs at all levels (e.g. interns to mentor medical students, residents mentoring interns, registrars mentoring residents, ATs mentoring BPTs, AMOs mentor BPTs/ATs.
5. Consider appointment of a Chief Medical Wellness Officer to design / implement strategy to address clinician burnout (e.g. MDOK program at RPA).
6. Ensure adequate communication back to trainees whenever their opinion is sought in either a survey or focus group (written and verbal).
7. Ensure all trainees are aware of the processes on bullying and harassment. Ensure these processes are robust and ensure junior staff feel safe to report such episodes.

4.3 Medical Workforce – Staff Rosters and leave processes

Issues identified

- Interviews with trainees and audits of rosters revealed that the EBA, safe working hours are often breached.

- Multiple trainees reported having their leave revoked in 2019, even when air tickets had already been purchased.
- There is conflict between the Calvary and Canberra Hospitals' rostering units with insufficient resources to cover the staffing required for both hospitals. Calvary reports that Canberra Hospital's service roster requirements are generally prioritised ahead of their own.
- Responsibility for roster development at Canberra Hospital rests with a single person with no allocated cover when they are on leave.
- The rostering unit and BPT training team are not currently co-located.
- There are currently insufficient BPT relievers to cover leave/study leave/sick leave etc. In addition, currently BPTs are being used to cover AT rosters and leave in addition to general on call rosters. This is not reciprocated by the ATs. This means that BPTs are unable to access their ADOs due to lack of cover.
- The sick relief roster did not appear to be adequately staffed and trainees reported feeling pressured to work even when unwell.
- Trainees currently undertake an entire term of nights (12 weeks). Many mentioned the impact this had on their exam preparation, health and wellbeing.
- There has been an apparent increase in both personal leave in 2019 as well as rostered overtime.
- Staff at Calvary Hospital reported a "clock in / clock out" system. Multiple staff reported that if you clocked in 10 minutes late, your pay was reduced even if you worked hours of unpaid overtime on the same day.
- Several BPTs reported regularly working a roster that comprised 12 consecutive days on, 2 days off followed by a further 12 consecutive days. One of the 2 days off was often utilised to sit a trial examination (thus BPTs effectively only had 1 day off in 14).
- There are a high number of service terms over the two or three years of training, with a limited number of specialty training terms.
- Rosters seem to be regularly changed/updated. Rosters are often circulated on a Friday afternoon, with no one at workforce to contact with requests for a shift change.
- Trainees who have completed their three BPT, core years are often rostered to non-core jobs where they receive no feedback.

Recommendations

1. Rostering unit and BPT unit be co-located when possible to improve communication.
2. Nights roster be reviewed and other models considered, e.g. rosters at the following institutions:
    - RPAH
    - POW
    - Alfred Health, Melbourne
2. Develop a policy with clear communication processes, rostering rules and expectations between Canberra and Calvary Hospitals and ensure compliance with this policy.
3. Policy regarding safe working hours to be reviewed and updated, including regular auditing process of BPT overtime (rostered and unrostered) to ensure hours meets safe working hours (as per ASMOF). Escalation processes for when safe working hours breached to be put in place.

4. Limit number of BPT night shifts (or avoid when possible) when in lead up to sitting written and clinical examinations. Use BPTs not scheduled to sit exams to cover when possible.
5. Real time monitoring system for hours worked implemented and reviewed regularly. A clear process instituted to follow up when hours are above those agreed. This should be possible at Calvary Hospital given the "clock in / clock out" approach.
6. Leave to be allocated at beginning of the year and not revoked unless exceptional circumstance. In the exceptional circumstances when leave does need to be revoked, this should have NDPE and DMS approval. Chronic understaffing that can be managed with locums is not deemed an exceptional circumstance.
7. Rostering of ADOs to be implemented. Consideration could be given to a model where leadership training terms (e.g. RPAH) or "research & redesign" terms (e.g. Alfred health) are available. These terms foster development of professional skill-sets relevant to working in health system (e.g. leadership, performance, medical education, quality and safety, medical media) and also provide an opportunity to cover ADOs (one day per week), contribute to after-hours rosters and provide sick relief (up to 2 weeks per term).
8. Management of the trainee roster must include oversight by the DPE.
9. We recommend a formal review of junior staff overtime (rostered and unrostered). This should also incorporate a review of call-ins to ensure that BPTs are not asked to work 12 consecutive days.

4.4 Structured training program for RACP clinical examination

Issues identified

- There are limited outpatient training / practice case opportunities currently.
- Examiner calibration session in February explaining the system to physicians and advanced trainees was poorly attended by consultants.
- Long case introduction on "How to do the long case" held in March. Many trainees had their first trial exam prior to the introductory session.
- Trainees assigned an experienced physician to present cases to. Described as mentors, but functionally were regular long case tutors. There was no rotating consultant long case roster.
- "Boot camp" initiative run by advanced trainee in mid-May (new concept). Very popular with the trainees. Concern about content of information given voiced from both trainees and consultants.
- While a trial exams are held each Saturday morning for 8 candidates, the exam is not run as a copy of the RACP exam. i.e. examiners do not review long case / short case independently. There is no individual feedback given to candidates. Case selection for these sessions were not always deemed ideal or realistic
- Feedback given by the supervisors was also thought to be too general without outlining strategies on improvements.
- Reported difficulty getting to do a long case with a member of the National Examining panel (NEP) if not allocated as a mentor. Experience in long cases very dependent on the allocated consultant.

- Canberra Clinical course for 1.5 days. NEP speakers from ACT and NSW. This was well received by candidates but it felt disconnected from the main program.
- Public long cases weekly at Canberra hospital were well received.
- "Scorpios" – short case masterclasses held for neurology, cardiology (3), endocrinology and rheumatology. These were very popular and are deemed necessary at most major training sites in order for candidates to see all required short case pathology.
- Sports psychology session in July on how to improve presentation skills and confidence.
- Sessions at the National Gallery of Australia. Focus on improving the observation skills, presentation and "seeing the bigger picture".
- The long case practice that is occurring does not replicate exam process. Trainees often present cases more than 24hrs after seeing the case. This is because it is too difficult to see a long case during a working day when needing to finish on time to drive to/ attend the teaching session.
- Case selection for long cases often via "word of mouth". There was a Whatsapp utilized with some APTs being very pro-active in adding to the list. However, the list was often out of date and not well utilized. Whatsapp is not the ideal form of communication given the sensitive nature of patient information.
- Trainees are often having to drive between Calvary to Canberra and vice versa after hours for teaching.
- A majority of the training program is currently scheduled after hours (Tues/Thurs/Sat). This is also contributing to trainees fatigue levels and attendances. It also impacts on the time that many patients are eating their evening meal.
- The clinician program currently does not begin until after the written examination. There are no clinical (long/short case, examination skills etc.) in the BPT 1or 2 program.
- Trainees need to find consultants to listen to case presentations. This can be problematic for trainees who are new to the hospital, or more timid in their approach. There is currently no long or short case roster in place.
- A mentor program is in place but only seems to be effective about 30% of the time based on the trainees interviewed. There are no clear guidelines on how the process should work, who should contact who, how often, etc. There is no mentor training and no mentor handbook currently available. This program appeared to be more a person to present long cases to rather than a true mentor program.
- There is currently no individual meeting with NDPE/ES for professional development planning, career discussions, term and mentor discussions.
- BPTs currently located in the emergency department (ED) are used as either extra ED staff or to complete the ED work up for medical patients. There is no direct physician supervisor of this term to review cases, discuss problems etc. This has been deemed a core general medicine rotation despite absent direct consultant supervision.
- Several trainees reported that there was no safe forum to inform the DPE / NDPE of tutors that "should not be teaching". There are concerns that open disclosure would lead to negative outcomes at work. This extended to unit end of term feedback which are impossible to de-identify as only one BPT on some units per term.

Recommendations

1. Ensure minimum 2hrs protected teaching time per week within routine hours to deliver program. Division of Medicine to endorse this and support its implementation to ensure trainees can attend training sessions.
2. Protected training attendance should be audited and reasons for not attending obtained and investigated by DPE/NDPE/MESO.
3. Commence clinical training program and professional development program in year one. This should include clinical short case examination workshops from term 1 (how to do short case examinations in 7mins on normal patients – medical students can be used in lieu as this also provides a great learning experience for them).
4. Implement professional development workshops for self-care, performance, CV and interview training.
5. Implement a weekly long case roster including a wide range of experienced consultants, rather than allocate a BPT to a single consultant for the entire period of preparation. To ensure some ownership of progression, the roster can ensure that each registrar rotates to a regular consultant every 3 weeks.
6. Implement a weekly short case roster. This can be conducted by interested consultants and all specialty registrars to ensure adequate exposure to all subspecialty signs. These should be conducted during working hours with the expectation that BPTs may miss up to 50% of tutorials and thus ensure adequate numbers scheduled. It will result in higher engagement by clinicians and better timing for patients (not after hours).
7. Hold Long Case weekend early in the year (1-2 weeks after results of written examination)
    - Skills based workshops including an introduction to long and short case examinations and overview of the rostering / plan until examinations.
    - Focus also on team building, relationship building and self-care.
    - NDPE attend other hospital weekend training programs to gain experience in other models.
8. Develop a mentor guide handbook to ensure expectations of mentees and mentors are similar.
9. Consider offering mentor training sessions as well as effective feedback sessions for senior staff.
10. Ensure a CV and career development meeting occurs for each trainee with NDPE/DPE or ES.
11. The program needs an orientation process, both when candidates enter the basic physician program and at the start of the written preparation year (start of BPT2) and at the start of the clinical examination process (BPT3 year).
12. Consider starting junior doctors that are new to the network at one of the major sites rather than commencing at a rural / remote site to ensure they gain adequate orientation and supports.
13. Reduce the number of trial examinations, but ensure the timing is appropriate (ie 4-6 weeks prior to exams). Ensure the trial examination is a dry run for the real day with examiners also seeing the cases blind with the same timing as the real exam day. Ensure an experienced examiner (NEP/SEP/DPE/experienced local examiner) is on each examiner team to ensure accurate assessment. Use earlier Saturday sessions as Saturday Drills with immediate feedback to the individual on long cases/short cases.
14. Ensure all senior clinicians giving effective feedback. For example, if candidate going overtime, being able to unpack this and give functional advice on how to prioritise issues is important. Additional consultant training may be required.

15. Consider what tool should be used by the hospital to allow communication by staff on appropriate long and short cases and to ensure patients are not excessively fatigued or coerced.

4.5 Senior clinician disengagement

Issues identified

- Historically heavy burden of teaching of small number of clinicians.
- Administration have single focus on clinical service delivery with KPIs.
- There is a VMO based work force at Calvary, which means limited on-site non-clinical time which could be utilized to contribute to teaching and mentoring activities.
- Many clinicians interviewed reported feeling burnt out.
- There have been recent changes in executive staff and a period of instability and conflict preceding this.
- There is currently no pride in the Canberra training program. Poor recent results are contributing to this.
- Importance of BPT training program to hospital brand, AT recruitment, patient care not seen as a priority by hospital administration, Division of Medicine.
- Communication between BPT training team and other senior clinicians limited.
- There are currently no clinical teaching champions in departments.
- There are no incentives or reward structures for teaching, mentoring or examining.
- Currently any successes are not routinely celebrated, and historically medical administration and many Heads of Departments have not been present at any celebration events.
- The level of expertise with the examination process is at expected levels for the training numbers. There are 3 NEPS and 2 SEPS in Canberra. There is also a prior NEP and a number of experienced local examiners.

Recommendations

Clinician engagement in the BPT training program will be critical to improving the morale, written and clinical examination results. To achieve this we suggest:

1. Establish a senior leadership team to support BPT team with delivery of program. This should consist of key influencers and opinion leaders in addition to the BPT training team. This should be co-led by the Head of Division of Medicine and NDPE with support from NEPs, other key clinicians and the Director of Medical Services.
2. Appoint teaching champions in each department and provide FTE to support this.
3. Division of medicine meetings to have BPT training program on agenda each meeting.
4. Offer professional development training opportunities: Difficult conversations with trainees, Leadership training, Providing effective feedback, Teaching on the Run.
5. Hold social events to build opportunities for engagement and social connection eg Division of Medicine Welcome Drinks (AMOs, ATs, BPTs).
6. Institute BPT Teaching Award for AMOs and ATs.
7. Division Medicine Chair to host regular exam results drinks to celebrate successes and thank those involved in the training program.
8. Sponsor leadership team and key teachers to attend the clinical examination weekend retreat.

9. Measure burnout / professional fulfillment levels in senior staff and look at ways to address this

4.6 Mentor program improvements

Mentor program issues

- Limited preferencing and matching process.
- Mentor program used largely for long cases currently with low rates of utilisation.
- No clear guidelines about program and expectations of mentees/mentors.
- No internal mentor training programs.
- BPTs not currently given opportunity to mentor interns or medical students.

Recommendations

1. Implement a new preferencing process taking into account trainee preferences for demographics, career type, and personality. Separate this from the long case roster.
2. Create Guide to Mentoring Canberra Hospital.
3. Appoint hospital mentor program co-ordinator.
4. Consider implementing mentor training program.
5. Consider implementing Registrar to RMO mentoring program and AT to BPT mentor program to build skill and culture of mentorship in the hospital.
6. Consider hosting a yearly BPT dinner with sponsorship for Mentors and teachers to attend

5 OBSERVATIONS

5.1 Survey Instruments

- A survey was distributed to basic physician trainees that completed the clinical FRACP examination in 2019. This was distributed via Qualtrics and completed in November 2019 prior to the reviewers' site visit.
- Interviews were conducted by the Reviewers in November 2019 during a two day site visit (Day 1 @ Calvary Hospital by A/Prof Anne Powell and Day 2 @ Canberra Hospital by A/Prof Anne Powell and Dr Bethan Richards). Interviews were open however they aimed to elaborate on themes identified in the pre-visit survey.
- A survey scoring burnout was distributed to basic physician trainees that completed the clinical FRACP examination in 2019. This was completed via Survey Monkey in December 2019 following the reviewers' site visit.

5.2 Interviews

The following notes document additional details from the interviews that may be useful in further defining the issues identified in Section 4. Statements from the basic physician trainees, DPEs and administrative staff were very homogenous whilst the greatest variation in opinion came from Senior Medical Staff.

Basic physician trainees

- This group of staff did express some frustration over workloads and the manner in which they were treated by some senior medical staff.
- Calvary hospital use Kronos to clock in and clock out. This documents hours of unpaid overtime, but staff felt undervalued as pay would be subtracted if late for work on one day even if hours of unpaid overtime documented.
- Without exception, staff reported being extremely busy and this had been compounded by the loss of staff at the end of 2019.
- Several staff commented that whilst all senior medical staff possessed excellent clinical skills, their ability to teach and the different teaching styles of the consultants sometimes made learning difficult.
- Orientation was not felt to be effective and focused on some administrative details rather than an overview of what was required to upskill and successfully complete their basic physician training.
- Scheduled sessions were often difficult to attend due to workload demands. However when they did attend, junior staff reported that they were useful and informative.
- Junior staff also indicated that the IT system used to review patients needed to be upgraded and was difficult to track patients between sites.
- Junior staff reported getting conflicting feedback on their long cases. However more often they reported not receiving any feedback other than a score.
- Several concerning stories about coercion to come to work despite requesting sick leave. Told that the system is “desperate”. Major concern that if you call in sick, you are leaving the system short as no coverage of sick leave.
- Reports of working 150 hour fortnight at Calvary hospital. When queried, was advised it is recorded by the Kronos system of check in/check out.
- Concerning behaviour reported by a consultant at Bega health.
- Calvary nights shift is difficult to manage covering CCU and ED admissions with no time for eating breaks reported.
- Candidates that had failed reported no clear plan on what they would do in 2020 to improve their chances of passing. One response was “work harder” despite acknowledging they had worked as hard as they could. Another response was “I don’t know – I will pray”.
- Trainees with families reported that it was hard to give up every weekend when they had children at home.
- Feeling that the Saturday morning examinations gave a “false sense of security” with several candidates reporting never having failed a trial examination (but failing both in the real examination).
- Trainee that passed reported having been allocated a good rotation for study prior to the examination. They did 1-2 long cases each week and had started them prior to the written examination. He also received an additional trial examination (5 in total). Did not feel adequately prepared for the short cases however.

- Several rotations listed as very difficult with the need to improve the rostering. Examples of this were night shifts, CCU and haematology/oncology. The General medical unit at Calvary hospital was also a problem with 30 patients per team reported. Did long cases instead of eating lunch. Advanced trainees were helpful in getting the basic physician trainees to afternoon short cases (ie leaving on time).
- Several rotations listed as good prior to the examination ie palliative care, neurology, rheumatology relieving, gastroenterology.
- Recognition that many consultants "burnt out". Calvary hospital will often have consultant VMOs appear at 6pm to do their ward round.

Advanced physician trainees

- Advanced trainees were expected to teach junior staff however due to workload pressures, this teaching was often postponed. There was no review on whether an advanced trainee had contributed to the teaching program and no adverse consequences if no contribution was made.
- Several APT were surprised by the low pass mark.
- Reported they found it difficult to get consultants involved in teaching. The APTs felt that the physicians didn't feel responsible for the pass mark. "If you're not invested in it, you don't feel responsible".

Senior Medical Staff

- Commentary was provided that the culture had improved significantly under the leadership of the current NDPE.
- The alleged behaviour of a certain senior member of staff was also drawn to the attention of the Reviewers independently by several clinicians. Specifically that this member of staff ha allegedly acted in an aggressive manner towards another senior member of the department on a number of occasions.
- Whilst it was not the function of the Reviewers to make findings of fact in respect of those alleged incidents, commentary was also provided from a number of junior medical staff about the alleged poor conduct of a small number of senior staff.
- Whilst the type and complexity of cases were considered to provide excellent training opportunities for junior staff, because of service demands there was not as contact with junior staff as some senior staff would have liked.
- The majority of senior staff expressed a genuine interest in the training and teaching of junior staff.
- Several staff expressed the view that several candidates should not have sat the examination for another one to two years until recommended by their supervisors/ consultants.
- Comparisons were made to other hospitals where consultants do additional long and short cases sessions during the week with the candidates. The consultants would then submit reports to the DPE.

- Saturday practice exams – felt that feedback should be given privately and immediately following the presentation.
- Consultant staff expressed a lack of time and high clinical work-load as the limiting factor towards physician involvement.
- Saturday morning examination did not match the actual examination. Occasional poor organization and/or case selection noted.
- Expectation was that it was unrealistic to expect candidates to participate in any sessions in their busy working hours.
- Felt that needed to change rostering to reduce workload during exam preparation period.
- Feeling need to limit the number of trainees sitting the examination to allow non-accredited medical registrars to fill the roster.
- High workload and lack of relieving staff
- Numbers sitting examination have increased from around 8-10 in 2004-2011 to current numbers. There are more service provision terms for trainees now with an increased need for more nights. Concern about numbers for capacity to train – not enough exposure to subspecialties.

National Examining Panel

- Busy clinical workloads for BPTs and specialists with very little discretionary time (described lack of 20% non-clinical time)
- Timing of short case sessions is when patients eating food and everyone is tired.
- Feedback directly after cases on Saturdays, rather than general non-specific feedback.
- Clarify for candidates who are the NEPs and experienced local examiners. All candidates should have feedback from a variety of these examiners.
- Candidates rarely brought a colleague to listen to long case and observe.
- Some NEP were surprised by the poor pass mark and some were not. Those that were surprised did not know the cohort well and had minimal interaction with the training program.
- A concerning quote was “a really good trainee will rise above the culture”.

Directors of Physician Education

- Dr Ken Khoo (Calvary DPE) and Dr Ashwin Swaminathan (ACT NDPE)
- Dr Carolyn Petersons (former DPE) and Dr Chandi Perera (formaer NDPE)
- Lack of recognition that the basic physician program and its importance for the hospital.
- Lack of cohesion of senior medical staff with no senior medical staff space and no social events. SMS apparent lack of pride in the BPT cohort.
- Attendance at Grand Rounds dwindling. It is no longer about the trainee but more about high level research. There is no Division of Medicine meeting.

Administrative staff

- Meeting with Natalie Monkivitch (MESO) and Robyn Hughes (Rostering) at The Canberra Hospital
- Meeting with Leslie Pollock (MESO) at Calvary Hospital
- Challenges in meeting the service needs of the respective hospitals whilst also ensuring the wellbeing of registrar staff.

6. REVIEW SUPPORT

1. The Reviewers would like to thank all staff that participated in the Review process and Ms Natalie Monkivitch for her administrative support in making documents available and scheduling interviews.
2. The Reviewers would like to thank the NDPE and Calvary DPE for their academic support during this review process.

SCHEDULE ONE **Terms of Reference**

SCHEDULE TWO **List of Documents Examined**

SCHEDULE THREE **Pre-visit survey**

SCHEDULE FOUR **Post-visit survey on Burnout**

SCHEDULE ONE – Terms of Reference

Yamba Drive, Garran ACT 2605

PO Box 11 Woden ACT 2606

Terms of Reference for the

Review into the ACT Physician Training Network Clinical Examination Program

Background

The ACT Physician Training Network ('the Network') is responsible for providing an appropriate training environment for Basic Physician Trainees (BPTs) to enable completion of Basic Training.

This includes providing support and training for the summative assessments undertaken in the last year of Basic Training, namely the Written and Clinical Examinations (CE).

The Network's CE Preparation Program ('Program') consists a suite of teaching and training activities and mentorship that is delivered concurrently by physician and support staff at Canberra and Calvary Bruce Hospitals between March and July.

The CE pass rate of our Network's BPTs for the past 2 years has been significantly below the national pass rate and Network's pass rate in preceding years. The reasons for this decline are not clear.

Aims of this Review

- To identify Program, trainee, educator and institutional (resourcing and support) factors that have led to the Network's low CE success rate in the past 2 years.
- Recommend culturally acceptable and sustainable changes to the Program to improve the CE success rate to
    i. at least the National average by 2021
    ii. a comparable level to a top-ranking metropolitan training network by 2024

Parameters for Review

In scope

- Surveying &/or interviewing local trainees who have sat the CE in current or past years
- Surveying &/or interviewing physician educators, support staff (e.g. Medical Education Support Officers) and Senior Medical Registrars involved in the Program in current or past years
- Reviewing the resourcing, governance and support of the Physician Training Office to enable successful conduct of the Program
- Reviewing Program activities, rosters and schedules
- Reviewing feedback from Program activities
- Reviewing examination venues
- Comparing with Programs from other historically successful Networks.

Out of scope

- **Review of other aspects of the Network's Training Program including:**
    - BPT recruitment
    - Written Examination preparation program
    - Hosting the CHS or Calvary Clinical Examination

Deliverables

- A written report summarising the findings of the review and recommendations
- Presentation to the Physician Training Committee and invited stakeholders

Timeline

- The review is to be completed by November 30, 2019

Secretariat

- The CHS Physician training office will assist with administrative and logistical tasks

Governance arrangement

- This review is commissioned by the ACT Network Director of Physician Education with funding provided by the Physician Training Office, Medical Services Group.
- Outputs from this review shall be delivered to the CHS Executive Director Medical Services

SCHEDULE TWO **List of Documents Examined**

ACT Physician Training Network Handbook 2019

Canberra Hospital - Basic Training Orientation 2019

2018 ACT Physician Network's Clinical Examination Review

Leave taken / Claimed Overtime The Canberra Hospital 2016-2019

2019 BPT rotation roster

2019 JMO (Registrar) Orientation Guide, Calvary Hospital

Minutes Postgraduate Training Committee Meeting December 2015

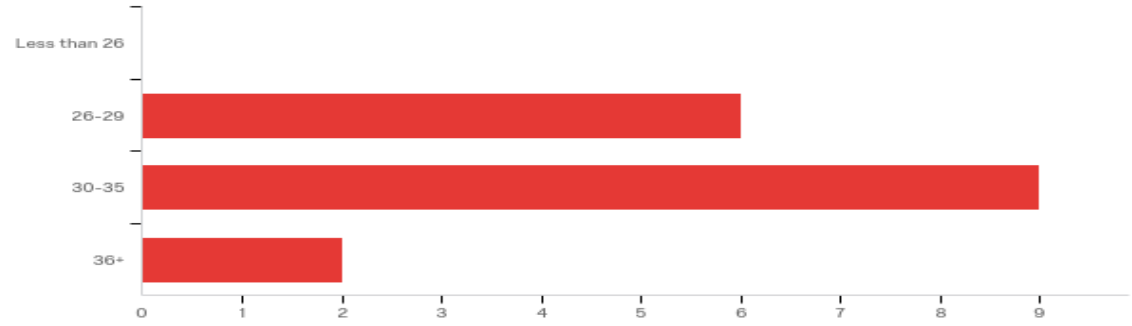
SCHEDULE THREE – Survey

ACT FRACP Clinical Program Assessment 2019

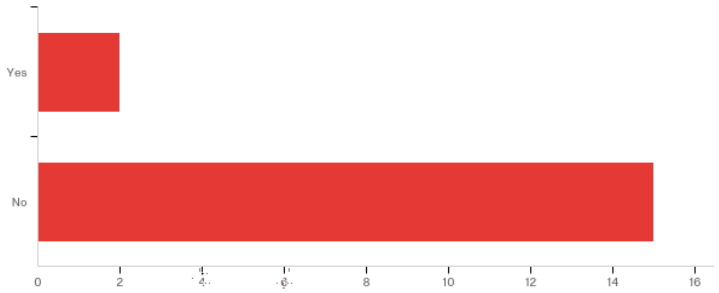
Sex

Male	11
Female	5
Prefer not to say	1

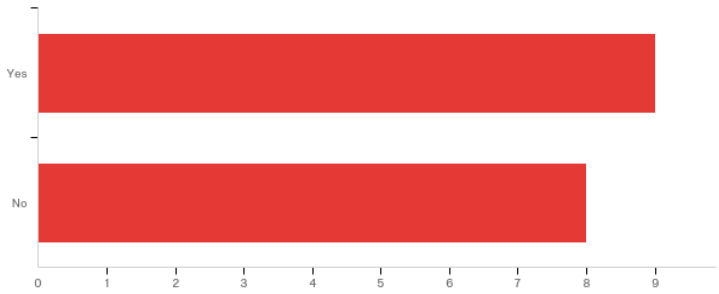
Age



Do you have dependent children at home?



Is English your first language?



At which university did you complete your medical degree?

ANU (4)
Flinders
Queen's University Belfast
UNSW (2)
University of Sydney
UHS, pakistan
n/a
James Cook University
Monash
National University of Ireland galway
University of Medicine 1, Myanmar

Where did you complete your intern year?

Alice Springs
Belfast
Brisbane
The Canberra Hospital (4)
Islamabad, Pakistan
n/a (3)
The Townsville Hospital
Goulburn Valley Health
Canberra hospital
TCH

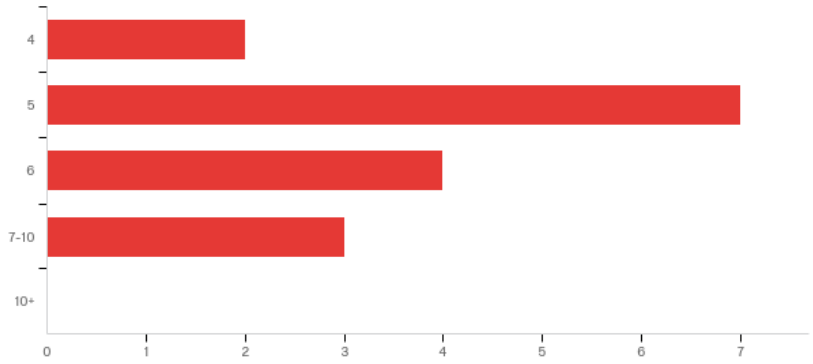
Where did you complete your BPT1 (not PYG1) year?

ACT Health (10)
Townsville Hospital (2)
n/a (2)
The Townsville Hospital
Goulburn Valley Health
TCH

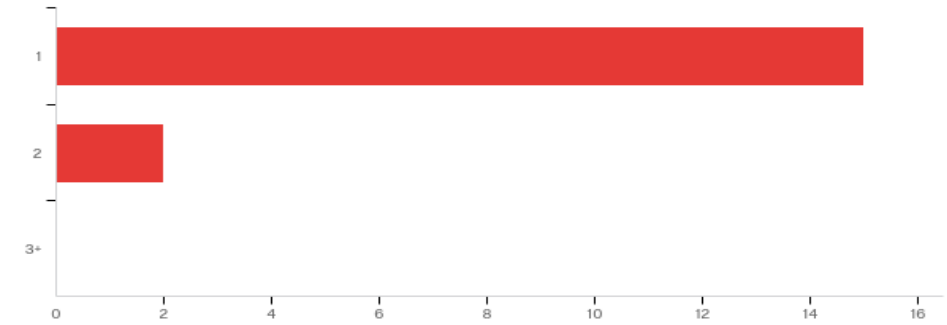
Where did you complete your BPT2 year?

ACT Health (10)
n/a (3)
The Townsville Hospital
TCH

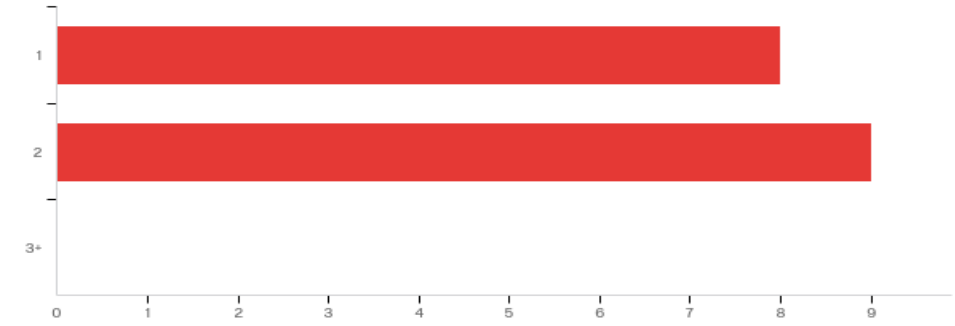
How many years post graduation are you?



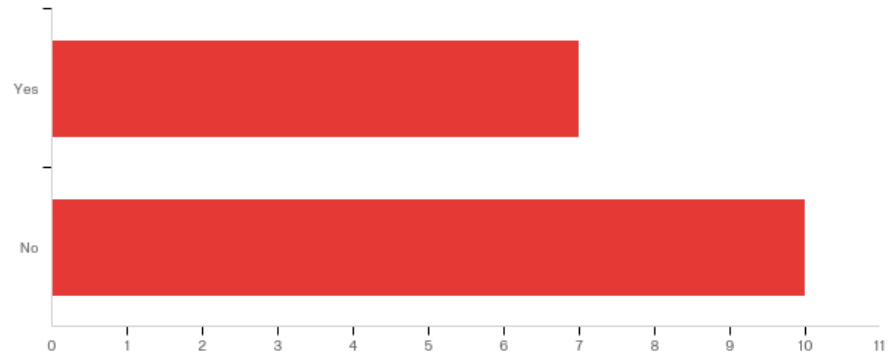
How many attempts did you have at the written examination?



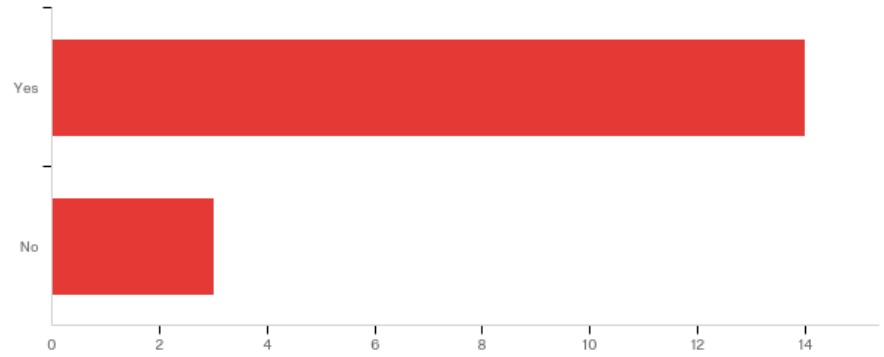
How many attempts have you have at the clinical examination?



Did you pass your clinical examination in 2019?



Were you in a study group?



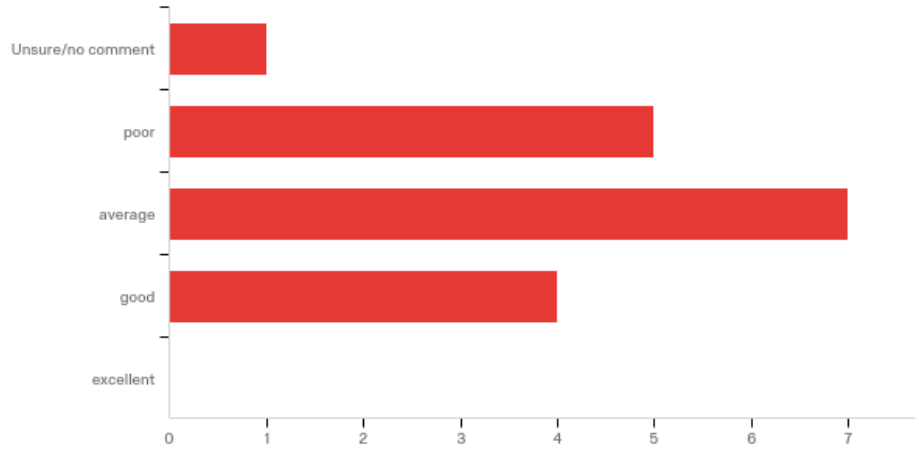
How effective was your study group? If you were not in a study group, what were your reasons for this?

How effective was your study group? If you were not in a study group, what were your reasons for this?

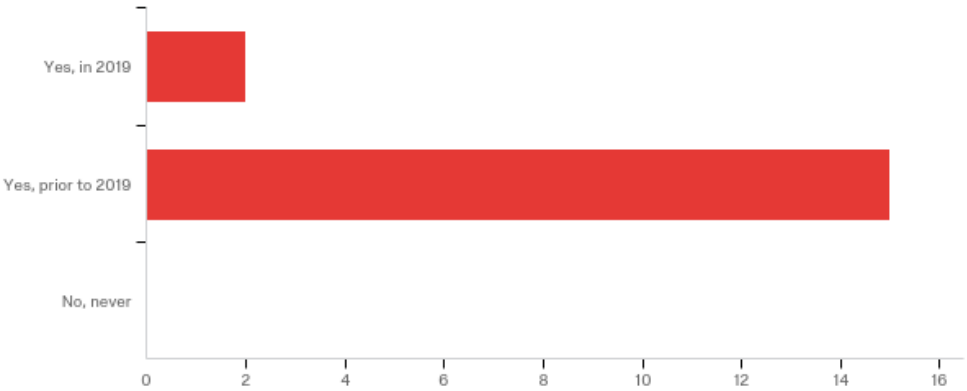
[redacted]

[redacted]

How would you rate the ACT lecture series preparing you for the MCQ examination?



Did you attend one of the 2 week written preparation courses interstate?



What did you find most helpful in the ACT written exam training program?

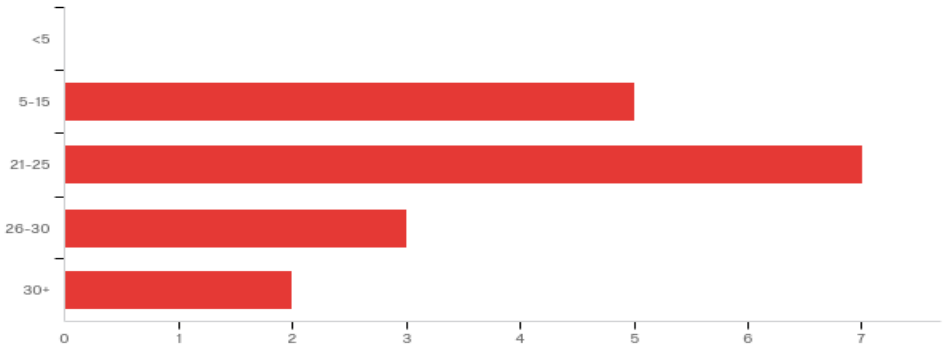
What did you find most helpful in the ACT written exam training program?

What do you think could be improved in the ACT written exam training program?

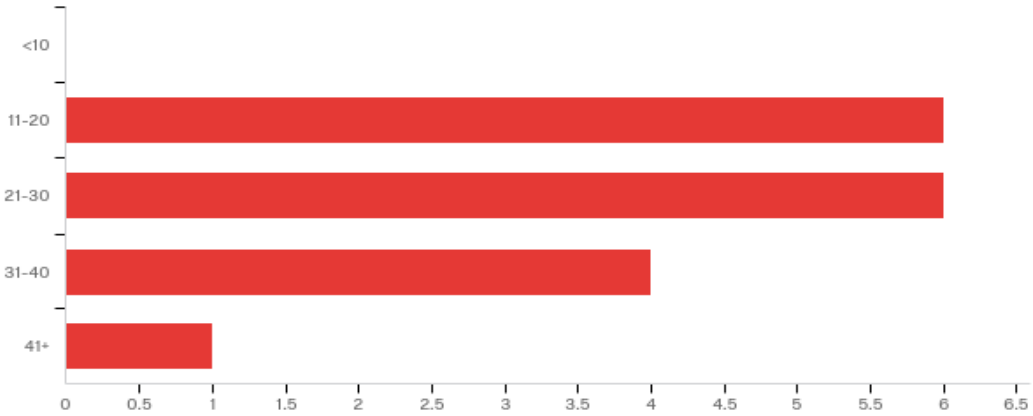
What do you think could be improved in the ACT written exam training program?

[redacted]

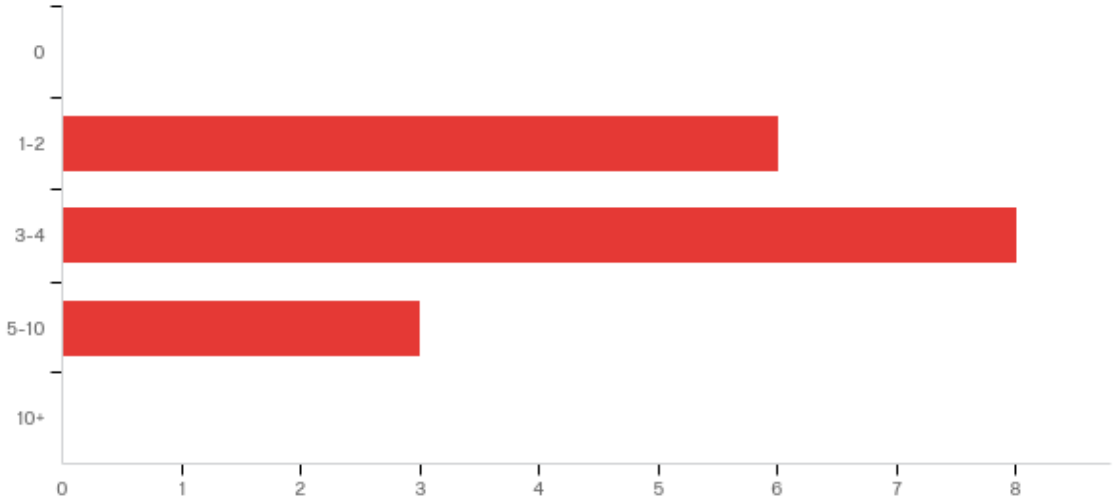
Please list the number of long cases done in the lead up to the exam (approximate).



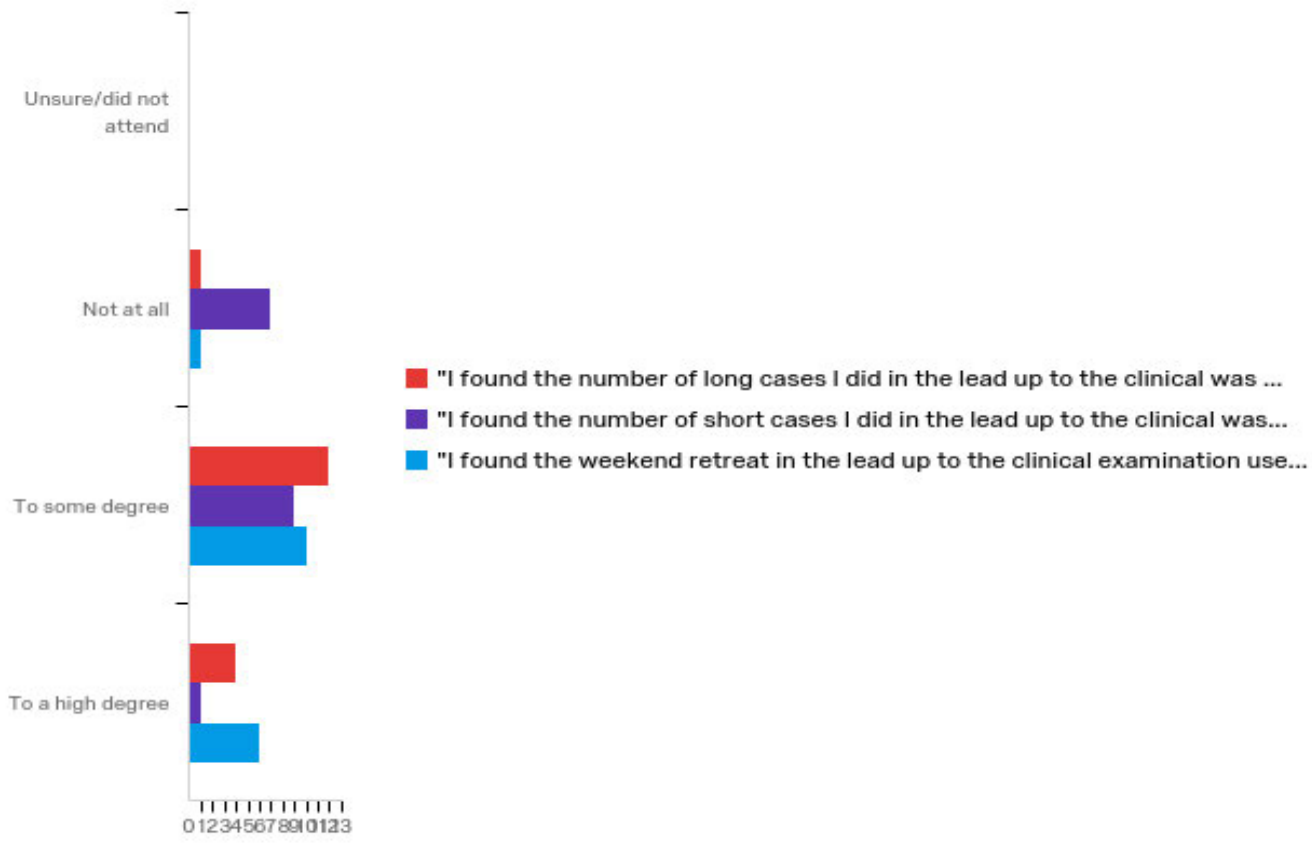
Please list the number of short case sessions attended in the lead up to the exam (approximate).



On average how many practise short cases per week did you personally do?

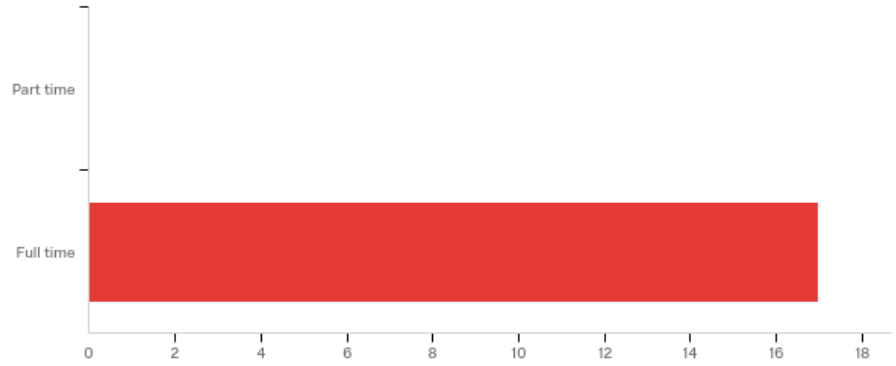


Please rate your response to the following statements.

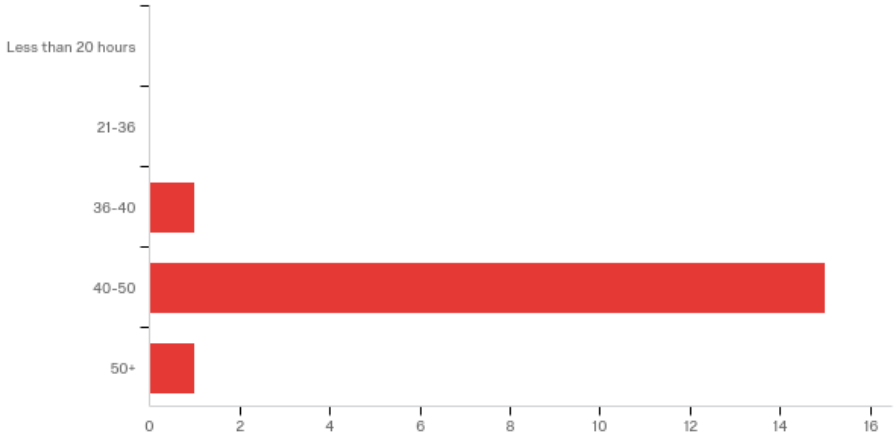


#	Question	Unsure/did not attend		Not at all		To some degree		To a high degree		Total
1	"I found the number of long cases I did in the lead up to the clinical was just right"	0.00%	0	5.88%	1	70.59%	12	23.53%	4	17
2	"I found the number of short cases I did in the lead up to the clinical was just right"	0.00%	0	41.18%	7	52.94%	9	5.88%	1	17
3	"I found the weekend retreat in the lead up to the clinical examination useful"	0.00%	0	5.88%	1	58.82%	10	35.29%	6	17

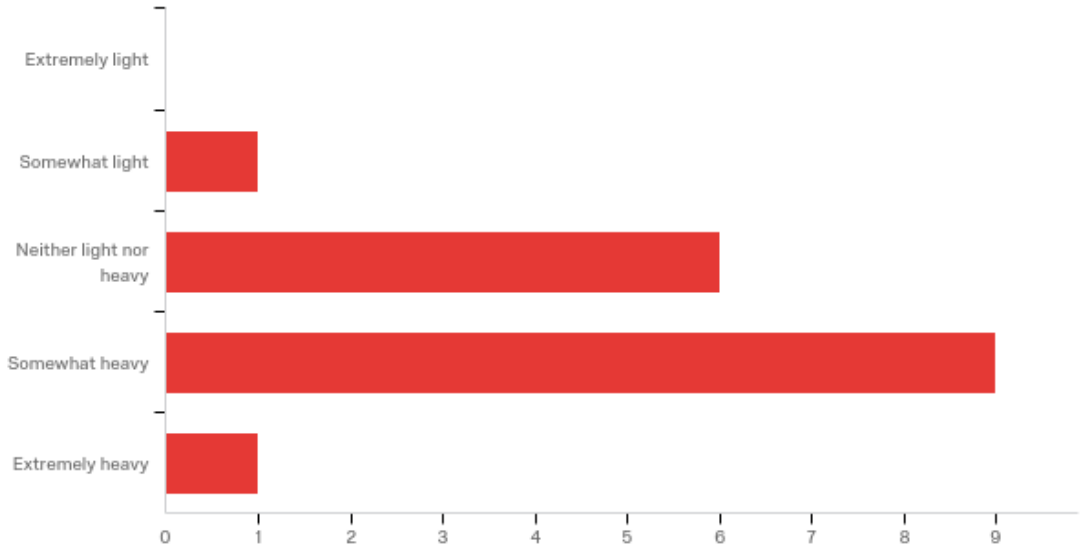
Do you work full time or part time?



On average, how many hours each week did you work in February until July 2019?

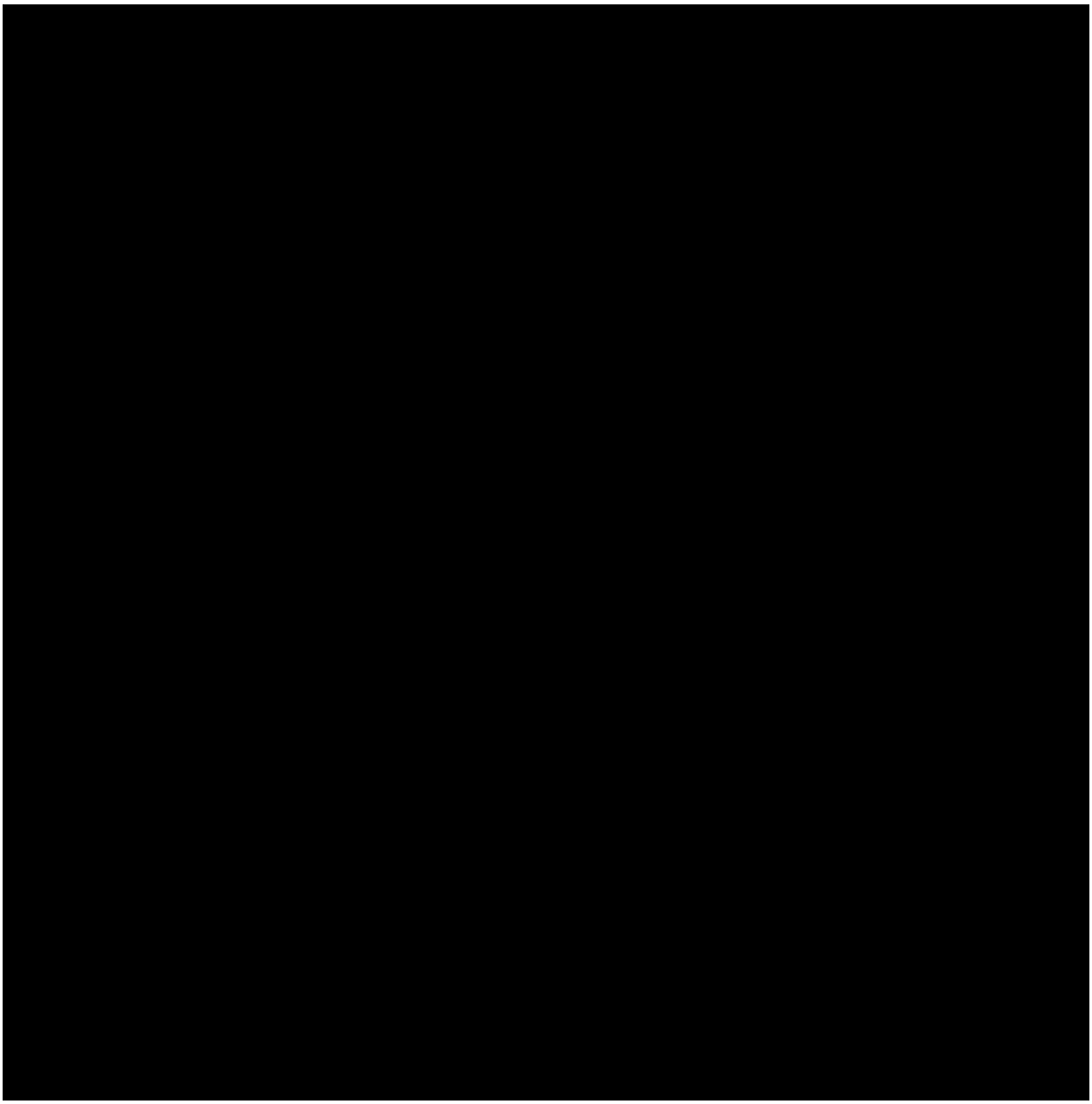


How would you rate your clinical workload from February until July 2019?

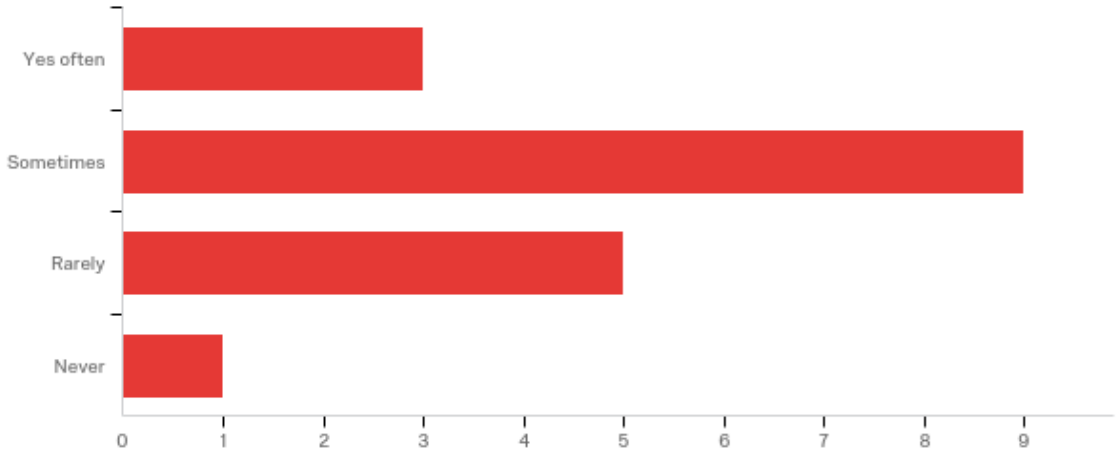


What clinical terms do you think best prepared you for the clinical examination? Why?

What clinical terms do you think best prepared you for the clinical examination? Why?



Did you attend outpatient clinics as part of your clinical responsibilities?



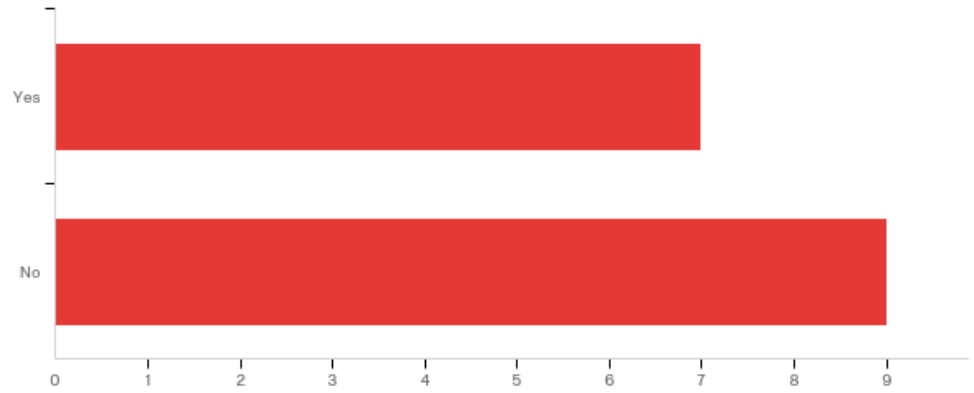
Did you have access to holidays? ADOs? Were you given study leave? Please give details.

Did you have access to holidays? ADOs? Were you given study leave? Please give details.

[redacted]

[redacted]

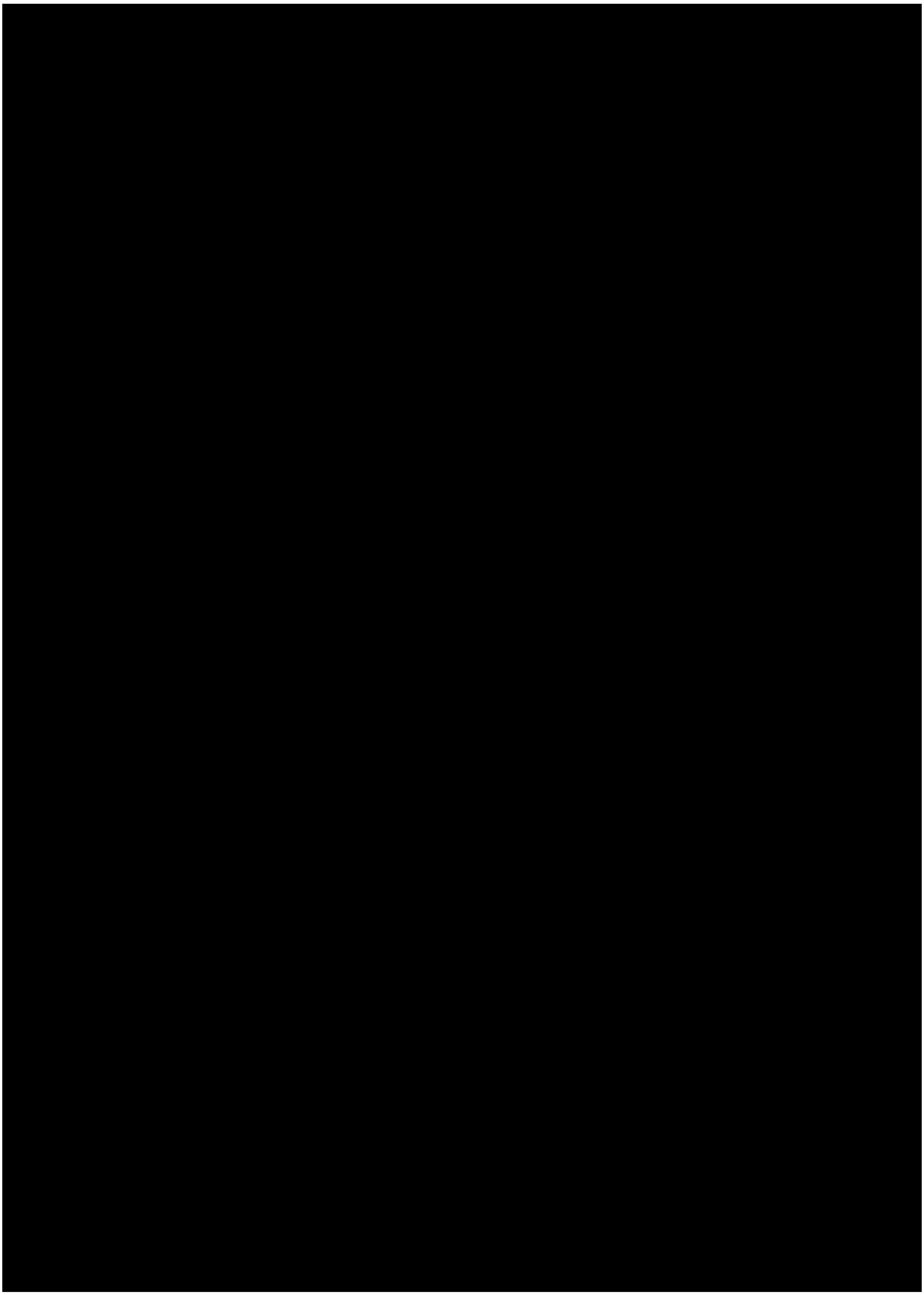
Would you recommend your BPT network to a junior colleague?



Why/ Why not?

Why/ Why not?

[redacted]



[redacted]

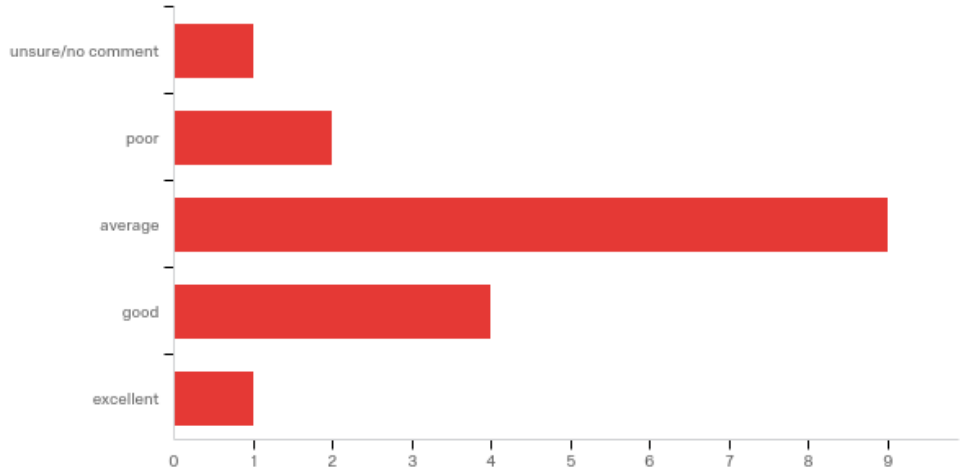
Describe how much of the teaching occurred in protected teaching time. Please comment on the impact of non-protected teaching time for tutorials / teaching sessions.

Describe how much of the teaching occurred in protected teaching time. Please comment on the impact of non-protected teaching time for tutorials / teaching sessions.

[redacted]

[redacted]

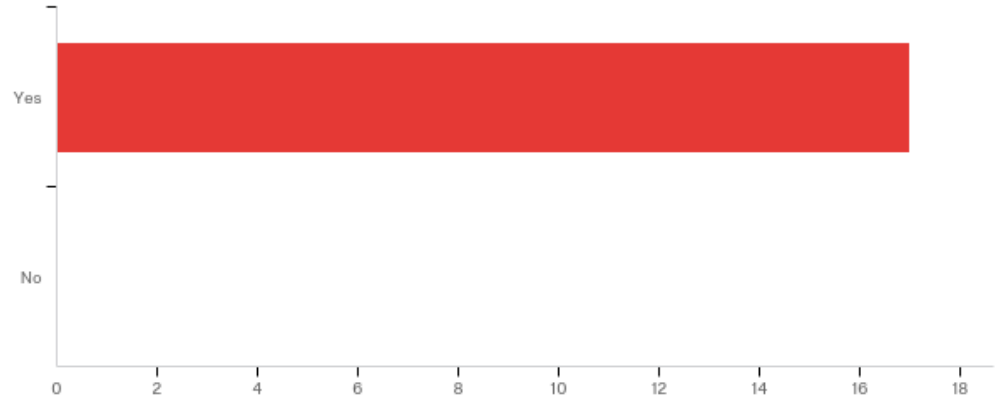
Please rate the administrative support in regards to the training program.



Please describe the impact of your work roster on your exam preparation - did it help or hinder in your opinion. Why?

[redacted]

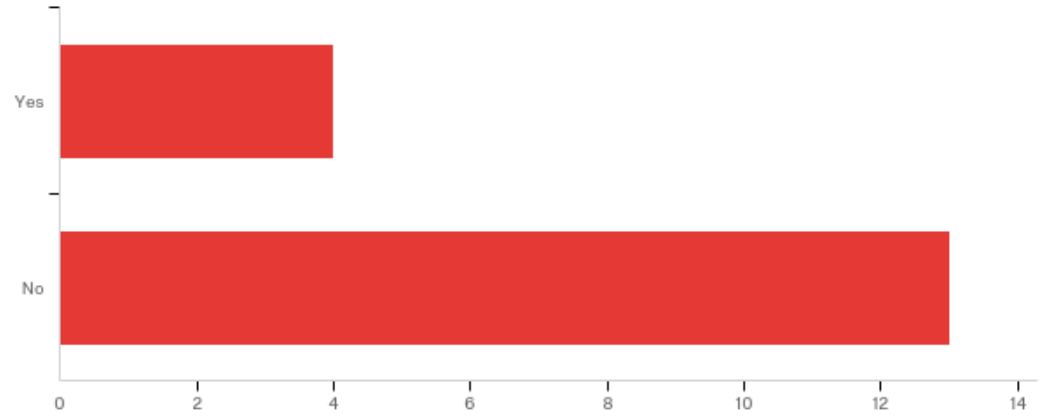
Did you have a consultant clinical examination mentor?



How often did you meet your mentor? Did you keep the same mentor for the entire period?

How often did you meet your mentor? Did you keep the same mentor for the entire period?

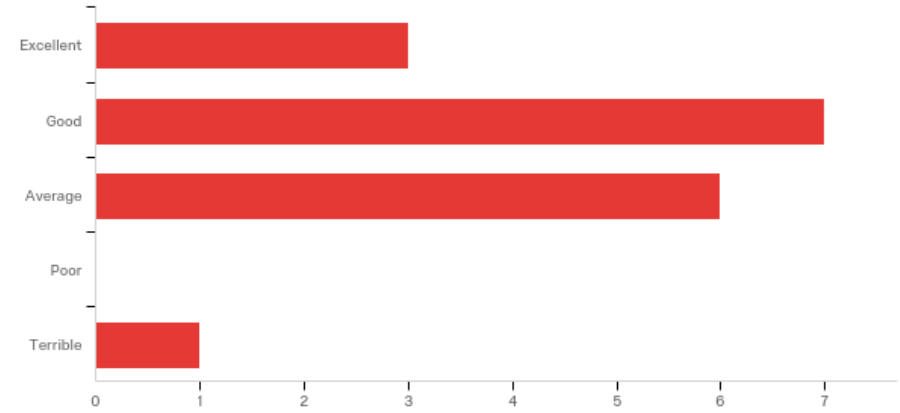
Did you have an advanced physician trainee (AT) mentor?



How often did you meet your AT mentor? Did you keep the same AT mentor for the entire period?

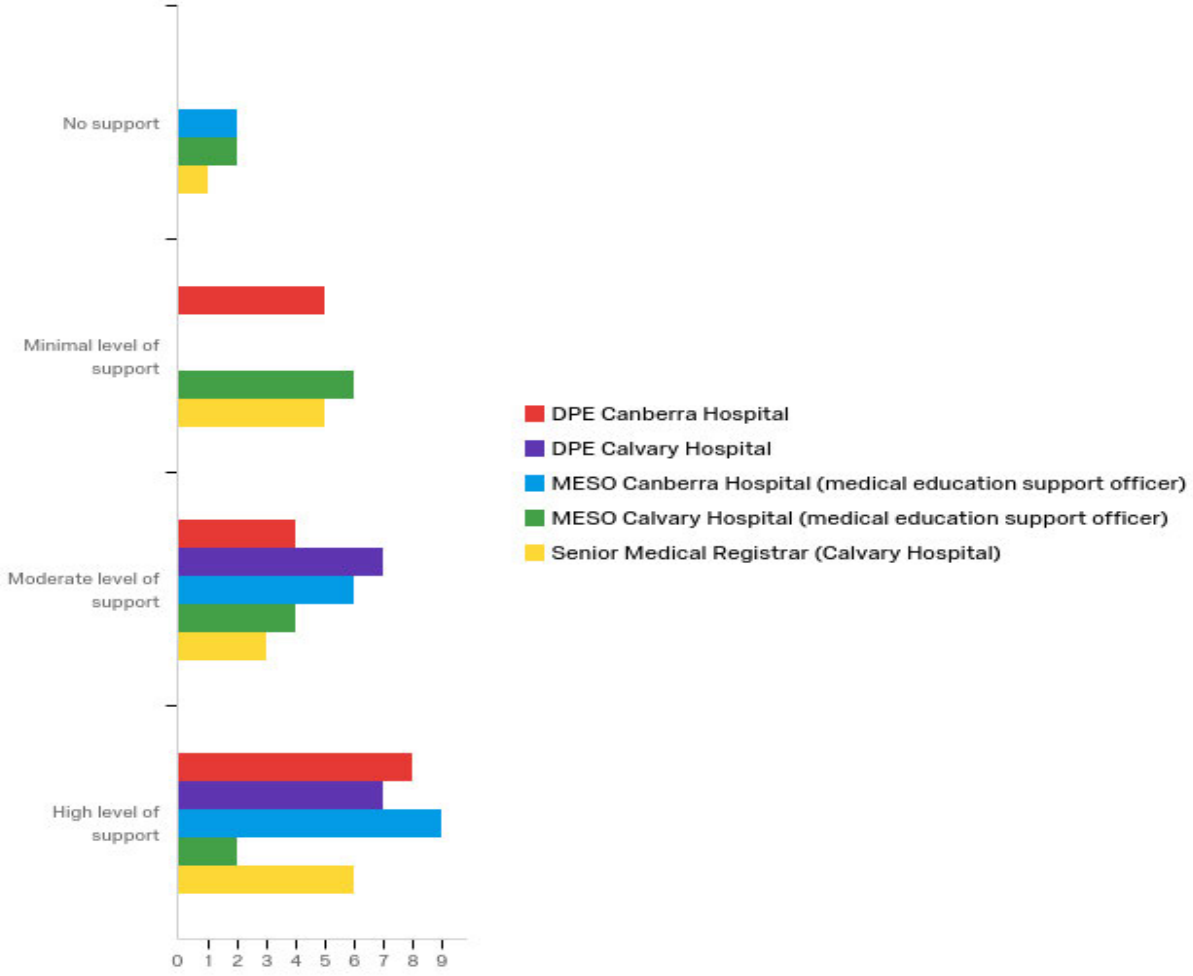
How often did you meet your AT mentor? Did you keep the same AT mentor for the entire period?

How would you rate the quality of your mentor program?

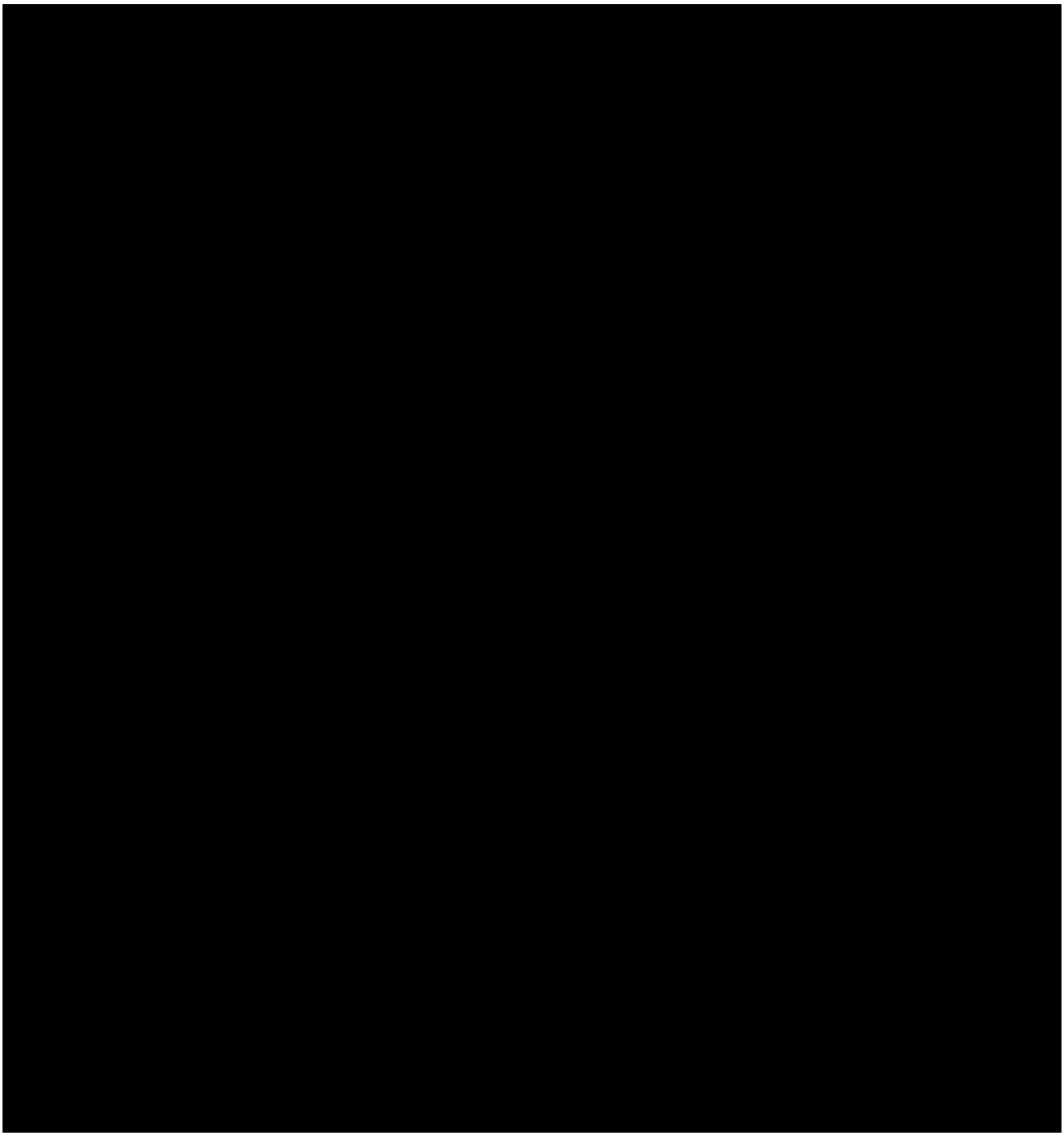


How would you do / suggest to improve the mentor program?

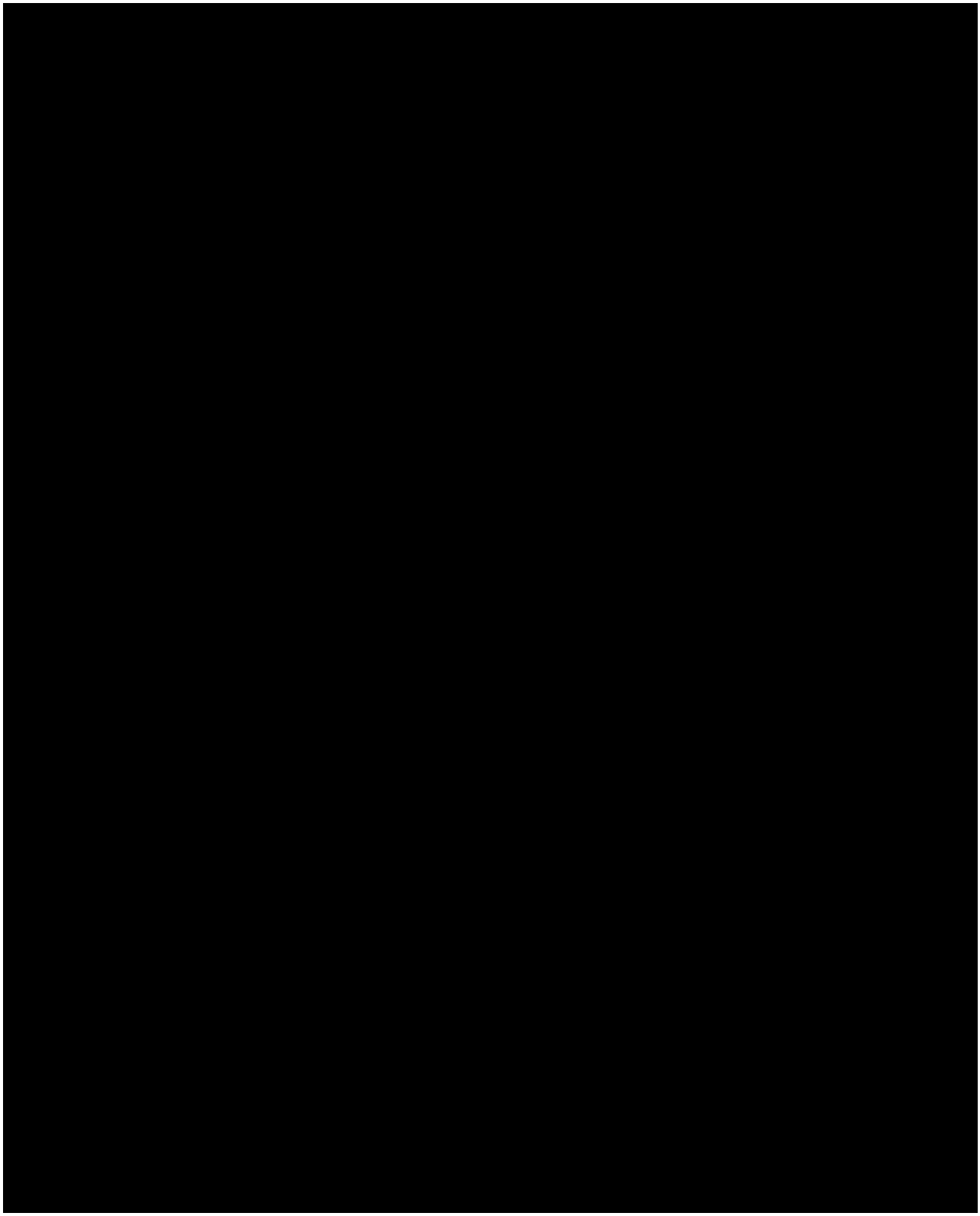
Please rate the level of support you received from the following people:-



How would you describe the teaching culture at Canberra and/or Calvary hospital?



How would you describe the level of camaraderie amongst your peers preparing for the examination? Please give details/examples.

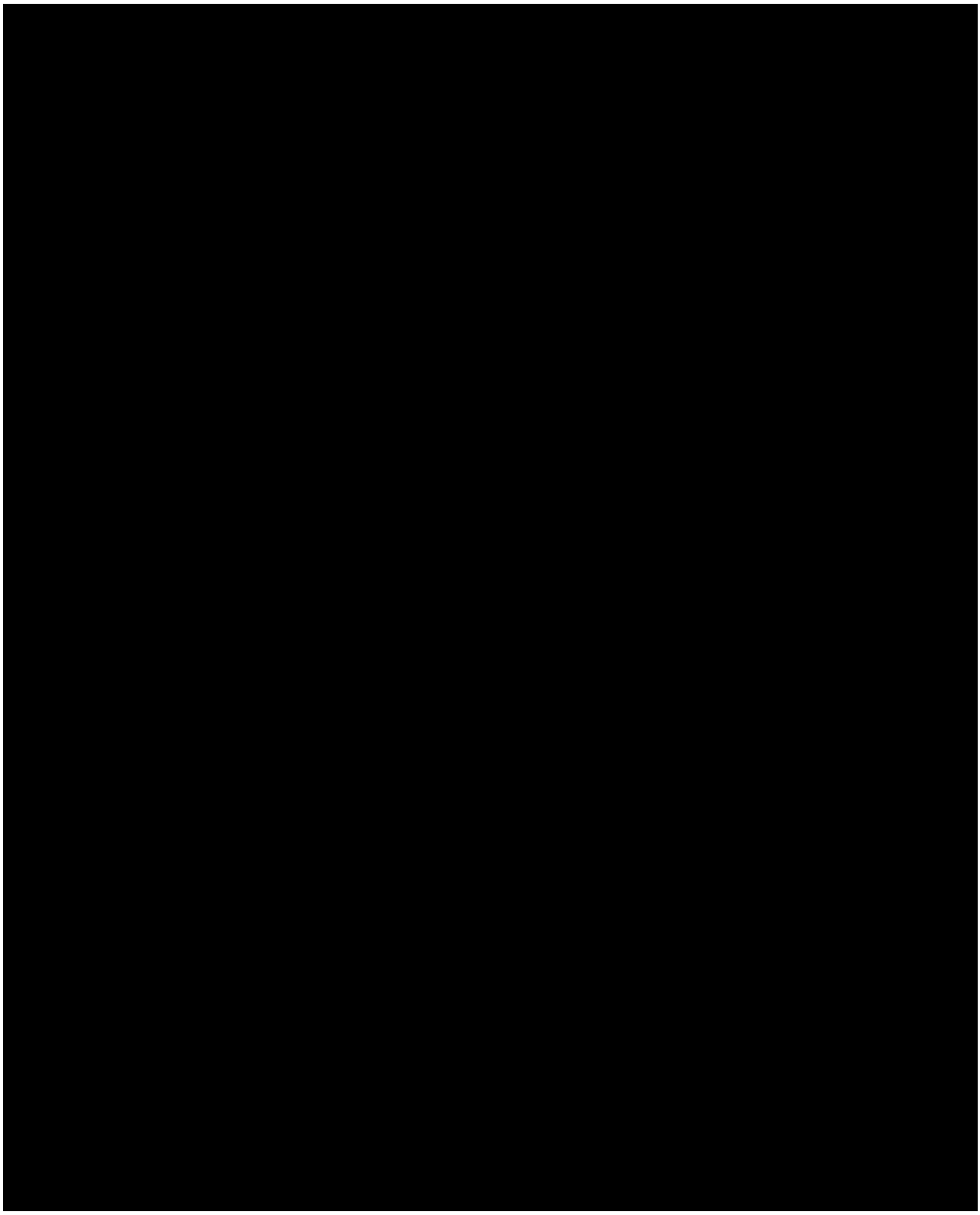


[redacted]

What are the three best things about being part of the Canberra Training Network?

[redacted]

If you could do just three things to improve your training program/workplace environment, what would they be?



SCHEDULE FOUR

Canberra Basic Physician Trainee Wellbeing 2019/20

	N	%
Trainee response	38/52	73.1%

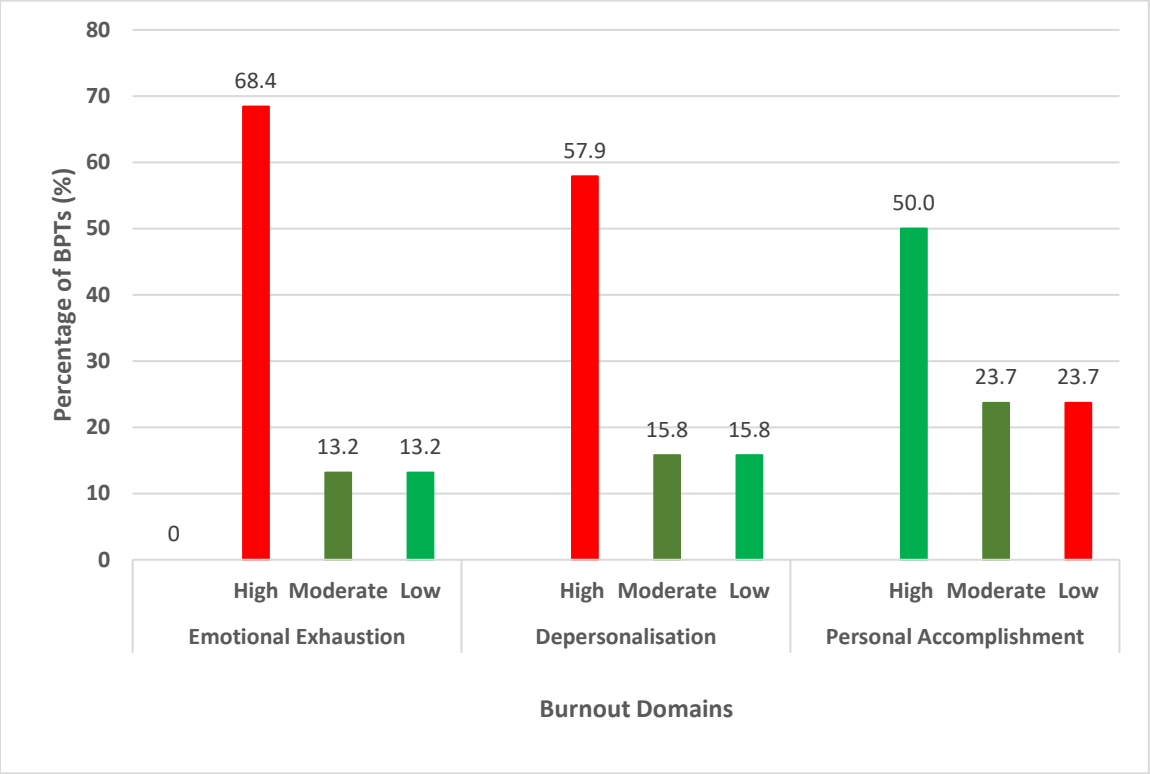
[redacted]

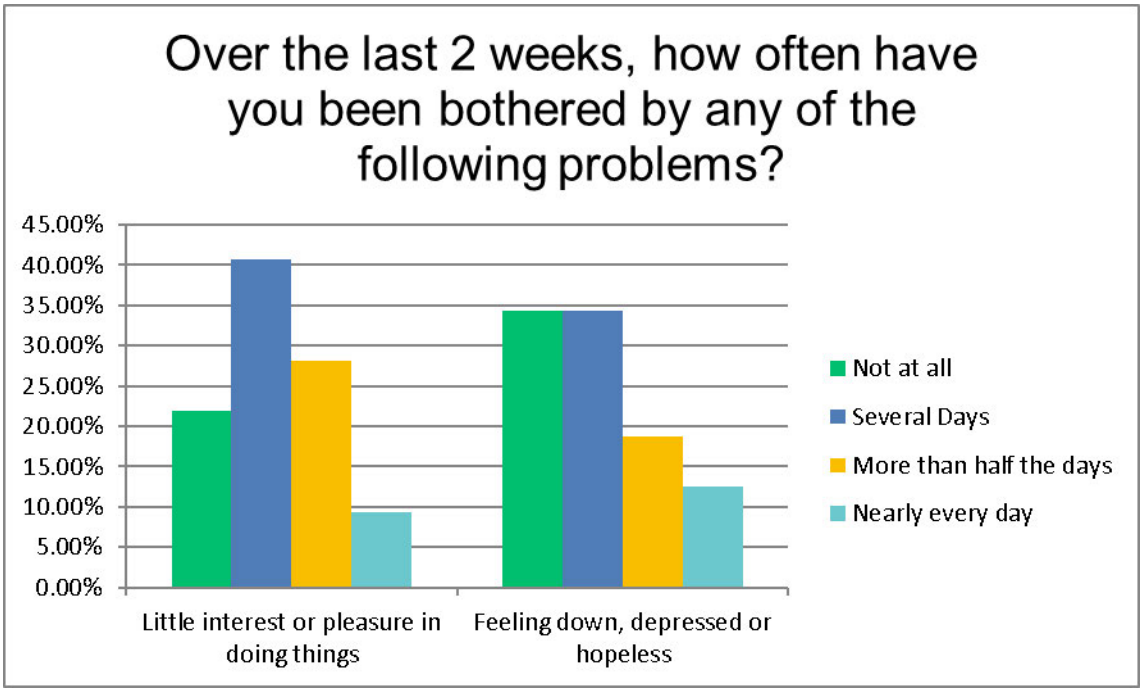
			International Average
Burnout (MBI-HSS EE ≥27 and/or DP≥10)		78.9%	51%*
Emotional Exhaustion		%	
	High	68.4	
	Moderate	13.2	
	Low	13.2	
Depersonalisation			
	High	57.9	
	Moderate	15.8	
	Low	15.8	

Personal Accomplishment

High	50.0
Moderate	23.7
Low	23.7

*Rodrigues H, Cobucci R, Oliveira A, Cabral JV, Medeiros L, Gurgel K, et al. (2018) Burnout syndrome among medical residents: A systematic review and meta-analysis. PLoS ONE 13(11): e0206840. https://doi.org/10.1371/journal




Over the last 2 weeks, how often have you been bothered by any of the following problems?
45.00%
40.00%
35.00%
30.00%
25.00%
20.00%
15.00%
10.00%
5.00%
0.00%
Little interest or pleasure in doing things
Feeling down, depressed or hopeless
Not at all
Several Days
More than half the days
Nearly every day