College of Intensive Care Medicine
of Australia and New Zealand

ACCREDITATION SUBMISSION TO THE AUSTRALIAN MEDICAL COUNCIL | March 2015

College Details

Name: College of Intensive Care Medicine of Australia and New Zealand (CICM)

Address: Suite 101, 168 Greville Street PRAHAN VIC 3181

Date of last AMC accreditation decision: 2011

Periodic reports since last AMC assessment: 2012, 2013, 2014

Re-accreditation due: 2015 (follow-up assessment)

This report due: 30th March 2015

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1. THE CONTEXT OF EDUCATION AND TRAINING

Accreditation Report recommendations and AMC feedback on progress reports

CC	***Put in place structures to support constructive working relationships with health departments and health services at the strategic and senior level to support high quality education and training in intensive care medicine. (Standard 1.4)***

The AMC suggests that the College can still strengthen these relationships, particularly to advocate and inform medical workforce planning, particularly given a potential mismatch between the number of trainees and the available specialist jobs.

College response:

The College continues to work hard to strengthen relationships within the health sector generally. Being a relatively small college we are heavily reliant on our Fellows, particularly Board members, making themselves available to attend meetings, etc. One of the main opportunities for interaction with local health services is through the hospital accreditation process, where the College inspection team meets with senior administrative staff at each hospital. Every Board member is expected to participate in at least three inspection visits each year.

Some examples of the interaction between the College and health departments and health services are listed in (d), below.

The College continues to liaise with Health Workforce Australia (and now the National Medical Training Advisory Network) on workforce projections and planning. On 19 November 2014 the College, in association with the intensive care society (ANZICS), hosted a 'workforce summit' meeting in Melbourne, to discuss in detail projections for the supply and demand of intensive care specialists over future decades. Representatives from other medical colleges, the AMC and the Department of Health made valuable contributions to the meeting. A manuscript accepted for publication is attached as Appendix 1.

Summary of other matters to be addressed in the 2015 submission

a. A brief review of the College's governance structure.

The College's governance structure remains essentially unchanged. The Board of Directors consists of 10 members elected from the general Fellowship and one elected New Fellows Representative. Term of office is three years, and Board members may re-nominate for election for a total of four terms (i.e. 12 years) with the exception of the New Fellow Representative, who is limited to a single three year term.

Apart from the 11 elected Directors, there are a number of co-opted (non-voting) Board Members, for instance a trainee representative, who is an annual nomination from the Trainee Committee, and representatives from Regions that do not have an elected member. The Presidents of the Australian and New Zealand College of Anaesthetists and the Australian and New Zealand Intensive Care Society are invited guests at Board Meetings.

There have been no changes to the College Constitution and the only one that is currently contemplated is to allow electronic (rather than just postal) voting in College elections.

The Board delegates responsibility for certain activities to various committees. The College's committee structure has changed to some degree since 2011; the current structure is described below. Each of the major committees is chaired by a member of the Board. Minutes of each committee meeting and a verbal report from the Chair are received at every Board Meeting.

b. A list of committees with roles in the College's training, assessment and continuing professional development activities, any changes since the 2011 accreditation and an outline of plans for further development.

The principal committees involved with the College's training, assessment and professional development activities are as follows:

- Education Committee
- Assessments Committee
- Admissions Committee
- Censors Committee
- Hospital Accreditation Committee
- Fellowship Affairs Committee
- Trainee Committee
- Paediatric Intensive Care Committee

In 2014 the College established a Community Advisory Group, which also reports to the Board.

A summary of the activities of each of the above committees and their sub-committees follows:

The **Education Committee** is responsible for the implementation of Board policy and provision of advice to the Board on matters related to teaching and education of intensive care trainees, and co-ordination of educational activities. This includes curriculum development, evaluation and review; appointment and accreditation of supervisors; development of educational materials and courses and development of educational policy.

The **Assessments Committee** has been established to oversee the assessment modes of the College, to ensure coordinated and continuous assessment throughout the training program. Sub-committees are:

- First Part Examination Committee
- General Second Part Examination Committee
- Paediatric Second Part Examination Committee
- Formal Project Panel

The **Censors Committee** oversees all matters relating to trainee selection and progress through the training program. Sub-committees include;

- Trainee Selection Panel
- Overseas Trained Specialist Assessment Panel
- Trainee Performance Review Committee

The **Admissions Committee** is responsible for assessing all applications for admission to Fellowship.

The **Hospital Accreditation Committee** is responsible for ensuring that intensive care units accredited for training provide adequate facilities, case-mix, supervision and teaching. Based on these criteria, the committee determines the appropriate period of training allowable at each unit.

The **Fellowship Affairs Committee** is responsible for oversight of the College CDP program, major events including the Annual Scientific Meeting, health and welfare of Fellows, consideration of honours and awards, supervision of the College scientific journal *Critical Care and Resuscitation,* and external relations with bodies such as ANZICS. Sub-committees include:

- CPD Committee
- ASM Organising Committee
- Overseas Aid Committee

The **Trainee Committee** was formerly a sub-committee of the Education Committee, but now reports directly to the Board and has a representative attend Board Meetings. The Trainee Committee represents trainee interests in the affairs of the College, particularly with regard to matters concerning education and training.

The **Paediatric Intensive Care Committee** was established to represent the views of the paediatric intensive care section on all relevant committees of the Board, to make recommendations to the Board regarding all matters pertaining to paediatric intensive care medicine and to assist the Censor in all matters relating to trainees in paediatric intensive care.

The **Community Advisory Group** was established in 2014, to provide a mechanism by which the Board can receive advice and feedback from a consumer and community stakeholder perspective, on broad issues which relate to the training of intensive care medical specialists. The CAG has a diverse membership, including representatives from the general community and the Consumers Health forum, as well as from associations with a particular interest in intensive care, i.e. the Australian College of Critical Care Nurses and the Australian Association of Social Workers.

A strategic planning day was held after the recent February Board meeting to identify other developments required in the coming years.

c. College's assessment of resources available to support educational activities.

Over 2012 and 2013 the College undertook a major review and redevelopment of the curriculum. As a result of this review a number of resources were developed to support learning and assessment.

The online In-Training Evaluation Report (ITER) is the regular (six monthly) report back to the College on trainee progress. The ITER rates trainee performance in 23 items across the 8 CanMEDS domains of medical practice. The trainee and supervisor each complete the ITER independently, which is then available for joint viewing, feedback and discussion. Each trainee's ITER's are stored in their individual on-line portfolio, which can also be viewed by the current supervisor.

Trainees are now required to undertake six specific face-to-face courses (previously only one – the ADAPT course - in the old curriculum). A number of these are provided by external organisations.

The external courses are:

- An approved introductory intensive care medicine course (usually, the BASIC Course)
- Either the Organ and Tissue Authority's ADAPT Course or their Family Conversation Skills workshop
- An approved advanced airways skills course
- An approved introductory ultrasound/echocardiography course

Two of the mandatory courses have been developed and are delivered by the College to address specific requirements of intensive care training; these are the 'Communication Skills in Intensive Care' and the 'Management Skills for Intensive Care' courses.

To supplement the hospital based educational programs, the College has developed an on-line learning platform which is accessible to all trainees (and Fellows). Resources available include recorded lectures and presentations (e.g. from the ASM and other College meetings) and a number of e-learning courses made in-house for our trainees, for example 'Brain Death and Organ Donation' (made in collaboration with the Organ and Tissue Authority) and 'Neuro-trauma Intensive Care'.

CICM is a relatively small college with limited resources. However the staff employed specifically to support education and training activity has grown to now total six FTE. These are:

- Manager, Education and Training
- Admin Officer, Examinations
- Admin Officer, Education
- Admin Officer, Training
- Admin Assistant, Hospital Accreditation
- Admin Assistant, Training

These staff are supported by a further eight FTE involved in other College functions and administration.

The College also utilises specific medical education expertise. From 2012 to 2014 Dr Megan Dalton was employed to assist with the review of the curriculum and the development of the new assessment tools, and from January 2015 Dr Bruce Lister has been employed to further develop educational material and in particular to enhance supervisor education and engagement.

The College publishes its own scientific journal, *Critical Care and Resuscitation* (CC&R). The Scientific Editor of the journal is an eminent College Fellow, Professor Rinaldo Bellomo. CC&R is distributed free to all Fellows and trainees and serves as an important vehicle for publication of local intensive care scientific research, although as the journal gradually achieves greater international recognition, an increasing number of manuscripts are submitted from overseas. CC&R now has an impact factor of 2.51, which makes it the highest ranking journal in the field of critical care medicine, anywhere outside North America and Western Europe.

d. The College's relationships with health departments to promote the education, training and ongoing professional development of intensive care medicine specialists.

The College actively pursues opportunities to develop and maintain good working relationship with the Australian Commonwealth Department of Health and the corresponding departments in the state and territory jurisdictions, and also the New Zealand Ministry of Health. As a recently formed independent college with limited resources, this has been an area that presents some challenges, having to establish a profile, develop relationships and gain representation at a variety of levels and in existing organisations, committees and working parties.

Some examples of the activities the College is involved in include:

- Working with the Organ and Tissue Authority to develop education programs around death and organ donation, including the creation of an online training package, authored by College Fellows, which is now a mandatory part of CICM training.

- The CICM President is a member of the Committee of Presidents of Medical Colleges (CPMC) in Australia and attends their quarterly meetings. At each of these meetings there are presentations from and discussion with representatives of various statutory bodies including the Department of Health, the AMC, the Medical Board, AHPRA, the AMA and others. The College CEO attends the briefing sessions of the CPMC and the corresponding meetings of the other college CEO's.

- The College works closely with the Commonwealth Chief Medical Officer on matters and policy relating to intensive care issues, for example during influenza outbreaks and the recent Ebola epidemic.

- The College C.E.O. and the Director of Professional Affairs, Dr Felicity Hawker met with representatives of the workforce planning and policy divisions of the Victorian Department of Health in August 2014 to discuss intensive care workforce issues in Victoria.

- The Chair of the N.S.W. Regional Committee, Dr Deepak Bhonagiri and the College C.E.O. met with the Director of Workforce Planning and the Chief Medical Advisor from the NSW Ministry of Health in February 2015 to discuss trainee selection and recruitment for intensive care units in New South Wales.

- Assisting health services with accessing funds through the Department of Health Specialist Training Program (STP) and liaising with the Department on administration of the STP funded training positions.

- Working with the Rural Health Continuing Education Program on projects aimed at facilitating continuing education opportunities for rural specialists. The College has had four successful projects funded through RHCE grants.

- Contributing to the Australian Indigenous Doctors Association 2014 annual conference through participation in the 'Growing Our Fellows' workshop.

- Serving as the Vocational Education and Advisory Body for intensive care medicine with the Medical Council of New Zealand.

- The College has representatives on many national and state committees and advisory bodies, including the Australian Resuscitation Council (the Chair of which is A/Prof Peter Morley, a College Board member), the National Blood Authority, the Australian Council on Healthcare Standards Clinical Indicator Report, the Royal Australasian College of Surgeons Road Trauma Committee. In New Zealand, there are representatives on the Perioperative Mortality Review Committee, the Quality & Safety Improvement Commission, the National Cardiac Surgery Network and the New Zealand Resuscitation Council.

- Contributing to the Medical Training Review Panel's annual report on medical workforce data.

- Interaction with multiple health facilities through the accreditation process. At the hospital level, this accreditation process is a major strength. In accrediting ICUs for training, the College works with healthcare institutions and ensures that teaching and supervisory roles are properly resourced (refer Section 8.2 for detail). On several occasions, when withdrawal of College accreditation seemed inevitable because of resource or organizational issues, the College has worked with local, state and national authorities closely and cooperatively to address the issues so that training could continue in an appropriately resourced environment.

- At the state level, representatives of the College sit on advisory intensive care committees in most states. These Committees usually review allocation and utilization of ICU resources, but are also an avenue for College representatives to discuss issues such as specialist and registrar staffing and potential conflicts between service and educational requirements. Such conflicts occur rarely in the Australian intensive care setting, and are addressed by the College on an individual hospital basis.

- The College works closely with other educational and professional bodies on matters pertaining to critical care education and ongoing professional development, particularly the local colleges of anaesthetists (ANZCA), emergency medicine (ACEM) and physicians (RACP) and the intensive care society (ANZICS). We have a number of joint policy statements with these bodies and also a number of joint educational initiatives, including a working party with RACP to explore the development of an accelerated pathway to joint Fellowship.

e. Challenges for the College and strategies to address them.

One of the current challenges for the College is to address the recent prevailing perception of a mismatch between the number of trainees entering the program (and the number of graduates) and the demand for intensive care medical specialists. This situation arises because of the high requirement for intensive care registrars to provide 24 hour coverage in the unit (along with safe work hours restrictions), which, in contrast to many other medical specialties, leads to a high capacity to train. The College has discussed the situation at length at Board level and has consulted widely with the Fellowship (by use of surveys and through the recent workforce summit). Recent changes to the curriculum and the Trainee Selection Policy will have some impact on trainee numbers, the College will continue to monitor the situation.

Other challenges include:

- Compared to some other colleges, CICM is relatively under-resourced and continuing to improve our level of interaction with other health service organisations, and external relations generally, is an ongoing challenge. We rely very heavily on the goodwill of our Fellows, in particularly Board Members, who give their time freely to these activities.

- The new curriculum for training was introduced at the start of 2014, for new trainees (trainees registered prior to 1 January 2014 remained on the old curriculum). So far the transition to the new curriculum has been very smooth, but as yet the new trainees are only part way through the program and we will need to continue to closely monitor trainee progress with certain aspects of the new curriculum, for instance when trainees start to reach the Transition Year of training.

- There is some debate within the intensive care community around the most desirable ‘model’ for an intensive care service, for example to what extent the unit should provide services (Rapid Response or Medical Emergency Teams) to other areas in the hospital, the involvement of trainees in retrieval (emergency transport) services, whether units should have 24 hour on-site consultant cover, etc. Although these are heavily dependent on hospital and jurisdiction policy, they have implications for training and ongoing development of the curriculum.

- Intensive Care Medicine is frequently perceived as a ‘hard’ and ‘family unfriendly’ career choice, due to requirement for 24 hour care. There is a high rate of burn-out in Fellows and the College has addressed this to some degree in its policy on ‘The Practice of Intensive Care Medicine and the Older Intensive Care Specialist’. However, the College is also aware of the current lack of gender balance at both Fellow and trainee level and will continue to pursue means to rectify this.

f. For each of the categories of fellowship and membership, information on the current numbers of fellows/members.

CICM only has one category of membership, which is Fellows of the College. At 20 January 2015 there were 912 active Fellows and 63 retired Fellows, 975 members in total. Their geographic distribution is as follows:

Australia	**768**
New South Wales	237
Victoria	178
Queensland	161
Western Australia	76
South Australia	73
Australian Capital Territory	21
Tasmania	15
Northern Territory	7
New Zealand	**89**
Hong Kong	**26**
Ireland	**24**
United Kingdom	**23**
India	**11**
United States of America	**10**
Other	**24**

2. ORGANISATIONAL PURPOSE AND PROGRAM OUTCOMES

2011 Accreditation Report conditions and AMC feedback on progress reports

5	***Provide evidence of processes for regularly reviewing the statement of graduate outcomes in relation to community need. (Standard 2.2.1)***

The AMC had previously requested an update regarding the Community Advisory Group. It is early days for this group and they have only met once a few months ago.

The survey of recently graduated Fellows is noteworthy. In particular addressing the issue that newly graduated Fellows who take up posts in rural and provincial settings may be confronted with paediatric issues for which they had not received any specific training.

College response:

The Community Advisory Group (CAG) held their second meeting on 15TH October 2014. The minutes of the last meeting are attached at appendix 2. The CAG are being asked to review various College policy documents from the perspective of community need and will review the College Definition of an Intensive Care Specialist (i.e. the statement of graduate outcomes; appendix 3) at the next meeting, which will be held In April 2015. The College believes that this will go a long way towards meeting Standard 2.2.1, particularly if the statement of graduate outcomes is reviewed by the Committee on a regular basis. It may be that the CAG recommends other strategies to review the statement according to community need. The College will provide additional information to the Accreditation Team after the meeting in April.

The College has acted on feedback from various sources (including feedback from the annual survey of newly graduated fellows) and paediatric experience is now mandated in the new curriculum (for trainees commencing after 1 January 2014). Although it has always been possible for trainees to seek out training positions that provide paediatric experience, mandating this experience will, in time, allow all Fellows to deal better with paediatric issues should they take up posts in rural and provincial settings.

Summary of other matters to be addressed in the 2015 submission

a. The purpose or mission of the College.

The College has made no changes to its purpose or mission since its formation in 2010. The 'Objects of the College' form the preamble to the Constitution which is available for public viewing on the College website.

b. The College's statement of graduate outcomes for training programs.

No changes have been made to the College's definition of an intensive care specialist (statement of graduate outcomes) since 2010. As discussed above the College plans to have the CAG review the statement of graduate outcomes in April this year. However, if a slightly broader interpretation of statement of graduate outcomes is made, there have been some developments. The Competencies, Learning Opportunities, Teaching and Assessments for Training in General Intensive Care Medicine document (previously submitted in the College's 2013 annual progress report), was revised in 2011 as part of the curriculum review. A similar document is being developed specific to paediatric intensive care medicine. The Objectives of

Training for the anaesthesia and medicine terms were last updated in 2010, and the Objectives of Training for the Transition Year was developed in 2013. Together these documents define the knowledge and skills expected of an intensive care specialist at the completion of their training. These documents are all available on the website.

The regular in-training evaluation report (ITER) is constructed along the lines of the seven CanMEDS roles of medical practice with a total of 23 items (key competencies) to be assessed. These items reflect the listed objectives of training and specific performance indicators for each item and at the top end of the scale describe the performance required of a Fellow. In that sense, a trainee who progresses to the point of performing at the standard required of a Fellow in each of the items (and each of the CanMEDS roles generally) could be said to have achieved the desired graduate outcome.

The 2014 survey of new Fellows showed that 81% thought their training prepared them adequately for taking on the role of consultant and 12% thought their training prepared them very well. More specifically, new Fellows felt that the 'medical expert' role was the one they were best prepared for, with some of them feeling that they were not as well prepared for other aspects of becoming a consultant, for example the 'manager' role. It will be interesting to see when the new curriculum has been in place for a few years and the new graduates have undertaken the Transition Year of training (and the College Management Skills course) whether this impacts significantly on the results of the survey. In summary, the results of the survey seem to indicate that the perception of the new graduates is that they are overall well trained for their role as a consultant and meet the expectations of their patients, employers and the community in general. A report on the New Fellows' survey can be found here.

c. Any other planned developments that relate to Standard 2.

The College is aware that the practice of intensive care medicine, as with all other medical specialities, is a dynamic field and changes in available technology, research findings, health service organisation (for example) will impact on the requirements of training. The College believes that the recent review of the curriculum has brought the training program up to date and reflective of current best practice in intensive care medicine. However, there will inevitably be further developments which need to be taken into account. One example is the gradual formalisation within health services of 'Rapid Response' or 'Medical Emergency' teams, which are often sourced from the intensive care unit. At this time there is no formal requirement for trainees to spend time training as part of a Rapid Response Team, but the College will continue to monitor the situation and may possibly in future change the training requirements to include this.

3. THE EDUCATION AND TRAINING PROGRAM – CURRICULUM CONTENT

Summary of matters to be addressed in the 2015 submission

a. A summary of how the College's plans for curriculum change, and any major changes to those plans since 2011. Append the College's Training Handbook or other documents that detail the learning objectives, curriculum and mandatory training requirements.

The College introduced a new curriculum for all trainees commencing training from 1 January 2014. Separate information is available for trainees commencing training before and after this date. The Guide to CICM Training is available on the website and has been edited to make it applicable to all trainees (regardless of which curriculum is relevant to them).

The College document Competencies, Learning Opportunities, Teaching and Assessments for Training in General Intensive Care (published February 2012) outlines the educational objectives and outcomes, details the nature and range of clinical experience required to meet these objectives, and outlines the syllabus of knowledge, skills and professional qualities to be acquired. A separate but similar document outlining the Competencies, Learning Opportunities, Teaching and Assessments for Training in Paediatric Intensive Care is at an advanced stage of development. A face-to-face workshop will be held in August 2015 chaired by the Education Director of Professional Affairs (Dr Bruce Lister) to finalise the content.

As previously reported the Objectives of Training are published on the website for the Anaesthesia Term, the Medicine Term and the Transition Year.

Mandatory requirements of the curriculum are clearly outlined on the website for trainees commencing before and after 1 January 2014. A summary of the requirements of the new curriculum is as follows:

TRAINING TIME
The training program is 6 years, consisting of a minimum of 42 months spent in accredited intensive care medicine training, 12 months of Anaesthetics, 12 months of Medicine (including 6 months of Emergency or Acute Medicine) and 6 months in an elective placement. At least 3 months of training must be undertaken in a rural hospital.

Intensive Care Training Time
The required 42 months of specific intensive care training is divided into three stages:

- Foundation Training of 6 months, undertaken prior to selection into the program
- Core Training of 24 months, after completion of the CICM First Part Examination
- Transition Year of 12 months, after completion of the CICM Second Part Examination

ASSESSMENTS
Examinations
Trainees are required to successfully complete the CICM First Part (Primary) Exam and the CICM Second Part (Fellowship) Exam.

In-Training Evaluation Reports
Regular (six monthly) reports from supervisors monitor trainee progress via an on-line In-Training Evaluation Report (ITER).

Workplace Competency Assessments
Trainees are required to satisfactorily complete a number of specific Competency Assessments. The required WCA's are: ventilator set-up; insertion of central venous catheter; brain death certification; insertion of inter-costal catheter; communication skills; performance of tracheostomy.

Observed Clinical Encounters
Trainees are required to satisfactorily complete a minimum of eight Observed Clinical Encounters (akin to 'Mini CExs'), two during each six months of Core Training.

Formal Project
All trainees must satisfactorily complete the requirements of the Formal Project. The Project must be submitted for assessment prior to commencing the Transition Year.

REQUIRED LEARNING ACTIVITIES
Trainees must complete a number of specific learning activities at each stage of training, either through attendance at specified courses or by completing on-line learning packages.

Courses
- An introductory intensive care medicine course
- The College Communication Skills course
- An advanced airways skills course
- An introductory echocardiography and ultrasound course
- Either the Medical ADAPT course or the Organ and Tissue Authority Family Donation Conversation workshop.
- The College Management Skills course

Online Learning
Trainees will be required to complete a number of online learning activities. In most cases these will be through the College online learning system, but in some cases may be external courses (e.g. the Mauriora Foundation Course in Cultural Competency)

b. The College's critical analysis of its progress against its own plans for curriculum development, curriculum challenges remaining and strategies to address them.

After the completion of the curriculum review the overseeing committee was dissolved and it was agreed that any remaining tasks would fall to the existing committees of the College, mainly the Education Committee. In addition, the College has formed the Assessments Committee responsible for the development and monitoring of all College examinations, ITERs, Workplace Competency Assessments (WCA's) and Observed Clinical Encounters (OCE's).

Fifty-seven trainees enrolled in the new program in 2014. At this stage only four have commenced core training in intensive care medicine. The number of submitted WCA and OCE forms is too small to complete any meaningful analysis at this stage. In the same vein it will be some time before the impact of the new curriculum on, for example, pass rates in the Second Part examination become apparent.

On the other hand the College has carried out a very robust analysis of the submitted ITER's (which are completed for all trainees). There have been over 900 ITER submissions in the first year of operation and in that time three upgrades have been made based on user feedback. There is a dedicated section in the bi-annual trainee survey that asks users to describe their experience with the ITER and to offer any suggestions for improvement.

Simultaneously with the launch of the ITER the College created an internal "IT enhancement log" that all staff are required to update after receiving feedback from key stakeholders (trainees, College supervisors, other supervisors, Fellows at large). Additionally, a dedicated CICM Assessments email address has been set up to assist users and give them the opportunity to request change. In an effort to ensure the introduction of the new curriculum is smooth, College staff respond to enquiries immediately.

As the number of trainees progressing through the new curriculum increases, there are a number of components that will require careful monitoring by the College, including how readily trainees are able to complete the required rural and paediatric components, whether the increased requirement for workplace based assessments imposes an additional workload on supervisors (and other Fellows involved in supervision) and how well placements for the Transition Year fit the objectives of that term.

c. Information on the numbers and % of trainees who seek and are granted RPL, and the periods of RPL granted.

Many College trainees are granted RPL, usually for the anaesthesia, medicine or elective components of training. The conditions are detailed in the College Regulations that are available on the College website.

From 2011 to 2014, The College had a total of 764 applications to the College's training program. Please see below a year by year analysis.

Year	Number of applications	RPL granted for previous training (minimum 3 months)	RPL granted for exemption from First Part Exam
2011	148	138 (93.2%)	89 (60.1%)
2012	226	213 (94.2%)	117 (51.8%)
2013	364	344 (94.5%)	133 (36.5%)
2014	26*	26 (100%)	1 (3.8%)

Note: data refers to fully completed assessments

d. An outline of plans for further development of the education and training program.

Below is a summary of the major projects the College has identified as crucial for further development of the new curriculum.

Short-term projects:

- New trainee dashboard – The business requirements have nearly been finalised and this will give all trainees the ability to see what requirements they have completed but more importantly what they have left to complete. This will also include important information on examination attempts.
- Finish developing all online courses and make them available for trainees and Fellows.
- The College is in the process of developing a policy document explaining RPL and how this is applied by the Censor.

Mid-term projects:

- Continue to develop the ITER and make improvements accordingly. A focus will be the statistical analysis of trainee, supervisor and hospital performance.
- Take WCAs and OCEs online using similar technology to the ITER. The WCA and OCEs will be geared towards hand held devices such as an iPad that can be used in the unit and at the bedside.

Long-term projects:

- Online submission of Formal Projects for trainees.

4. TEACHING AND LEARNING METHODS

2011 Accreditation Report recommendations and AMC feedback on progress reports

FF	***Develop methods for continuous monitoring of the quality of the teaching program on a more frequent basis than the seven-year accreditation cycle. (Standard 4.1.1)***

It is recognised that site accreditation process is resource intensive and that this is an issue for all colleges. Reducing the cycle to five years may partially address the issue of continuous monitoring of the quality of the teaching program.

It is pleasing to note the collaboration with ANZICS and it is recognised that this will go some way to ongoing monitoring of minimum (clinical) standards.

The AMC notes the Quality of Training Survey used for trainees to provide feedback on teaching and supervision at the end of their training term. The College states that trainee feedback received from these surveys has not raised issues requiring College intervention, however the survey responses indicate that trainees have had issues such as bullying during their term. The AMC has asked for further information about the survey outcomes (see response to condition 9).

College response:

As noted above the College has reduced the accreditation cycle from every seven years to every five years, which will have a positive effect on the ability of the College to monitor the quality of its training program. By far the best source of information is however, the Quality of Training survey that is circulated to all trainees twice yearly in February and August.

This survey is referred to in numerous parts of this submission (Standards 4, 6, 8.1 and 8.2). It is potentially the most relevant to Standard 8.2 and is discussed in detail in that section. It was first conducted in 2011, and has been sent out on a six-monthly basis since 2013. The response rate has generally been of the order of 40%. The findings of the most recent survey in September 2014 are shown in appendix 4. The areas covered included clinical experience, teaching provided, supervision provided and trainee administration and resources. Ninety-one per cent said they would recommend the term to a colleague.

With respect to teaching, 65% of respondents were satisfied with the teaching provided during the term and 35% thought the teaching in their unit could be improved. Areas said to be deficient were non-technical and management skills teaching, and access to teaching when rostered to clinical duties or night shift. The College has addressed the former issue to an extent with the new curriculum that requires a 'Transition Year' (that has a major focus on the acquisition of non-technical and management skills) and learning modules and a WCA involving communication skills. Access to teaching sessions when rostered on is a more difficult problem to address because of the unpredictable and urgent nature of intensive care practice.

Bullying was noted in several free text responses. As noted under Standard 8.2 four trainees chose to supply their contact details. Each was contacted by telephone and none chose to take the matter further by requesting formal College involvement.

Until 2015, this survey has been anonymous – mostly because of the widely held view that trainees will not feel able to make an adverse response or comment if they can be identified, perhaps jeopardising their future in the specialty. This has meant the College has not been able

to address any of the specific issues raised, except in the rare instances where a trainee has requested follow up from the College.

The survey circulated in February 2015 underwent a number of changes. Several new questions have been added (teaching skills of teachers, quality of feedback, presence of mutual respect during the term, bullying etc.). More importantly the survey now asks trainees to identify themselves and their training rotation. This decision was not taken lightly and involved discussion with the Trainee Committee. Trainees have been assured that no action will be taken without their consent. However, it is possible that the response rate will drop significantly. The findings of this survey should be available in April/May 2015.

The agreement with ANZICS for the College to receive annual updates from their ICU data collection process will be a valuable mechanism for the College to monitor on a yearly basis any changes to unit staffing, patient numbers, infrastructure and case-mix. This will then inform the accreditation process and if deemed necessary, trigger inquiry from the College or accelerate the usual inspection cycle.

Summary of other matters to be addressed in the 2015 submission

a. Summarise the teaching and learning methods used in the different components of the program and identify any changes as a result of the curriculum development.

Clinical Attachments

The program involves a number of components for which the trainee is employed as a resident medical officer, registrar or senior registrar. These are:

- Intensive Care Training (total 42 months) divided into Foundation Training (6 months); core Training (24 months) and the Transition Year (12 months).
- Clinical Anaesthesia (12 months), Clinical Medicine (12 months), Elective (6 months)

Trainees are required to spend a minimum period in a rural placement and also in a clinical setting with adequate exposure to a paediatric caseload, at some stage in their clinical training. They are also required, as part of their intensive care clinical experience, to work in units that have the required exposure to cardiothoracic, neurological and trauma patients.

For these components, the teaching is predominantly practical. Trainees learn through clinical immersion and as 'apprentices' supervised by specialists qualified in the particular discipline. Much of the teaching is at the bedside as clinical scenarios unfold. However, the College requires all accredited ICUs to have an educational program that involves theoretical instruction. Activities should include research, data collection, a quality improvement program, morbidity and mortality meetings, tutorials, bedside review and case presentations and review sessions. The educational program is assessed during accreditation visits and by the trainee questionnaire referred to earlier in this chapter. Components added as part of the curriculum review are the Foundation ICU Term, Rural Exposure, Paediatric Exposure and the Transition Year. The former three involve no particular changes in learning methods but rather a broadening of clinical exposure. The aim of the Transition Year is for trainees to acquire non-clinical skills such as expertise in administration, teaching and quality assurance. Learning methods will involve a mix of theory and practice.

The Formal Project

The Formal Project requirement is unchanged from the previous curriculum. It is designed to encourage trainees to address research methodology, carry out a critical appraisal of the literature, collect and analyse scientific data, write a manuscript and present a scientific paper to a potentially critical audience. It is predominantly a practical exercise but substantial self-

motivated reading is required to learn about research methodology and to complete the literature review

On-Line Courses

The requirement to successfully complete a number of on-line courses was part of the new curriculum introduced in 2014. Currently they are:

- Intercultural Competency Course (Australia) and Foundation Course in Cultural Competency (New Zealand)
- Brain Death and Organ Donation (CICM course)
- Neuro-Intensive Care (CICM course)
- Spinal Cord Injury (CICM course)

In most cases these are available through the College online learning system, but some may be external courses (e.g. the Mauriora Foundation Course in Cultural Competency). These courses involve theoretical learning. It is intended to gradually develop several more courses over the next year, specifically to address possible gaps in the hospital based teaching that most trainees receive.

Face to Face Courses

Apart from the Medical ADAPT course, the requirement to undertake these courses is new to the 2014 curriculum. The required courses are listed in the response to Standard 3. These courses have either been developed under CICM direction or by CICM Fellows, with the exception of the Organ and Tissue Authority's Family Donation Conversation Workshop (where the College has a representative on the steering committee). Approval by the College is based upon direct observation and reports by appointed Fellows, course outlines and specific feedback from trainees. All external courses are mapped by the Education Committee to the current curriculum for relevance. There are usually pre and post workshop assessments and certificates of completion. A number of teaching approaches are used depending upon the material. They include formal lectures, small group tutorials, case-based problems, manual skills training, clinical scenarios and problems, and role plays with actors. There is consequently a mix of theoretical and practical learning required.

b. Comment on the range of educational activities available to trainees and their accessibility, with emphasis on any developments since 2011.

In addition to the program components discussed above, College Fellows provide Examination Preparation Courses and a wide range of other educational activities for trainees across the various jurisdictions that are not mandatory components of the training program. Although the majority of CICM trainees are located in hospitals in the main metropolitan centres (as few smaller rural hospitals have intensive care units accredited for training), the College is conscious of the need to make educational material available to all. College run courses (e.g. the Communication Skills Course) are rotated around the main centres, and where appropriate educational sessions (e.g. from the Annual Scientific Meeting) are recorded and made available to all trainees through the on-line learning portal on the website.

Trainees are encouraged to attend the College's Annual Scientific Meeting and particularly to present the outcome of their Formal Project at the 'Felicity Hawker Medal' session, which is a highly valued award.

The College journal, *Critical Care and Resuscitation*, published quarterly, is provided free to all trainees. It contains scientific articles, review articles and opinion pieces. Many trainees are co-authors on published articles

c. Any other planned developments that relate to Standard 4.

The College plans to further develop the educational knowledge and skill development of its Fellows and trainees. This will involve more formalised training in teaching and learning especially for the supervisors but also for the general Fellowship and trainees. The College aims to define standards for ensuring the minimal set of competencies for teaching and assessment consistent with the CanMeds statement on professional skills.

Specific activities include:

Support of Supervisors
The training materials made available to supervisors will be reviewed and the format for the supervisor workshops will include how the new curriculum requirements can be practically incorporated into the activities of a busy ICU. Attendance at a supervisor workshop will be compulsory for all supervisors

The Education Conference
A successful Education Conference was held in 2013 and again in 2014. The Education Committee are currently reviewing the sustainability of the conference as an annual event and it seems likely it may be changed to a biennial event.

The On-line Learning Platform
This will be developed further as an educational resource for both trainees and Fellows. The Education Committee will continue to work to identify educational resources best suited to the electronic learning environment. Materials will be reviewed by appropriate individuals with content and context expertise to ensure the accuracy and relevance of the material.

On-line Assessment Resources
The Assessment Committee will continue to develop recommendations regarding making assessment processes available on-line. At this stage only the In-Training Evaluation Report is fully on-line, however over the next year both the Workplace Competency Assessments and the Observed Clinical Encounters will become fully electronic, once the final structure of the forms is agreed. Although the use of these forms online will be largely intuitive it is acknowledged that all Fellows will need some instruction in how to administer them.

5. ASSESSMENT OF LEARNING

Summary of matters to be addressed in the 2015 submission

a. An outline of the College's plans for development and review of its assessment strategies as they were in 2011 and how these have evolved since then. Comment on challenges remaining for the College and strategies to address them.

After the completion of the curriculum review process, the Assessment Committee was formed in 2014 to oversee the development and review of all of the College's assessment strategies

Prior to this, the main form of assessments were the First Part and Second Part examinations, the paper-based In-Training Assessments and the Formal Project. With the new curriculum introducing a more sophisticated In-Training Evaluation Report, a greater emphasis on workplace based assessments and the introduction of courses, it is important to have a Committee specifically focused on monitoring these assessment processes. The Committee has appointed a dedicated member responsible for workplace based assessments.

Developments and Reviews Common to all Examinations

- Creation of an online short answer question (SAQ) database that gives access to all examiners to previously used questions. Information will include the year it was used, the performance of the question and the answer template. This will be available from April 2015.
- Each SAQ has a very detailed answer template to assist with marking concordance
- In depth analysis of SAQs and feedback from each examiner regarding the performance of the question and the candidates. This may result in changes for future questions.
- Examiners practice vivas and role play with a good and bad candidate. This teaches the examiner how to deal with a wide variety of candidates
- Detailed feedback letters to candidates who fail now give a mark range. In the past they were simply given a pass/fail mark for each section.
- Detailed examination reports are produced and made available to all trainees and Fellows.

Development and Review of Primary Exam Since 2011

The major developments are:

- A day and a half face to face workshop is attached to every examination (that is three days per year).
- Implementation of a Viva Assessment Record (VAR) that is used on each examiner. Senior examiners analyse the performance of all the examiners and provide immediate feedback.
- Workshops for trainees, supervisors and educators are run at the CICM Annual Scientific Meeting. These are interactive sessions providing information relating to the format of the exam process and answering questions.

Development and Review of Second Part Examination Since 2011

- Regular committee meetings are held throughout the year
- Three face to face exam workshops are held per year. These include video analysis of candidate and examiner performance.
- The First Part Examination implemented a Viva Assessment Record (VAR) that is used on each examiner. This has been adopted by the Second Part exam and was first used in October 2014. Senior examiners analyse the performance of all the examiners and provide immediate feedback.
- The Chair and deputy Chair of the Second Part Examination Committee attended the College of Physicians exam to learn more about other College examinations.
- In an effort to improve candidate preparation during the hot case section, the Second Part Examination Committee have implemented a two minute period for candidates to read an introduction to the hot case. A template has been developed to include information such as fluids, ventilator settings etc. This will be used at the next examination in May 2015.

Development and Review of Paediatric Second Part Examination

- The Paediatric Examination Committee hold an annual face-to-face meeting in July to workshop examination questions in addition to the workshop help in November of each year at the time of the examination.
- Regular committee meetings throughout the year
- High pass rates suggest the model is working.

Development and Review Formal Project

- A yearly meeting is held to discuss any issues.
- Internally the College is developing a standardised template to assist with marking concordance that will improve the quality of feedback given to trainees.

Development and review of the workplace based assessments, in-training evaluation reports, workplace competency assessments and observed clinical encounters are discussed in detail under Standard 3, section b.

So far only 57 trainees have enrolled in the new program with not all of them providing the necessary documentation to be considered a “full trainee”. Only four have commenced core training in intensive care medicine. The number of submitted OCE forms is too small to complete any meaningful analysis. It will therefore be some time before an analysis can be performed.

On the other hand the College has carried out a very robust analysis of the ITER. There have been over 900 ITER submissions in the first year of operation and in that time three upgrades have been made based on user feedback. There is a dedicated section in the bi-annual trainee survey that asks users to describe their experience with the ITER and to offer any suggestions for improvement.

Simultaneously with the launch of the ITER the College created an internal “IT enhancement log” that all staff are required to update after receiving feedback from key stakeholders (trainees, College supervisors, other supervisors, Fellows at large). Additionally, a dedicated CICM Assessments email address has been set up to assist users and give them the opportunity to request change.

b. Provide a table showing the number and percentage of trainees who passed the various summative assessments at their first, second, third and subsequent attempts for the period 2011 to 2015.

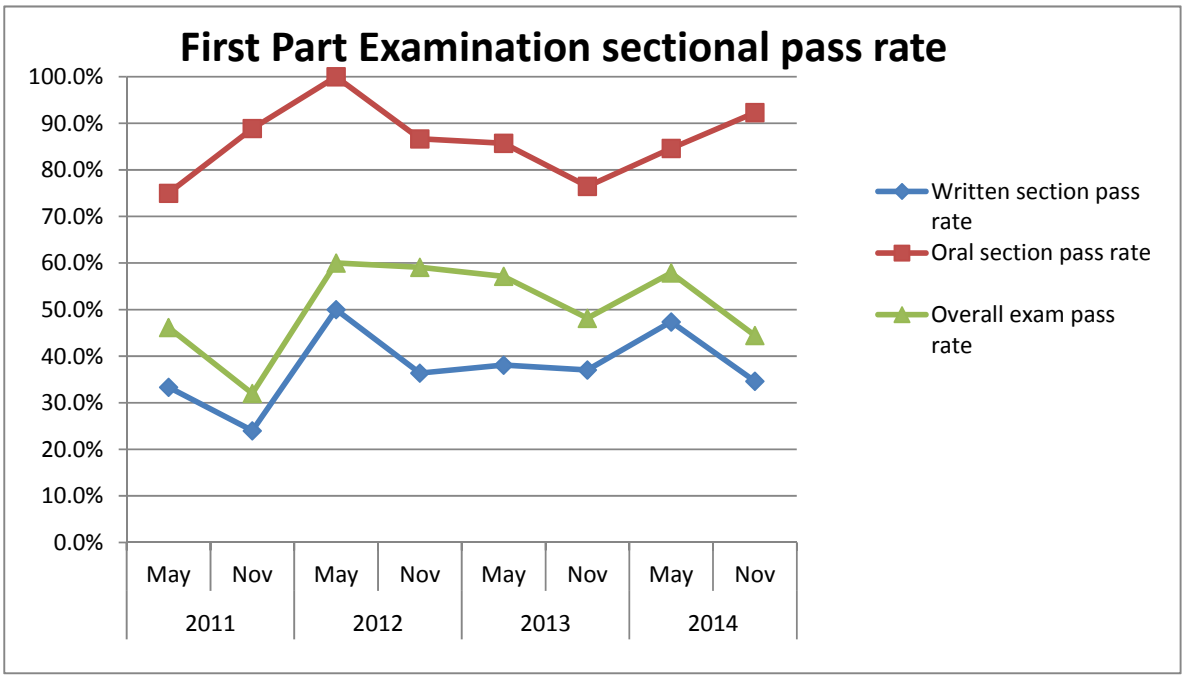
The following tables and graphs are shown for the First Part Examination, the Second Part Examination and the Paediatric Examination. There are insufficient data for the other assessments because they have not been active for long enough. The College does not record information on how many attempts a trainee might have taken to complete a WCA, it only requires them to submit the satisfactory one.

First Part Examination Statistics

Note: The 45% rule refers to candidates who receive a mark greater than 45% but less than 50% in the written section. This mark allows the candidate to receive an invitation to the oral section however if unsuccessful at the oral section, the candidate must re-sit the written at their next attempt.

Category	**2011**		**2012**		**2013**		**2014**	
	May	**Nov**	**May**	**Nov**	**May**	**Nov**	**May**	**Nov**
Total exam candidates	13	25	10	22	21	27	38	27
Carrying written mark	1	0	0	0	0	0	0	1
	7.7%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	3.7%
Written section	**2011**		**2012**		**2013**		**2014**	
	May	**Nov**	**May**	**Nov**	**May**	**Nov**	**May**	**Nov**
Total written candidates	12	25	10	22	21	27	38	26
Successful candidates	4	6	5	8	8	10	18	9
Pass percentage	33.3%	24.0%	50.0%	36.4%	38.1%	37.0%	47.4%	34.6%
Candidates scoring 45 - 50%	3	3	1	7	6	7	8	3
45% rule percentage	25.0%	12.0%	10.0%	31.8%	28.6%	25.9%	21.1%	11.5%
Number invited to oral section	8	9	6	15	14	17	26	13

Pass rates	2011		2012		2013		2014	
	May	Nov	May	Nov	May	Nov	May	Nov
Written and viva section pass	4	6	5	8	9	10	15	9
	100.0%	100.0%	100.0%	100.0%	64.3%	100.0%	83.3%	100.0%
Carry and viva pass	1	0	0	0	0	0	0	0
	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
45% mark and viva pass	1	2	1	5	3	3	7	3
	33.3%	66.7%	100.0%	71.4%	50.0%	42.9%	87.5%	100.0%
Viva section passing number	6	8	6	13	12	13	22	12
Viva section pass %	75.0%	88.9%	100.0%	86.7%	85.7%	76.5%	84.6%	92.3%
Overall exam pass %	**46.2%**	**32.0%**	**60.0%**	**59.1%**	**57.1%**	**48.1%**	**57.9%**	**44.4%**

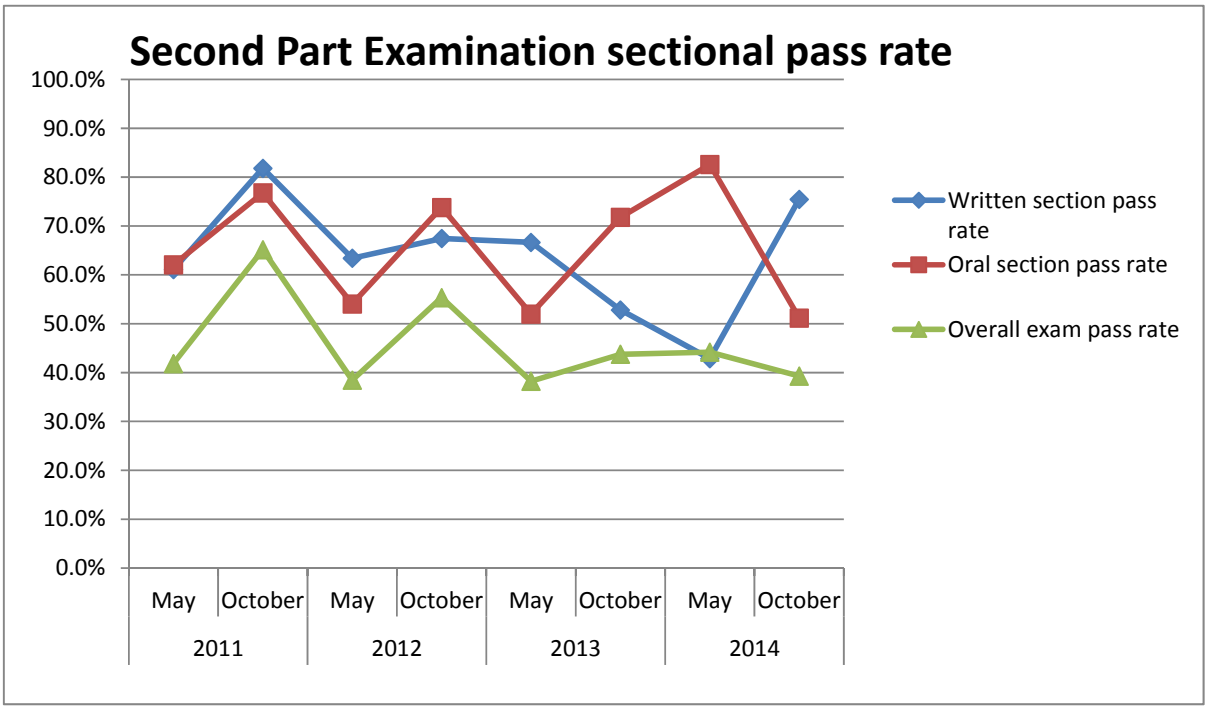


Second Part Examination Statistics

Category	2011		2012		2013		2014	
	May	October	May	October	May	October	May	October
Total exam candidates	43	66	52	56	34	64	43	56
Carrying written mark	7	11	11	13	7	11	8	3
	16.3%	16.7%	21.2%	23.2%	20.6%	17.2%	18.6%	5.4%

Written section	2011		2012		2013		2014	
	May	October	May	October	May	October	May	October
Total written candidates	36	55	41	43	27	53	35	53
Successful candidates	22	45	26	29	18	28	15	40
Pass %	61.1%	81.8%	63.4%	67.4%	66.7%	52.8%	42.9%	75.5%
Number invited to oral section	29	56	37	42	25	39	23	43

Pass rates	2011		2012		2013		2014	
	May	October	May	October	May	October	May	October
Written and oral section pass	17	36	19	24	11	18	15	20
	77.3%	80.0%	73.1%	82.8%	61.1%	64.3%	100.0%	50.0%
Carry and oral section pass	1	7	1	7	2	10	4	2
	14.3%	63.6%	9.1%	53.8%	28.6%	90.9%	50.0%	66.7%
Oral section passing number	18	43	20	31	13	28	19	22
Oral section pass %	62.1%	76.8%	54.1%	73.8%	52.0%	71.8%	82.6%	51.2%
Overall exam pass %	**41.9%**	**65.2%**	**38.5%**	**55.4%**	**38.2%**	**43.8%**	**44.2%**	**39.3%**

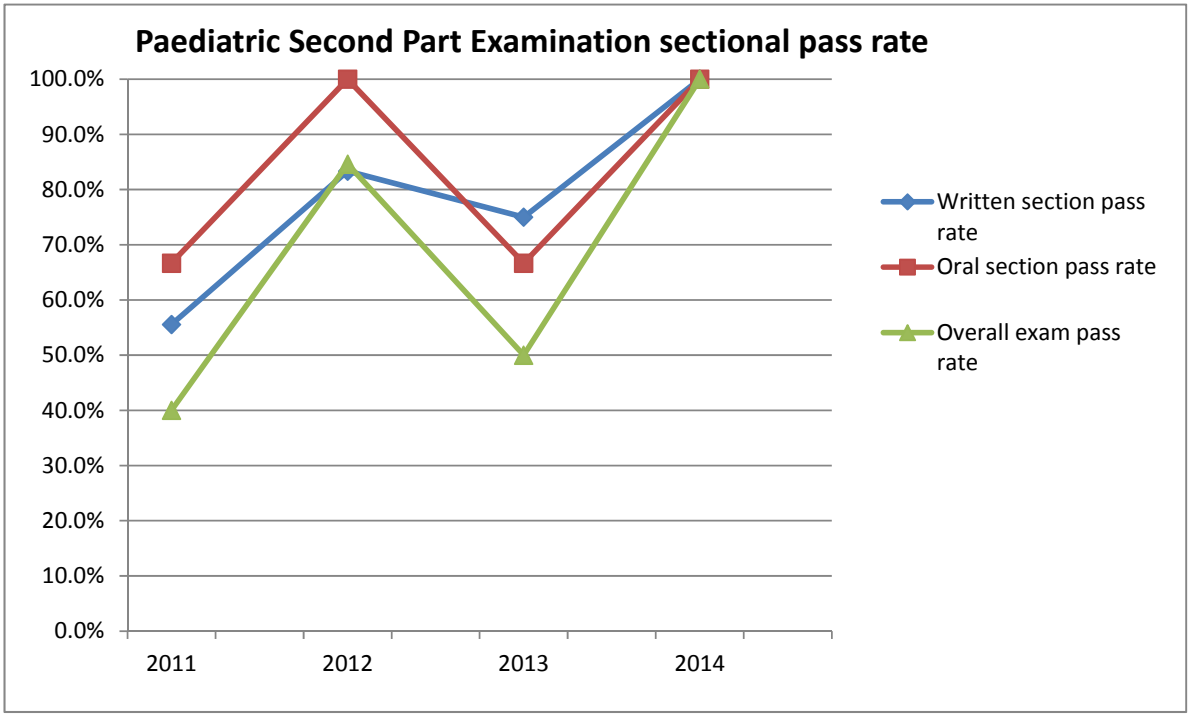

Second Part Examination sectional pass rate
100.0%
90.0%
80.0%
70.0%
60.0%
50.0%
40.0%
30.0%
20.0%
10.0%
0.0%
May
October
May
October
May
October
May
October
2011
2012
2013
2014
Written section pass rate
Oral section pass rate
Overall exam pass rate

Paediatric Second Part Examination Statistics

Category	2011	2012	2013	2014
Total exam candidates	10	13	4	6
Carrying written mark	1	1	0	1
	10.0%	7.7%	0.0%	16.7%

Written section	2011	2012	2013	2014
Total written candidates	9	12	4	5
Successful candidates	5	10	3	5
Pass %	55.6%	83.3%	75.0%	100.0%
Number invited to oral section	6	11	3	6

Pass rates	2011	2012	2013	2014
Written and oral section pass	4	10	2	5
	80.0%	100.0%	66.7%	100.0%
Carry and oral section pass	0	1	0	1
	0.0%	100.0%	0.0%	100.0%
Oral section passing number	4	11	2	6
Oral section pass %	66.7%	100.0%	66.7%	100.0%
Overall exam pass %	**40.0%**	**84.6%**	**50.0%**	**100.0%**



Data on Formal Projects

1. New Projects

State/Country	2014	2013
NSW	13	17
VIC	12	16
QLD	10	12
SA	4	3
TAS	0	1
WA	4	3
NZ	3	7
ACT	3	0
Total	**49**	**59**

2. Types of Projects Received

Type of project received	2014	2013
Retrospective Chart Reviews / Retrospective Observational studies / Retrospective Cohort Studies	22	30
Published Manuscripts	13	9
Prospective Scientific Studies	10	16
Case Series	2	3
Thesis	2	1

3. Assessment Outcomes

Outcomes	2014	2013
Accepted on first submission	29	30
Accepted on first resubmission	9	21
Pending resubmission	11	8

4. Other (2014)

Average review days	25
Resubmissions from previous years	5

c. Outline how the College monitors, analyses the cause, and addresses the performance in the examinations.

The requirement for a number of Observed Clinical Encounters (OCEs) as part of the new curriculum should result in candidates being better prepared for the clinical part of the examination and consequently a higher success rate.

For all unsuccessful examination candidates, the relevant Examination Committee member in the region makes a phone call to the supervisor of the candidate who will then feedback to the candidate. The College may therefore become aware of what the cause of the failure might be.

The document Guidelines for Assisting Trainees with Difficulties outlines a process for assisting trainees who struggle to pass College Examinations. This requires the trainee to meet with their supervisor and mentor (if applicable) to complete an in-unit action plan based on specific exam feedback, after any College examination is failed. This must be submitted to the College prior to the next attempt. As mentioned earlier in this chapter candidates who fail receive detailed feedback letters that give a mark range for every question/viva/station. This allows the trainee and supervisor to construct an action plan that addresses the deficiencies. After a third unsuccessful attempt the matter is escalated to a Regional Review Panel and after the fourth a meeting is arranged at the College with the trainee, the Censor, the Chair of the relevant Examination Committee, a senior College Fellow and a community representative. Permission to proceed for the final attempt at the examination must be obtained from the trainee's current supervisor. At each of these meetings the trainee is counselled and provided with resources specific to their needs.

In January 2015 the College ran its first face-to-face workshop for candidates struggling to pass the exam. The workshop consisted of a series of icebreaker exercises that set the tone of the day, acknowledged the potential feelings of anger that some of the previously unsuccessful candidates may be experiencing but allowed the participants to 'ventilate' if necessary. Attendees were exposed to the structure of the exams and given three short answer questions they had to answer under examination conditions. These were marked by examiners in the room and immediate feedback was given. The workshop included a presentation from a performance psychologist (Patsy Tremayne) on understanding the psychology surrounding preparation for exams and 'exam failure'.

A Trainee Support page that will be posted on the College website will outline the processes described above and relevant resources is nearing completion.

The College has also analysed the results of the Fellowship Examination for the years 2009-2011 and examined the factors predictive of success in the examination. The performance and predictors of success in the examination were analysed and the outcomes of international medical graduates attempting the examination were compared with those of local trainees (defined as those from Australia, New Zealand and Hong Kong). This has now been published in Critical Care and Resuscitation (attached as appendix 5) and is available on Pubmed.

d. Provide a table for the period 2011 to 2015 showing the numbers of trainees who withdrew from the program before completion and a summary of the reasons for withdrawal.

The table below shows the number of trainees who have formally withdrawn from the program since 2011.

Year	No.
2011	1
2012	7
2013	6
2014	4

A number of our trainees are also simultaneously registered with another College for training (most commonly ACEM or ANZCA). The most common reason that they no longer wish to pursue a career in intensive care medicine is because they wish to focus on finishing the training requirements of another College they are registered with.

e. Append the document(s) provided to trainees that explains the assessment policy, the nature of the assessments and the standards of performance required.

The following documents are available on the website:

- The *Regulations*
- *Competencies, Learning, Teaching and Assessments for Training in General Intensive Care*
- *Guide to Training for Trainees*
- *Trainee Selection Policy*
- General information for each of the three examinations

Not on the website:

- *Trainee Agreement,* this is sent directly to trainees (appendix 6).

f. Any other planned developments that relate to Accreditation Standards 5.1 to 5.3.

The College has identified the following areas that require further development:

- Improve the administration of examiner performance and assessment. The First Part exam has a template used to track the performance of the examiner, this will be developed for the other two exams the information kept in a database.
- Take the application to sit the exam online through the use of the online forms tool of the new website.
- Improve the marking process at exams and provide examiners with the ability to mark using a hand held device to avoid double handling the marks. This would decrease the time it takes to finalise results.
- Improve the quality of candidate feedback. This is linked to the previous point, allowing the examiner to easily obtain information on candidate performance, which can be included in a feedback letter.
- Develop within the education portal an examiner "mini dashboard". This could include examinations attended, performance, the viva stations they have examined etc.

5.4 Assessment of specialists trained overseas

Summary of other matters to be addressed in the 2015 submission

a. The College's response to the nationally agreed policy for the assessment of international medical specialists, including actions to implement AMC recommendations and/or alternative approaches agreed by the College.

Since the release of the Preliminary Consultation Paper on January 30th 2013 regarding a review of the Specialist Pathway, the College has supported the AMC recommendations. The College reviewed its internal procedure associated with the Overseas Trained Specialists (OTS) and Area of Need (AON) Pathways and edited all published documentation to coincide with these changes. With reference to the Implementation Plan provided by the Medical Board of Australia in December 2013, the College undertook the following actions:

Development of an Application Form and Checklist
With ideas sourced from the College's previously used paper-based application forms for College trainees an application form and checklist of supporting documents for applicants was developed. The College produced an application form that included information regarding comparability of an OTS and also covers the assessment of AON applications.

With regard to the development of an application form, the College implemented this recommendation as this was the first time the College would have applicants apply directly instead of applying via the AMC.

Development of Steps and Procedures for Receiving and Processing Applications
As per AMC recommendations, the College drafted new internal procedures for processing applications from OTS. The following steps were implemented;

- All applicants are advised to visit the College OTS/AON webpage for information on the specialist pathway. The College has included a series of FAQs to clearly outline the requirements and application process for the OTS pathway.

- If the OTS contacts the College regarding the application process for this pathway, the designated staff member will provide information regarding a preliminary assessment of their qualifications, specialist registration, and work experience. The applicant is also requested to forward to the College (electronically) copies of the above documentation. At this stage, the OTS is also provided with a copy of Training Document T-27 Assessment of Overseas Trained Intensive Care Specialists and is also encouraged to review the requirements of the CICM Training Program should they found to be either not suitable during the preliminary assessment or non-comparable at the interview stage.

- Once all requested documentation is submitted to the College, the application can progress. Please see appendix 7 for the CICM Overseas Trained Specialist/Area of Need preliminary cover sheet that is forwarded along with all paperwork. The OTS Officer/Censor will conduct a paper-based (preliminary) assessment on the eligibility of the applicant to the OTS pathway and determine if a face-to-face interview should be conducted. If found to be suitable, the OTS is then provided with an application form. If found not to be suitable, the applicant is advised to apply for the training pathway.

- If the applicant has received an application form, all required paperwork must be forwarded to the College before an interview date is offered. Upon submission of their application, the OTS must have also submitted his/her qualifications for Primary Source Verification and provide an AMC and EICS number.

- Once the application form and required paperwork is submitted, the OTS will then be informed of an upcoming interview date. The College conducts interviews three times a year (February, July and November) to coincide with Board Meetings. If necessary, interviews outside of these dates can be arranged.

Although not a recommendation outlined by the AMC, the College also reviewed its interview process and structure. No changes were made to this process.

The interview structure has been provided below for the AMC's reference:

- The applicant will be interviewed by selected members of the OTS Committee. The interview will be organised by the College at a time and location that is suitable for all parties. When preparing for the interview, the College works to ensure that the Censor will Chair the interview and that there is a Fellow who was admitted via the OTS pathway and a community representative present.

- The Chair will outline to the applicant the nature and structure of the interview. The interview panel will also use the following criteria to assess the comparability of an OTS:
    - Undergraduate training;
    - General hospital appointments;
    - Anaesthesia and internal medicine training;
    - Non-intensive care postgraduate training (i.e. Fellowship of another speciality);

- Previous training and assessments in intensive care medicine (including exit examination);
- Experience as a specialist;
- Participation in relevant continuing professional development programs
- Assessment of formal publications;
- Completion of an ADAPT workshop or equivalent.

- After the interview the Panel will discuss the comparability of the applicant. A decision on comparability and if applicable, any remaining training and assessment requirements needed in order to become a Fellow.

- After the interview has concluded, the OTS will then receive a College letter and a copy of their Report 1. If they are found to be either substantially or partially comparable, the applicant must inform the College (either via email or post) they either accept or reject the College's recommendations.

- Once the OTS has accepted the College's recommendations, a College Registration letter is issued. The letter informs the applicant in greater detail of their remaining training and assessment requirements and they will also be issued access to the College's Member Portal.

If the applicant disagrees with the assessment they received, either their paper based assessment or interview outcome, their file is first referred to the OTS Committee for review. The Committee may review their decision, or refer the case to the Censor's Committee or the College Board. At this point if the applicant is unhappy with the ruling, they are provided with information on the appeal process; however the Committee endeavours to resolve the issue first.

Review of Communication with OTS, AHPRA and the AMC

Upon reviewing the incoming changes to the specialist pathway, the College found it necessary to change only marginal aspects of its communication methods with OTS and the appropriate health bodies.

The College continues to have a designated staff member who oversees all OTS/AON related matters. In line with recent changes, the College has also endeavoured to improve its assistance to OTS when completing their application for Specialist Recognition. OTS are encouraged to contact the College for assistance regarding the suitability of their documentation and any other questions they may have. They are also able to come into the office for further assistance.

Frequent contact with the AMC and AHPRA has also continued. Staff and a senior Fellow representing the College attended the Specialist Pathway Forum presented by AHPRA and the AMC on 21 February 2014. Feedback on the Report 1 templates and the working paper 'Guidelines on Good Practice in the Specialist IMG Process' was also submitted. The College has also continued to participate in the network of college IMG managers group.

Review of the Redefined Comparability Definitions

As per the AMC's recommendations, the redefined comparability definitions were adopted into the assessment process. The definitions are a strong reference point for the College when determining the suitability of an OTS applying for the specialist pathway. To accommodate these changes (and the new administration processes), the College included the comparability definitions in its revised document T-27. The College Board and OTS Committee were also made aware of these changes during the approval of this document at the July 2014 Board meeting. As also previously mentioned, the College has also included these definitions on its website so OTS are better informed of the different assessment outcomes.

Discussion of Change to Fee Structure

The fees charged for OTS and OTS/AON assessments were reviewed as per AMC recommendations. Although the College adopts a 3% fee increase per annum, it was concluded that a restructure of fees is not required at present. This decision is due to a number of factors:

- With the increase of fees for Primary Source Verification and the already considerable fee to conduct a fact to face interview ($4,422), it was considered unnecessary to charge applicants a paper-based assessment fee or significantly increase the interview fee.

- As interviews are conducted to coincide with the CICM Board Meetings (and many of the OTS Committee are Board members) the costs of flights and accommodation for the Interview Panel are already taken into account.

Although the College hasn't made an adjustment to its fee structure to coincide with administration changeovers, fees may be reviewed if we were to receive a sizeable increase in applications.

Updating of the CICM Website

As the information on the CICM website regarding application for the specialist pathway was due to change, the College published information in June 2014 regarding the new assessment process. These changes were further incorporated into the new CICM website launched on 19 January of this year.

b. Report on the number of applications considered from overseas-trained specialists and the outcomes of their applications from 2011 to 2015.

Applications

From February 2011 to the end of 2014, the College has received 53 applications for the Overseas Trained Specialist Pathway. At this time, the College has not received any applications for 2015.

Year	Number of Applications	Outcomes recorded	Fellowship obtained
2011	10	6 Partially comparable 4 Non-comparable	• 2 IMGs who applied in 2011 have been awarded CICM Fellowship.
2012	15	9 Partially comparable 3 Withdrawn 2 Non-comparable 1 Pending	• 4 IMGs who applied in 2012 have been awarded CICM Fellowship.
2013	16	8 Partially comparable 4 Pending 3 Non-comparable 1 Withdrawn	• 1 IMG who applied in 2013 has been awarded CICM Fellowship.
2014	12	6 Pending 5 Partially Comparable 1 Withdrawn	• 1 IMG who applied in 2013 has been awarded CICM Fellowship.

OTS Examination Attempts

From 2011 to 2014, 23 OTS applicants have presented for the CICM Second Part Examination.

Year	Number of OTS sitting Exam	Outcomes recorded	Attempts Recorded
2011	6	4 Passed 3 Failed written section	• All were on first attempt of the exam.
2012	8	7 Passed 1 Failed written section	• Five were on the first attempt. • The candidate who failed the written section sat the exam on both sittings in 2012. They passed on their third attempt. • One passed on their second attempt.
2013	2	2 Passed	• Both passed on their second attempt. • One sat the exam at both sittings in 2013. They initially failed the oral section on their first attempt. Written mark was carried.
2014	9	5 Passed 3 Failed Oral Section 1 Failed Written Section	• All were on their first attempt of the exam. • The candidates who failed the oral exam will have their written mark carried.
2015	0	Applications closed 02/02/15	Applications closed 02/02/15

c. An outline of plans for further development.

The College has no plans to further amend the current process for the assessment of specialists trained overseas in the short term.

6. MONITORING AND EVALUATION

2011 Accreditation Report conditions and AMC feedback on progress reports

9	***Implement methods for systematic, confidential trainee feedback on the quality of supervision, training and clinical experience, and for analysing and using this feedback in program monitoring. (Standard 6.1.3)***

The Quality of Training Survey is sent out twice yearly. To date no trainee has reported difficulties with their training unit and requested review of the unit by the College. Given that the survey is completed anonymously in order to encourage honest feedback with no fear of penalty, the College is unable to identify a particular unit unless a trainee specifically requests College intervention. However the responses to the survey indicate that there were issues for trainees. The twice annual survey is a good way to identify themes in the overall program.
In the 2015 submission, the AMC asks the College to provide information on how it gains feedback from individual trainees in difficulty, in a protected and safe manner, and what is the process is for addressing feedback.

College response:

As already discussed under Standard 4 and further in Standards 8.1 and 8.2, until now the twice-yearly Quality of Training Survey has been submitted anonymously, but in the most recent one, sent to the 304 trainees coming to the end of a training rotation on 23 February, trainees were invited to identify themselves and their training location. At the time of writing this submission it appears, not surprisingly, that this has had an effect on the response rate, however the College is confident that the data obtained will be more meaningful than when sourced anonymously.

As previously stated trainees are asked to respond to questions regarding the clinical experience, the teaching, the supervision and trainee administration and resources provided by each training rotation. The survey is conducted twice yearly and the data is provided to the Education Committee for analysis, consideration and to monitor the program.

It is the intention to collate and analyse data for each unit, so that when a minimum number of responses (perhaps 10) from trainees at a particular unit have been collected, this de-identified data can be fed back to the unit with comparison across all other similar units. In addition confidential feedback is obtained from trainees at accreditation visits that now occur every five years rather than every seven years.

Individual trainees in difficulty can provide feedback to the College using both of these mechanisms. The Guidelines for Assisting Trainees with Difficulties document (T-13) outlines the steps that should be taken for both the trainee who performs below expectations and the trainee who is unable to pass College examinations. This latter circumstance is discussed under Standard 5. If a trainee performs below expectations and the issues cannot be resolved during the term (or in the first six months of a longer term) the supervisor will reflect the unsatisfactory performance in the ITER. The ‘triggers’ that will cause an ITER to be followed up by the College are:

- The supervisor clicks ‘did not demonstrate safe practice’ on any section of the ITER
- The supervisor marks the ITER as unsatisfactory

- The supervisor answers YES to the question 'Is there a need to refer the trainee to the College for additional support?'
- The supervisor answers NO to the question 'Has the trainee made sufficient progress during this term?'

Because the ITER is submitted electronically if any of the above occurs an alert is sent to a College staff member who contacts the trainee notifying them of the unsatisfactory report and confirms that they have viewed it on the ITER dashboard. The staff member also asks for feedback on the assessment and suggests the trainee contact them if they have questions. The trainee is assured of the confidentiality of any discussion with the staff member and is reassured and made to feel safe. Although several trainees have voiced concerns, none has been prepared to put these concerns in writing. Although this process is somewhat informal, the staff member involved feels she would be likely to recognise patterns should they occur.

As outlined in the guidelines if the trainee continues to have difficulties an initial interview with the College is conducted in the relevant region and if matters remain unresolved, at the College in Melbourne. In these interviews the trainee is free to voice any concerns he/she may have. The situation in which a trainee makes a formal complaint about a supervisor or a training unit has not yet occurred. The College would take such a matter very seriously. The complaint would be handled by the Censor and the Censors' Committee in the first instance while the trainee is provided with support.

11 Implement processes for engaging health care administrators, other health care professionals and consumers in the evaluation process. (Standard 6.2.2)

As the Community Advisory Group has just been set up, the AMC asks the College to provide an update of its outcomes in the submission.

College response:

The Community Advisory Group (CAG) has been discussed under Standard 1 and 2. It has met twice so far with the next meeting scheduled to be held in April. The CAG now has members representing major stakeholder groups, including the Australian College of Critical Care Nurses, the Australian Association of Social Workers and the Consumers Health Forum, as well as two community members with lengthy experience in similar roles with health related organisations.

The CAG has already provided important advice on a number of College documents and policies, including the 'for patients and families' section on the website; the quality of training survey and the process for following up the progress of overseas trained specialists. At the next meeting it is intended to ask the CAG to review the College 'Definition of an Intensive Care Specialist' from a community perspective.

Summary of other matters to be addressed in the 2015 submission

a. Give details of evaluation activities undertaken since the 2011 Accreditation assessment and how this feedback is analysed and used to improve the program.

The College routinely makes use of surveys to gain feedback from Fellows and trainees, in an effort to constantly improve the delivery of the training program. The results of a particular

survey will be fed back to the responsible committee (for most training issues, the Education Committee) for consideration. Some examples of surveys undertaken are:

- The trainee survey discussed above. This was initiated in 2011 and first collected identified responses in 2015 (evaluated by the Education Committee).
- The annual supervisors of training survey commencing in 2013 (evaluated by the Education Committee).
- Survey of exam candidates after each examination (evaluated by the relevant examination committee of the Assessments Committee).
- New graduates survey commencing 2013 (evaluated by the Education Committee).
- Evaluation surveys done after every College Communication Skills and Management Skills course (evaluated by the course steering committee).

Of major interest to the College is the effect that the new curriculum will have on new graduates' perception of their preparedness to make the transition from trainee to consultant. At this stage it is too early to see any effect, but this will be closely monitored as trainees on the new curriculum progress through the program.

Confidential interviews with trainees are an essential component of the hospital accreditation process and are valuable in framing the list of recommendations that goes to units following an accreditation inspection. Trainee feedback has been crucial to the decision making process on the rare occasions that a unit has lost its accreditation for intensive care training.

b. An outline of plans for further development.

The major focus for the College in the next two or three years will be evaluation of the components of the new curriculum as new trainees undertake the various new tasks and terms mandated in the new program. As stated earlier too few trainees have undertaken these tasks to date to provide any meaningful analysis. The evaluation will focus on such things as accessibility of resources, including whether they can be provided (and evaluated) on line, the quality of educational resources and the capacity of supervisors to take on the additional assessment tasks

There were over 900 completed ITER forms submitted in 2014. These are all collected in a central databank and provide a great opportunity to analyse the rate of trainee progress, to compare results between trainees in different training units and to look at specific areas (i.e. the different CanMEDS roles) to see how progress in each area may differ. At this stage most trainees only have one or two submitted ITER's, but by the end of 2015 it will be possible to start tracking trainee progress across three or four completed ITER's.

7. IMPLEMENTING THE CURRICULUM - TRAINEES

Summary of matters to be addressed in the 2015 submission

a. Report on the further development and evaluation of the trainee selection process since the 2011 assessment and comment on the success of the changes made. If relevant, append the selection policy.

A new selection into training policy was developed in 2013 and applied to all trainees registering for training with the College since 1 January 2014. It is outlined in Policy Document T-1 (2013) and detailed in Section 5.1 of the CICM Regulations. A clear statement of the principles underpinning this process and the selection criteria are included in the document, which is published on the College website. An online application pack is available on the website for prospective trainees.

Currently selection into training involves attaining a 'minimum entry standard' with the number of training positions uncapped. Consequently there is no weighting of elements and no marking system. This is different from some other Colleges that have a finite number of training positions and appointment to these positions is based on merit. The aim of the process is to ensure that a prospective trainee has the capacity to complete the training program successfully and become a competent specialist in intensive care medicine. All applicants must complete a six month introductory term in an accredited intensive care unit (Foundation Training) with satisfactory references from two Fellows of the College to be eligible for selection.

A satisfactory reference is one in which no area is marked 'falls short of expected standard' and the referee endorses the candidates suitability for intensive care training. The files of all applicants are reviewed by the Trainee Selection Panel according to the requirements set out in T-1. This Panel aims to ensure an independent, fair and consistent approach to reviewing each training application. To date, the trainee selection panel has reviewed 71 trainee applications, with 63 deemed 'successful' and one 'unsuccessful' (the others are still pending) There were three trainees unable to provide structured references from College Fellows, of whom one has so far been interviewed.

The Appeals Policy (Regulation 14 and 15) covers all applicants, including those who are not trainees or Fellows of the College. To date, there have been no appeals requiring implementation of Regulations 14 and 15.

b. Provide copies of information available to prospective trainees on:

- **The selection process**
- **The nationally available opportunities for entering the training programs**
- **Any quotas and other limits, such as the number of training positions**
- **Mandated training experiences**

The requirements for mandatory experience are discussed under Standard 3 and published on the website. These only apply for trainees commencing after 1 January 2014. There have been no requests for exemptions so far, apart from those that have been requested on the basis of retrospective accreditation of prior learning, which are referred to the Censor (see Standards 3 and 5).

Unlike some other specialties, there is a need for large numbers of junior doctors within ICUs to meet the clinical service delivery requirements. All of these are potential training positions. Training positions are available in all ICUs accredited with the College i.e. in all capital cities and in most large urban and regional centres. Individual hospitals appoint registrars to work in

intensive care units, many of whom are part of other college training schemes. The trainee selection process pertains only to those who wish to be selected into vocational training in intensive care medicine. These trainees are selected by the College centrally, not hospitals or regions and the application of the selection process is consequentially consistent.

The selection policy was reviewed by the Censor's Committee in February 2015. It was decided that it was operating satisfactorily and that no changes were necessary at present but it would be reviewed in 12 months after collection of another year of data to ensure that the entry criteria remain appropriate. The College is currently considering development of training rotations. Because the number of positions on training rotations is finite, a merit-based selection process will need to be developed if this system is introduced.

As discussed earlier in this submission, there have been concerns raised that the College may be training too many intensive care specialists in relation to the number of specialist positions that may become available. The College has shared all the available information with trainees and potential trainees through published newsletters, articles and presentations at the Annual Scientific Meeting. The summary of the recent workforce summit was sent as a newsletter to all trainees and Fellows and has been submitted for publication in the College journal.

c. Provide information on the number of applicants and number of trainees entering the training program from 2011 to 2015 (for each year include the number and distribution across training centres of both continuing and newly commencing trainees). Please include the statistics and annual trends.

Data on trainee registrations are presented in the tables below.

Number of Trainees				
	2011	**2012**	**2013**	**2014**
New Trainees	149	208	334	65
Basic Trainees	152	192	199	208
Advanced Trainees	312	302	281	336

New Trainees by Region				
	2011	**2012**	**2013**	**2014**
NSW	36	47	102	17
VIC	27	36	77	9
QLD	34	55	79	10
SA	16	19	20	4
WA	8	28	31	6
TAS	4	1	5	1
NT	3	2	10	0
ACT	2	4	11	2
NZ	14	32	40	15
International	4	7	17	4

d. Outline the formal processes and structures that facilitate and support the involvement of trainees in the governance of their training.

Trainees are involved in College governance by their participation directly and indirectly in several College committees. The Trainee Committee was first established in 2004, the Terms of Reference are included in Section 2.18 of the College Regulations. It has full access to dedicated administrative support. Over the following ten years it has evolved in size to include a representative from all training regions in Australia and New Zealand, as well as a representative of trainees in paediatric ICU. Each Trainee Committee member is invited to sit on their respective College Regional Committee to provide continuity between the Board and the regions. The contact details of the Committee members are available on the College website. Trainee Committee members are elected to the committee from each region following a call for nominations and, if necessary, an election from among the trainees in each region.

The Chair of the Trainee Committee (the New Fellows Representative) is a voting member of the College Board, and a trainee nominated from the committee attends Board Meetings (for a 12 month term). This allows direct representation of the interests of trainees and communication of issues related to education back to the Trainee Committee. The New Fellows Representative also sits on the Education and Assessments Committees to provide a trainee perspective.

A Trainee Committee member is invited to be part of the Hospital Accreditation Committee. Trainee representation on accreditation inspections has been expanded outside the members of the Trainee Committee to enable wider trainee involvement in this process.

The College values the opinion of the Trainee Committee. For example the Committee was consulted before the Quality of Training survey was changed from anonymous to identifiable in 2015.

In addition to regular teleconferences, the Trainee Committee now meets annually at a face-to-face workshop immediately before the February Board Meeting. This enables the Committee members to visit the College, meet the staff and engage with Board Members.

Trainee Committee members have a number of opportunities to interact with the broader cohort of trainees. They provided a conduit to receive feedback from trainees during the consultation process for the 2014 curriculum review and provide reassurance that the College remained dedicated to a policy of not disadvantaging existing trainees. The College Annual Scientific Meeting has a specific trainee workshop scheduled in the main program, chaired by the New Fellows Representative. This is open to all CICM trainees, and provides an opportunity for face-to-face updates, and an open forum for trainees to question the trainee committee.

Trainee Committee members attend several regional educational activities organised outside the College which provide an opportunity for communication with trainees. Examples include the Intensive Care Network Meetings and the Bedside Critical Care Conference; the latter having a dedicated trainee day.

e. Outline developments in relation to College communication with and support of trainees since 2011 and comment on the success of these developments and any plans for further development.

The College is aware of the importance of maintaining open communication with trainees and several developments have occurred since 2011. A specific trainee edition of the regular College ‘e-news’ has been developed. This includes contact details for each regional representative and a communication of College developments relevant to training; this can be found here on the College website.

The College continues to provide a personalised training portfolio to each trainee (accessed by their own login) to keep them updated about their training requirements – those completed and those yet to be undertaken. The trainee web interface has been upgraded in early 2015, making it easier to navigate and the organisation of material more logical. The next major I.T. project the College is undertaking is the development of a more sophisticated 'Trainee Dashboard' which will give trainees much greater detail about their progress through the training program and also contain all submitted assessment material.

f. Provide data on any appeals by trainees and/or overseas-trained specialists from 2011 to 2015 and the outcome of the appeals.

The College has a formal process for reconsideration, review and appeals that is contained in Regulations 14 and 15 and is published on the website. These allow trainees to seek impartial review of training related decisions. There have been no appeals by trainees or overseas-trained specialists from 2011 to 2015.

8. IMPLEMENTING THE PROGRAM – EDUCATIONAL RESOURCES

2011 Accreditation Report conditions and AMC feedback on progress reports

17	***Implement more regular and formal feedback processes with regards to the role and performance of supervisors of training. (Standard 8.1.3)***

Whilst the trainee survey partially answers this difficult question it is hard to accept that there is no situation thus far where supervision has been an issue. Also, as the Trainee Survey is anonymous and does not identify units or supervisors of training, capacity to provide formal feedback to supervisors would be difficult.

College response:

As discussed earlier in this submission, the College has conducted a regular trainee survey since 2013. All trainees are asked to complete a customised survey after each accredited training term. This usually occurs in February and August to ensure trainees are reached after they finish a six month block of training, regardless of the region they are in. The survey covers a number of topics and is made up of multi-choice responses and free text. Trainees have the opportunity in this survey to highlight areas of concern they have about their training experience and the performance of their supervisor.

As outlined under section 8.2, some issues with inadequate rapport and relationship with supervisors has arisen. As already mentioned, from 2015 the questionnaire is no longer anonymous. In time the College aims to batch responses from a single unit and provide feedback to supervisors.

Summary of other matters to be addressed in the 2014 submission

a. The College's role in selecting and setting standards for supervisors. Please outline the processes in place and any plans for change or review.

College training document T-10 *The Role of Supervisors of Training in Intensive Care Medicine* clearly documents the standards required of specialists applying for supervisor positions. Applications are assessed by the College Education Committee and where necessary applicants may be rejected if they do not meet the standards or approved with conditions if they partially meet the standards. An example of the conditions imposed is: for applications by specialists less than three years post qualification, a nominated more senior supervisor must be in place to mentor the individual until they have met the standard criteria. The Education Committee also examines the proposed number of trainees being supervised by each supervisor and ensures an appropriate amount of time is quarantined to perform this important function.

b. Comment on processes for review of supervisor performance.

Appraisal of supervisor performance using the trainee survey is discussed above. The performance of the supervisor is also a major part of each hospital accreditation visit. The site visit includes interviews with trainees that are confidential and encourage trainees to be honest about their training experience and the support provided. The accreditation team assesses the amount of supervision, support and teaching provided and examines the role of the supervisor in the trainees' weekly schedule. The team also interview the supervisor and ask detailed questions about the performance of their role.

Although the College has no role in the regular workplace performance assessment by the supervisor's employer, it is available to provide support and assistance if issues are identified. The College training document T10 is a useful tool for the workplace performance processes.

c. Describe the College's processes for informing supervisors about changes to the curriculum and assessment methods and any supervisor training activities undertaken or planned.

The College provides new supervisors electronic copies of all the relevant documents and assessment information that they will require. It also sends out quarterly supervisor newsletters by email.

Three types of training activities are planned:

1. Regular Fellow Education Workshops, not exclusive to supervisors. The first in 2015 was held in Melbourne for Victorian and Tasmanian Fellows on 10 March. The program involved trainee mapping and the trainee having difficulty, using simulated scenarios involving actors. The majority of attendees were actually supervisors. This will be held in NSW, QLD, SA, WA and NZ before the end of 2015

2. The College has in previous years held supervisor workshops that focus on specific supervisor activities and responsibilities. The content of that workshop is now being revised. It is intended to make attendance at a supervisor workshop mandatory for all new supervisors.

3. The Assessments Committee has been given the specific task of monitoring the WBAs and ensuring that Fellows who conduct the assessments are appropriately trained. A specific Assessments Committee member has been given the task of developing a series of workshops based on WBAs.

d. Report on other developments relevant to Standard 8.1.

The College will continue to explore supervisor engagement and to work in partnership with workplace employers to ensure the quality of the trainee experience consistently meets College standards in all training units. It plans to make supervisor engagement a permanent responsibility for a staff member at the College. This will involve:

- Improving the material the College already send them (to include podcasts and other resources)

- Facilitating communication with other supervisors by creating a supervisor network they can use for advice – perhaps by appointing 'supervisor champions' in each region.

2011 Accreditation Report conditions and AMC feedback on progress reports

18	***Review its processes for monitoring and assessing non-intensive care terms against College's requirements. It is acknowledged that the learning objectives of the medicine and anaesthesia terms may change as a result of the curriculum review planned by the College. (Standard 8.2.2)***

The College has attempted to address the difficult issue of trainees ending up in very marginal and indeed non training positions for their medical term, i.e. an unsupervised night relieving roster. This places a significant weight on the censor's discretion.

The learning objectives of the medicine and anaesthesia terms are set out in the respective Objectives of Training documents and have not changed significantly with the new curriculum.

Processes for monitoring and assessing non-intensive care terms include:

- Feedback from the trainee survey, which is sent to all trainees undertaking an approved period of training (i.e. anaesthetics and medicine as well as intensive care). In general it can probably be assumed that a College trainee would be more likely to be direct in their appraisal of a non-ICU term since there would be less perceived influence on career prospects.

- Anaesthesia terms can only be undertaken in departments accredited by ANZCA (or equivalent overseas bodies) or when the College has undertaken its own accreditation process (in collaboration with ANZCA) to determine the post's suitability for the anaesthetic component of intensive care training.

- Review by survey and case logs of the experience of trainees undertaking anaesthetic training in hospitals that do not have ANZCA accreditation. It is possible that the breadth of experience of trainees in non-ANZCA accredited sites may be equal to or superior to those of ANZCA accredited sites. The supervision of trainees in non-traditional training sites however, must be assured.

- Medicine terms are undertaken in departments accredited by the RACP for physician training. Occasionally, trainees may request approval for terms in non-RACP accredited posts. In these cases, the Censor may approve the training after submission of a detailed position description. There are some medical terms that are not accepted for training due to their narrow clinical focus (for example hyperbaric medicine or sleep medicine).

- Many trainees apply for recognition of prior learning for their required anaesthetic or medicine training time. Currently the Censor evaluates these requests on an individual basis, however the Censor's Committee is cognisant of the need to provide more guidance to trainees on what prior training is likely to be accepted. Specifically at its meeting of 13 May 2014 the Censors Committee agreed that no night relieving terms would be accredited; the minutes of this meeting are found in appendix 8.

Summary of other matters to be addressed in the 2014 submission

a. Append a copy of the College's policy for accreditation of training units. Please outline the processes in place and any plans for change or review.

The College process and criteria to select and recognise intensive care units for training processes are defined in the following documents:

- *IC-1 Minimum Standards for Intensive Care Units*
- *IC-3 Guidelines for Intensive Care Units seeking Accreditation for Training in Intensive Care Medicine*
- *IC-13 Recommendations on Standards for High Dependency Units Seeking Accreditation for Training in Intensive Care Medicine*
- *IC-4 The Supervision of Vocational Trainees in Intensive Care Medicine*

Supplementary documents provide guidance in particular situations:

- Minimum Criteria for Accreditation of Units for Basic Training
- IC-3 Minimum Standards for Intensive Care Units Seeking Accreditation for Training in Intensive Care Medicine
- Guide for Hospitals Seeking Accreditation of Training
- Guide for the College Accreditation Team
- Application for Accreditation for Foundation Training.

There have been several changes implemented in relation to accreditation since the original submission:

- The accreditation cycle has been shortened to five years instead of seven
- Data on ICU activity are being sourced on an annual basis from the Australian and New Zealand Intensive Care Society (ANZICS) based on the AORTIC database. This now covers most but not all ICUs accredited for training. In conjunction with this, the requirement for ICUs to submit data to AORTIC or to a similar national or international comparative database has been enhanced with specific responses sought on the accreditation visit report form.
- IC-3 has been modified in response to the new curriculum and is now available in two versions to reflect the changes (i.e. pre 2014 and post 2014). The original version will be phased out when the last trainees complete training under the old curriculum.
- All accredited ICUs have received notification of their classification under the new curriculum. This includes the suitability of ICUs for subspecialty (cardiac surgery, neurosurgical and trauma) experience. A small number of ICUs have also been accredited for the paediatric component of the new curriculum requirements. This requirement may be met over 12 months for those units with a smaller paediatric case load or six months for busier ICUs.
- Criteria for accreditation for Foundation Training have been approved and a process for effecting accreditation has been implemented. These are currently listed in the Application for Foundation Training document.
- Criteria have been established and a process successfully implemented for the accreditation of sites for the anaesthetic component of ICU training in hospitals that are not accredited for training by ANZCA.

Changes and developments that are proposed:

- Incorporation of the requirements for the Transition Year into the hospital accreditation process. While it may be possible to complete the Transition Year in units not specifically accredited for training by CICM, it is anticipated that most trainees will undertake this component in accredited units. It will likely be of advantage to both trainees and ICUs to maintain a register via the accreditation process of units that have an established and approved Transition Year role available. A specific document outlining the Transition Year requirements will be developed.
- Through ongoing collaboration with ANZICS, it is hoped to achieve closer scrutiny of ICU activity in accredited units in the period between formal accreditation inspections.

b. Summarise the College's accreditation activities since the 2011 AMC assessment, and the outcomes of these activities.

The following table shows the number and type of College accreditations by year:

Year	Re-accreditation Applications	New applications received	ICUs inspected	Applications approved	Total Units Accredited
2011	17	9	20	26	107
2012	9	9	16	17	115
2013	15	12	20	21	128
2014	16	8	20	16	131

As well as the above, 15 ICU's have applied for accreditation for Foundation Training and all achieved accreditation. Six hospitals have applied for accreditation for the anaesthetic component of intensive care training and all six were successful

c. Outline mechanisms for trainees or supervisors to raise concerns about the training environment outside accreditation process. Indicate how many concerns have been referred to the College since 2011 and how the College has addressed them.

Trainee Survey

The trainee survey has been discussed in the previous section (8.1). Initially, very few trainees expressed concerns. However, more recently a small number of trainees have requested further assistance. A CICM staff member has been allocated to call each person individually and have an open discussion with the trainee. The conversation is not recorded and only minuted if the trainee wishes this to occur. Pursuit of matters raised via the Censor's committee is offered together with the possibility of a formal written submission.

Among issues raised under these circumstances by trainees have been:

- Bullying
- Inadequate presence of consultants on the floor
- Insufficient time allocated to bedside teaching or tutorials
- Inadequate rapport and relationship between the supervisor and trainees in the unit
- Difficulty in accessing resources that may assist in examination preparation

Trainees are reassured of anonymity and confidentiality unless they choose to make a written submission and are offered follow up. To date, phone discussion has been sufficient. Survey results are summarised and reported to the Education Committee.

Trainee Committee

Additional opportunities for support and having grievances addressed are afforded by the Trainee Committee that is chaired by the New Fellow Representative of The Board (discussed above under Standard 7). Committee membership is openly publicised on the College website to facilitate direct contact with local representatives.

Direct Contact

Trainees are able to contact the College via telephone, in writing or by email. The College believes that the provision of multiple contact routes best meets the needs and preferences of different trainees. With all contacts, trainees are advised that their discussion with the College will remain confidential unless they require the involvement of the Censor's Committee and specifically agree to disclosure.

Key issues identified by trainees using direct contact via these mechanisms have mostly revolved around issues with supervisors; specifically, inadequate supervision and education and a disinterest shown by the supervisor towards trainees. In general, trainees are advised to

first discuss their concerns with the supervisor if this had not already been undertaken with a provision for active follow up via further direct contact if unresolved.

Support for Supervisors

There are also mechanisms in place for providing support to supervisors overseeing trainees that are experiencing difficulties. Training resources are made available to supervisors and training workshops are available. Resources include training document *T-13 Guidelines for Assisting Trainee with Difficulties.* A detailed process for response to trainees in difficulty is in place. Such trainees are directly identified by supervisors or others and are also identified on the basis of one or more periodic reports (ITERs). The process has involved experienced clinician members of the CICM Regional Committees to assist both the trainee and the College to resolve any perceived difficulties. Specific remediation, however, is more usually a workplace function.

Mechanisms are available for direct contact by supervisors with College officers for confidential or more formal discussions. Concerns can be escalated to experienced staff and office bearers. As for trainees, a range of contact processes is facilitated to best meet the preferences of the individual supervisor. Another avenue for a supervisor to seek College involvement is via the ITER. Supervisors can submit the ITER with specific details, identifying the key areas in which the trainee in question is having difficulties.

Specific Challenges

The College has encountered some difficulties with specific training sites. Most commonly, this has revolved around local work practices and personalities. Accreditation has been withdrawn from three sites, two of which no longer met criteria for accreditation in respect of patient throughput or physical and organisational infrastructure. Withdrawal of accreditation for training can have a very serious impact on staffing and management of ICUs and is not undertaken lightly. On each occasion, discussion amongst experienced Board members has been extensive and opportunities for remediation have been offered. It is likely that the problems encountered with smaller units relate to the difficulty in maintaining appropriate infrastructure and support; and with the larger ICUs the problems often relate to the very large senior medical staff establishments. The latter is an evolving problem and it may be necessary for the College to facilitate some discussion of the management problems associated with these ‘mega-units’.

d. Outline any other challenges or plans the College is addressing in relation to Accreditation Standard 8.2.

Although not directly linked to accreditation, the emerging manpower issues raised within the speciality may have some impact. Any increase in the number and scope of accreditation of ICUs across Australia and New Zealand will create the potential for and even a need for, ever more trainees at a time when graduands of the Fellowship program are not all able to achieve satisfactory employment. Under the circumstances, it is appropriate that criteria for assessing units for accreditation be strictly and consistently applied.

9. CONTINUING PROFESSIONAL DEVELOPMENT

Summary of matters to be addressed in the 2015 submission

a. Outline of the College's CPD program. Please outline the processes in place and any plans for further development.

The philosophy behind the CPD program is to foster ongoing learning of all intensive care specialists, both Fellows and Non- Fellows, in order to promote a high standard of clinical practice, scholarship and quality improvement, as well as to encourage personal development. The emphasis is on self-motivated education and the promotion of adult life-long learning.

Each participant is expected to develop a 'Personal CPD Plan'. Self-evaluation and reflection are crucial to this process and so the components of self-assessment and peer comparison are strongly encouraged. Each individual records his or her program structure, activities and reflective self-assessments in a user-friendly online CPD diary. Deficient areas and educational activity types can be self-targeted for improvement. Activities are varied and the program offers flexibility and diversity in crediting educational activities to meet the varied needs of individual participants, including those in rural and private practice. The CPD program is compulsory for all active Fellows.

The CPD program is managed by a designated member of the College staff. Overall responsibility for CPD lies with the Board. The College has established the Fellowship Affairs Committee that oversees general aspects of the CPD program, such as its development and evaluation, and matters relevant to Fellows such as welfare, safe hours, credentialing and certification. The CPD Officer is a Board Member and chairs the CPD Committee. This committee also has representation from a new Fellow, the trainee member represented on the Board, and staff members employed by the College. The CPD officer is responsible for developing and maintaining the structure and function of the CPD program with the assistance of the committee. Specific questions are directed to the CPD Officer, who is responsible for maintaining a register of approved courses and activities. The College substantially follows the structures and requirements set out in Medical Board of Australia's Continuing Professional Development Registration Standard.

A working group involving Fellows and College staff, under the supervision of the Fellowship Affairs Committee, completed development of the program and it was successfully implemented in January 2012. The CPD program has different educational frameworks, with added credit provision for activities with high quality educational features. Technical improvements have enhanced the working interface for participants. Several initiatives to improve access to educational material have been developed and initiated.

Key features of the program are:

- The cycle is two years, with the current cycle beginning January 2014 and ending in December 2015.
- Self-reflection and evaluation processes have been incorporated as compulsory activities.
- CPD activities that develop knowledge, skills and attitudes essential for meeting the changing needs of patients and the health care delivery system, and for responding to scientific developments in medicine as well as changing societal expectations are encouraged. Credit for such activities are accrued and rated appropriately. For example, receptive self-learning accrues one credit unit per hour, while educational activities that have components of situated and experiential learning, or robust reflective and assessment components, are credited advantageously and may accrue up to three credit units per hour. Focused learning projects that address self-determined deficiencies are encouraged. Participants may pursue projects in areas of interest in a structured and systematic manner. The projects should be

learner-initiated, appropriately planned and must have educational objectives. Activities addressing new scientific developments are appropriately encouraged and accredited.

- Opportunities for the inclusion of activities relating to QA (including audit), medical professionalism (including cultural awareness), and patient safety have been provided. Participation in activities within this category is compulsory. Some relatively new practical and procedural skills have become integrated into intensive care practice in recent times. These include use of video laryngoscopy, echocardiography, localisation and cannulation of blood vessels using ultrasound guidance, and extra corporeal membrane oxygenation (ECMO). The College accredits hands-on courses on all of these procedures as part of its CPD program, and provides Fellows with easy access to potential providers through the College website.
- Participants must obtain at least 100 points over a two-year cycle. Activities are recorded in the online diary. Participants are required to submit an annual return of their activities online from 1 January to 31 December of each two-year cycle. Upon satisfactory completion of the cycle a certificate of successful completion is generated online and can be printed by the participant.
- It is acknowledged that many CICM Fellows are also fellows of another College. Other college programs judged to be a reasonable alternative to that of CICM are those of ANZCA, ACEM and RACP. Therefore CICM Fellows who complete one of these other college programs may apply to have this recognised for their CICM CPD. It will be necessary for them to provide a certificate of compliance from the respective college in order to fulfil the CICM requirements.
- Fellows residing overseas can complete the College CPD program otherwise are required to complete the CPD Program in their country of residence.
- The process for assessing and recognizing CPD providers and individual CPD activities has been standardised. Accreditation of providers is for a fixed term, followed by re-application, to ensure a high standard is maintained. All educational activities are assessed for suitability by the CPD Officer who is a member of the CICM Board and has been appointed to the CPD portfolio.

The principles and criteria used for evaluation of CPD activities are:

- Relevance of learning objectives of the activity to the objectives of the CPD program.
- Qualifications and track record of activity providers.
- Modality of learning used in the activity.
- Assessment of the level of participation undertaken during the activity.
- Formative and/or summative assessment processes.
- Availability of participant feedback (that may be provided to the College on request).
- Time spent completing the activity.

Based on the degree of compliance with each of these criteria, activities are approved and credited appropriately. An example of the application template for accreditation of an activity for CPD points can be found on the College website and a full summary of the current activity program framework is detailed in the manual.

Random audits (of 5% of participants) are undertaken each year. Records of activities reported in the CPD diary are expected to be kept by participants, and each year 5% of participants are reviewed to verify the accuracy of returns and the relevance of activities claimed. Non-Fellow participants have full access to the online diary, educational material, and statements of participation and/or completion are provided yearly for an annual fee. The program for Fellows and Non-Fellows, including requirements and minimum standards is equivalent.

As the program is compulsory, steps have been taken to ensure that Fellows are participating, and if not, advice and assistance offered. Non-participating Fellows are made aware of potential

consequences of noncompliance. A clear process for dealing with non-complying Fellows has been developed. Details of the online diary, activity framework, and regulatory documents are available in the CPD Manual.

Formal Assessment of Ongoing Competence and Performance (Professional Practice Review)
Where a Fellow finds it impossible to participate in the CPD program (e.g. because of practice in a remote location), he or she may apply to the College to undergo a Professional Practice Review (PPR). This is a one to three day review of a participant's practice, on-site in the intensive care unit, by a peer nominated by the Regional/National Committee of the College, and endorsed by the CPD Officer. For participants who work at the same institution, up to two participants can be reviewed by the peer at one time. When the visit has been completed and PPR is approved, the participant will be awarded appropriate activity points.

The PPR provides an opportunity for participants to gain specific information about their practices that will assist them to maintain the best possible standards of care. Participants need to register and pay a fee as determined by the College. A written report is required from the reviewer. Despite the availability of this form of assessment, the College has received few enquires to date and no Fellow has requested a PPR. Consequently the College has no data to support its validity or reliability.

b. Challenges remaining for the College and strategies to address them.

Strengths of the current program include its educational construct, flexibility, simplicity and the ability of Fellows to target specific areas of interest or deficiency. Challenges remain, and developing appropriate IT solutions to enhance understanding of the program and maximise ease of use remains a goal. Although a new platform was initiated with the roll out of the new CPD Program in 2012, based on user feedback, the College is again revising the IT platform on which the CPD program runs to improve user friendliness. The main focus will be to allow the processing of automated credits for College run educational activities.

Despite the challenges and resources required, the College also sees the provision of educational material to Fellows as an important initiative and is enhancing its role as a deliverer of educational material as part of the CPD Program.

- The major Continuing Medical Education activity run by the College remains the Annual Scientific Meeting (ASM). This meeting is based on a single theme which is specifically chosen as an area that is "cutting edge" and controversial. Consequently Fellows who attend have the opportunity to learn in a setting that is modern, relevant and very much in tune with the latest models of care.

- Every ASM has a one-day, pre ASM program, "ICU Update Program", incorporating lectures and workshops that provide up to date clinical educational material.

- The College now offers online educational material which is available to Fellows as well as trainees. Courses include "Brain Death and Organ Donation", "Neuro Intensive Care", and "Spinal Cord Injury". Several others are in development

- The College facilitates or provides generic educational courses for Fellows designed to fill gaps in currently available educational opportunities, e.g. BASIC Paediatric Intensive Care, ICU Management Skills Course.

- The College journal Critical Care and Resuscitation is circulated to all Fellows and trainees and provides another educational resource.

c. Please provide data showing the number and proportion of fellows participating in the College's continuing professional development programs from 2011 to 2015, showing Australian and New Zealand information separately.

Note: All figures include retired Fellows who are not required to undertake CPD, however some opt to do so.

2011 – MOPS

	Total	Australia	New Zealand	Rest of the World
Number of Fellows	798	625	71	102
Number of MOPS Participants	324	275	41	8
Percentage of Fellows	40%	44%	58%	8%

2012/2013 – CPD

	Total	Australia	New Zealand	Rest of the World
Number of Fellows at the end of 2013	931	725	83	123
Number of CPD Participants	861	680	76	105
	92%	93%	91%	85%

2014/2015 CPD (mid–way through the cycle)

	Total	Australia	New Zealand	Rest of the World
Number of Fellows by end of 2014	978	776	88	114
Number of CPD Participants	565	453	64	48
	57%	58%	73%	42%

d. Outline how the College's retraining and remediation policies have developed since the 2011 AMC accreditation.

The College has developed a guideline document to address this standard. It is based on the current College Professional document IC-15 *Recommendations for Practice re-Entry for an Intensive Care Specialist* and has been expanded and renamed IC-15 *Guidelines on Practice Re-Entry, Retraining and Remediation for Intensive Care Specialists*. This document was reviewed at the Fellowship Affairs Committee and was ratified by the Board in November 2012. It was the view of the College that it is preferable to include the newly documented structured process for remediation of Fellows with the existing process for re-entry of Fellows after a period of absence, rather than to create a new policy document.

The document outlines methods for specialists to upgrade their knowledge, clinical skills, and professional qualities prior to returning to independent practice. A "refreshment of knowledge and skills" program will be advised, generally with the assistance of a mentor. The re-entry program has several components, including, a "return to work plan" detailing areas that require up-skilling, supervised experience, in-training evaluation reports, and approval by the Fellowship Affairs Committee. When re-training/remediation is required and approved by the Fellowship Affairs Committee, a program will be devised under the supervision of a nominated supervisor. Supervision will be appropriate to circumstances but at least at the level required for a College trainee. Methods of assessment will vary, but include in-training workplace assessment reports. Should the program be completed to the satisfaction of the Board, the appropriate regulatory body will be informed.

APPENDICES

APPENDIX 1:	**Intensive Care Workforce Summit**
APPENDIX 2:	**Minutes of Community Advisory Group meeting - 15 October 2014**
APPENDIX 3:	**Definition of an Intensivist**
APPENDIX 4:	**Results of the Quality of Training Survey - September 2014**
APPENDIX 5:	**Analysis of Performance and Predictors of Success in the Final Fellowship Examination of the College of Intensive Care Medicine**
APPENDIX 6:	**Training Agreement**
APPENDIX 7:	**Recommendation to OTS Committee**
APPENDIX 8:	**Minutes of Censors Committee meeting - 13 May 2014**

APPENDIX 1

Intensive Care Workforce Summit

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2) A Prof Andrew Turner MBBS FCICM FRACP
President, Australian and New Zealand Intensive Care Society

Abstract

In the last 5 years, there has been a significant rise in the number of trained and fully qualified specialists in intensive care medicine. Concerns about saturation of specialist employment opportunities in recent times and the prospect of new fellows unable to find appropriate employment following completion of training has brought intensive care workforce issues to the forefront. The Board Members of the College of Intensive Care Medicine (CICM) and Australia and New Zealand Intensive Care Society (ANZICS) held a Workforce Summit meeting, with invited guests including Presidents of other medical colleges, government officials and legal experts. Current data were presented on College trainee numbers, graduates and compared with similar data from other colleges. Results of workforce surveys of intensive care units and recent CICM graduates were also presented Projections of future workforce requirements are notoriously uncertain, however there was clear agreement among the group that at the present time, the employment opportunities for new Fellows at Consultant level are limited. Recent changes to the selection process for new trainees have had a dramatic impact on the number of new trainees in 2014, however the enduring effect of this is yet to be determined. The group discussed potential growth areas for employment of intensive care consultants including changes in employment patterns and also the impact of reduced numbers of trainees on unit staffing. CICM and ANZICS have agreed to continue to monitor and discuss the situation on a regular basis.

The College of Intensive Care Medicine (CICM) of Australia and New Zealand was established in 2008 and formally assumed the responsibility for training and certification of intensive care specialists from the Joint Faculty of Intensive Care Medicine on 1st January 2010(1). Although formal Intensive Care Units (ICUs) were established in Australasia in the 1950s and 60s, vocational training in intensive care commenced in the 1970s. Over the last 40 years, there has been a steady expansion of the scope and practice of intensive care medicine. Expansion of ICUs has followed advances in understanding the pathophysiology of multiple organ dysfunction syndrome and development of new therapies and technology which could be provided safely only within the ICU. The availability of a distinct and a well-defined training program coupled with increasing demand for fully trained specialists led to a steady increase in the workforce supply over the last 30 years.

One of the original publications into intensive care workforce in Australia was the AMWAC (Australian Medical Advisory workforce Committee) report published in 1999(2). After a detailed analysis of several sources of

data and survey of Fellows and trainees, the Working Party concluded “that the workforce is currently undersupplied and that trainee intake will need to be boosted to reduce this shortfall. The Working Party believes the key factor influencing future supply and requirements will be hospital role delineation and available intensive care infrastructure.” Concerns about general medical workforce shortage were also echoed in other reports published a few years later (3,4).

Prior to 2005, there was still a significant dependence on international medical graduates (IMGs) for specialist service provision. The JFICM, in an effort to boost trainee numbers modified the regulations to facilitate dual training (that is trainees wishing to do other training programs simultaneously), and facilitate entry of IMGs into the intensive care training program. The net result of this effort was that there was a marked increase in the number of trainees who subsequently went on to complete the Fellowship of the Joint Faculty and become fully qualified intensive care specialists. Early indications that this approach was effective were noted in a report on medical staffing trends of ICUs in Australia and New Zealand. In this report, data was collected using annual surveys for financial years 1999/2000 to 2005/2006 to compare the proportion, number and full time equivalent (FTE) of intensivists and other specialists working in intensive care medicine(5). Across all levels of ICUs, there was a significant increase in both intensivist numbers and proportion of fully qualified specialists in intensive care as compared to other specialists in ICU such as anaesthetists etc. Rural and provincial ICUs were now staffed adequately with fully trained and qualified specialists. Increase in specialist numbers also allowed the creation of jobs with specific areas of responsibility such as organ donation and rapid response teams.

In the last 5 years, there has been a significant rise in the number of trained and fully qualified specialists in intensive care medicine. However this increase has not been accompanied by a parallel increase in or availability of specialist jobs. Two surveys of recently qualified specialists indicated that there were a significant proportion of fellows who may be underemployed (6,7). There was also a trend towards part time employment. Thus, concerns about saturation of specialist employment opportunities in recent times and the prospect of new fellows unable to find appropriate employment following completion of training has brought intensive care workforce issues to the forefront. Questions have therefore been raised about workforce planning to match the output of the training program with available job opportunities. This in turn will have implications about the optimal number of trainees that CICM should train in order to match demand.

To address these important workforce issues, the CICM in conjunction with the Australia and New Zealand Intensive Care Society (ANZICS) hosted a workforce summit to examine the following issues.

Aims of the Summit

a) To review the current registration and training completion status of trainees registered with the CICM.
b) To obtain comparative data on trainee numbers from other Colleges.
c) To review the current status of New Fellows employment across Australia and New Zealand.
d) To obtain data on potential future increases in intensive care specialist requirements across Australia and New Zealand and
e) To review alternative models of trainee selection.

Methods

The Conference was held on the 19 November 2014 in Melbourne. The Conference convened the following invitees:

1) Members of the Board of the CICM
2) Members of the ANZICS Board
3) Regional Chairs of CICM
4) Regional Chairs of ANZICS
5) Paediatric Intensive Care representative
6) CEO's of CICM and ANZICS
7) Presidents of the Australian and New Zealand College of Anaesthetists (ANZCA) and the Australasian College of Emergency Medicine (ACEM)
8) President of the Australian Medical Council
9) Department of Health workforce division representative
10) Editor-in-Chief, *Critical Care and Resuscitation*
11) Senior intensivists from other ICUs including a 24 hour consultant roster ICU

Selected participants were assigned a specific topic to prepare and provide a summary. In the latter half of the day, four parallel workshops were held on selected topics.

Key Findings

Summary report form national and regional surveys

1) CICM currently has 898 active Fellows (including overseas Fellows) and 594 active trainees.
2) Advanced trainees to Fellows ratio is 0.44, substantially higher than most other Colleges. (See Table 1).
3) With increasing numbers of trainees, concerns were raised about ability to provide quality supervision, and diminishing access to anaesthesia training jobs.
4) A small proportion of trainee positions were occupied by Fellows who remain employed as senior Registrars in tertiary centres.
5) Compared to most other colleges, CICM graduate a high proportion of new Fellows each year although there is a high attrition rate. Only about 30-40% of registered trainees go on to complete the full Fellowship of the CICM.
6) Recent changes to trainee selection has had a dramatic impact on new trainee numbers with a substantial reduction in trainee registrations in the year 2014 (although the extent to which this will continue is uncertain).
7) Around 22% of recent graduates are 'underemployed' (although data around this needs more exploration) (based on surveys of New Fellows by CICM and recent ANZICS survey of Fellows).
8) New public ICU positions are increasingly fractional appointments and VMO contracts are gaining in popularity.
9) There has been a decrease in area of need positions across the regions.

10) A number of regional hospitals prefer to employ anaesthetists to provide cover for ICU, as it is more cost-effective rather than employing full time intensivists.
11) Work practices in some jurisdictions may result in an individual holding multiple appointments across different intensive care units with a total commitment sometimes exceeding 1 FTE (Full Time Equivalent).
12) There is no oversupply of paediatric intensive care specialists at the present time.
13) Data from ANZCA suggest that they are also experiencing increases in Fellow throughput and a number of underemployed Fellows. Reports from ACEM indicate that they are not experiencing the oversupply of Fellows experienced by CICM and ANZCA.
14) Trainees naturally have expectations of employment as a specialist as part of their career progression. It is essential that trainees have access to better information to enable them to make individual career choices. Medical students and basic trainees are increasingly aware that ICU specialist jobs are scarce.

Summary report from AMC, Department of Health Workforce Division and Legal Experts

- Under consumer protection law (Australian Competition and Consumer Commission) the College may not engage in conduct that has the purpose of restricting or limiting supply (of graduates).
- The College sets the standards for training, including selection of trainees into the program. The selection criteria may have the effect of limiting the numbers of trainees entering the program, but the process must be fair and transparent.
- Workforce planning is not solely the responsibility of the College. Government, hospitals and others have a stake in determining health workforce planning and the number of vocational trainees
- The AMC's main concern is that the college's stated criteria for selection into the training program are fair and align well with the suitability for intensive care training, and are consistently applied across all jurisdictions.

Summary report from workshops:

- Predicting future demand for graduates is complex and subject to great variation. Retirement and migration patterns are hard to predict, and future increases in ICU bed numbers, rostering arrangements, expanded roles, etc., are likewise complex and difficult to forecast accurately. There is likely to be demand for an increased number of ICU specialists in the future (overall population growth and ageing will ensure this) but accurately quantifying this on available data and economic predictions is impossible.

- A reduction in the number of trainees entering the program may have an impact on unit staffing. The potential consequences include:
    - The need to develop a second tier qualification at a 'Hospitalist' level.
    - Difficulty in filling all registrar positions at some hospitals.
    - Working with other colleges to increase the requirement for ICU training time in other specialist programs (e.g. Cardiology, Respiratory Medicine) may assist with this.
    - Changes to rostering and on-call arrangements for consultants

  - An increase in the number of Career Medical Officers (CMOs) working as registrars in ICUs.

- Unit staffing is the responsibility of the hospital, not the College. Under a situation of permanently reduced trainee numbers, jurisdictions and individual hospitals would need to come up with strategies to ensure adequacy of staffing.

- There exists the potential to develop regional training programs, where trainee selection, progress and training rotations (e.g. through anaesthetic, medicine and rural terms) are monitored and directed locally. In some cases this could be state-wide (or even multi-state), and in other larger states, more localised.

- Demand for the non-ICU components of training (e.g. anaesthetics) and access to the specific clinical components of ICU training (e.g. trauma) may restrict trainee numbers due to the limited availability of those placements.

- The current trend to fractional appointments is a concern. If the trend continues it would suggest that Fellows with dual qualifications will be more likely to obtain full time employment by a single hospital.

Discussion

This is the first ever workforce summit held by the CICM and ANZICS to address workforce issues. The key findings are that projections of future workforce requirements are notoriously uncertain, but there was clear agreement among the group that at the present time, the employment opportunities for new Fellows at consultant level are limited. Recent changes to the selection process for new trainees have been associated with a dramatic reduction in the number of new trainees from 334 in 2013 to 55 in 2014, however the enduring effect of this is yet to be determined.

Several recent publications have outlined global workforce issues with an estimated shortage of 4.3 million healthcare professionals (8,9). Despite an increased intake of medical students across Australian universities, it is projected that there will be a shortage of doctors until 2025.

With respect to intensive care medicine in particular, the figures do not suggest an absolute shortage of specialist numbers across Australia and New Zealand at the present time. There are however rural versus metropolitan ICU staffing discrepancies. These conclusions are based on current data and do not assume changes to ICU scope and practice in the future. These data are also consistent with ICU workforce projections in resource rich countries such as the USA, as well as in resource poor countries (10,11,12). Alternative staffing models in ICUs in the USA have challenged the notion that there is a critical care workforce shortage (13).

However a number of potential issues may influence the number of intensive care specialists required in the future. For example, increases in ICU bed numbers, requirements of hospitals and/or jurisdictions for intensivists to work shift work providing 24 hour cover, and the increasing role of intensivists outside of ICU such as in retrievals, and perioperative medicine may increase the demand for the workforce. Moreover, these

projections do not factor in retirement plans of intensivists, healthy and sustainable work patterns for the "ageing Intensivist" (14) and higher rates of burnout amongst intensivists (15).

In summary, this summit highlights an emerging area for ongoing attention, and has provided the CICM and ANZICS with baseline data and a framework on which to plan future summits. The CICM and ANZICS plan to host regular summits to discuss the workforce issues on a regular basis to ensure appropriate trainee selection processes, maintenance of training standards and satisfactory career progression for those opting to pursue a career in intensive care medicine.

Acknowledgement: The workforce summit was supported by funds from the College of Intensive Care Medicine and the Australian and New Zealand Intensive Care Society.

Table 1: Trainees-Fellows ratio in the Australasian Colleges for the various specialties

	Australian Fellows 2012	Admissions in 2012	2013 Advanced Trainees	Trainee/Fellow Ratio
Emergency Medicine	1,340	135 (10.0%)	1,339	1
Intensive Care Medicine	640	56 (8.7%)	281	0.44
Paediatrics	2,325	146 (6.3%)	556	0.24
Anaesthesia	3,815	229 (6.0%)	657	0.17
Adult Medicine	7,754	456 (5.8%)	1,513	0.2
Obstetrics & Gynaecology	1,559	81 (5.2%)	159	0.1
Surgery	4,467	217 (4.8%)	983	0.22
Ophthalmology	822	38 (4.6%)	90	0.11
Psychiatry	3,073	136 (4.4%)	418	0.14
Dermatology	487	20 (4.1%)	49	0.1

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APPENDIX 2

College of Intensive Care Medicine
of Australia and New Zealand

COMMUNITY ADVISORY GROUP

Meeting to be held on Wednesday 15th October 2014 at 14:00 AEDT

ATTENDEES
Laura Fernández Low, *CICM Policy Officer*
Phil Hart, *CICM CEO*
Felicity Hawker, *CICM Director of Professional Affairs*
Henry Ko, *Consumer Representative* (via teleconference)
Helen Maxwell-Wright, *Chair and Community Representative*
Natasha Tritico, *Allied Health Representative*
Sophie Panagiotidis, C*ommunity Representative* (via teleconference)

APOLOGIES
Jason Watterson, *Australian College of Critical Care Nursing representative*

AGENDA

	ITEM (* denotes attachment)	**ACTION ITEMS**
1.	Introduction of new member	
2.	Review of previous action items*	a) Natasha to provide feedback on public page content to the Group
3.	Appointment of Group Chair	
4.	Nomination for Assessments Committee, Community Representative*	b) Laura to arrange for Henry to receive information on Assessments Committee and assessment processes
5.	Feedback on Policy Document IC-11: *Assessment of Overseas Trained Specialists**	c) Send out numbers on the OTS pass rate at the Exam from 2010 – 2014; review at next meeting. d) Survey former OTS to collect feedback on their experience e) Review the Appeals Policy at the next meeting
6.	Australian Medical Council Response to CICM Annual Report*	f) Review Definition of an Intensivist at next meeting g) Henry to send through information on the Macquarie University School of Advanced Medicine's post graduate training in ICM h) Provide a copy of the responses from the most recent Trainee survey at the next meeting i) Provide a copy of the AMC Standards at the next meeting j) Circulate a copy of the 2015 AMC review outline to the Group once received k) Look at ACEM process for anonymous trainee surveys l) Henry to provide a copy of the ACGME ICM program requirements guideline for information
7.	Next meeting	April 2015

MINUTES

1. Introduction of New Member

Phil opened the meeting and introduced the newest member of the Group, Ms Natasha Tritico, recently appointed as the Group's Allied Health Representative. Natasha has worked as a clinical social worker in acute hospitals for over 10 years and is currently working at Monash Medical Centre as the Team Leader for the critical care team.

2. Review of Previous Action Items

The Group briefly reviewed the list of action items from the previous meeting, and in reference to item 2 and the addition of a page for the public on the CICM website, Helen suggested monitoring the use of resource through Google Analytics.

Sophie suggested that former intensive care patients may wish to provide feedback to the College on their experience in ICU. This suggestion will be considered by the College when designing the new website.

As a newcomer to the Group with no previous involvement in developing the content for the public page, and with extensive experience in dealing with patients and their families, Natasha agreed to review the content and provide feedback to the Group.

3. Appointment of Group Chair

The position of Chair on the Group remains vacant so Phil invited interested members to nominate for the position. Helen nominated unopposed and was accepted to the position, and chaired the rest of the meeting.

4. Nomination for Assessments Committee, Community Representative

The College Board agreed that a member of the Community Advisory Group should sit on the Assessment Committee. Helen invited members to nominate for the position, and Henry nominated to fill the position. To assist in his new role, Laura agreed to send Henry information on the role of the Assessments Committee and the College's assessment processes.

5. Feedback on Policy Document IC-11: *Assessment of Overseas Trained Specialists*

The Group was presented with the IC-11 for review to ensure the document not only addresses clinical and training needs, but also ensures the best interests and welfare of those undergoing the OTS assessment process. Members read through the document and discussed various points of interest and sought clarification on some matters.

Helen pointed out section 2.2.2 of the document, and questioned whether the College has a process in place to assist OTS candidates who do not pass the Second Part Exam. Felicity agreed this would be useful and is addressed by Training Document T-13 *Guideline for Assisting Trainees with Difficulties* could be used as a reference.

The Group agreed that data on the number of OTS candidates who have sat the Second Part Exam over the last five years could be reviewed by the Group at its next meeting. It was also suggested that OTS who had previously sat the exam could be surveyed to collect feedback on their experience of the process as a QI initiative.

Phil suggested it would be valuable for the Group to review the *Appeals Policy* at the next meeting.

6. Australian Medical Council Response to CICM Annual Report

The Group reviewed the AMC's response to the College's annual accreditation submission. The Group discussed Condition 5 of the report and Henry questioned the purpose of the statement of graduate outcomes (the College's *Definition of an Intensivist* document) and whether the requirements of Condition 5 relate to the statement itself, graduate outcomes or community need. College staff agreed they too were unclear on this and would seek clarification from the AMC in order to properly address this condition in the 2015 submission. The Group also agreed to review the *Definition of an Intensivist* at its next meeting.

Helen suggested that in the College's response to Recommendation CC (relating to AMC Standard 1.4), rather than list specific documents the College has made contributions towards, we could provide evidence of actual

relationships established with health departments and health services. This could assist in successfully addressing the AMC's requirements for this recommendation.

The Group discussed Condition 9 of the report (relating to AMC Standard 6.1.3) and Felicity suggested looking at how ACEM has addressed the issue of anonymity when conducting trainee surveys as there process has worked successfully.

Laura agreed to provide the following documents to the Group for further discussion at the next meeting: the responses from the latest Trainee survey, a copy of the AMC Accreditation Standards, the outline of the 2015 review of the College by the AMC (once received).

Henry agreed to provide information on the Macquarie University Australian School of Advanced Medicine's post-graduate, sub-specialty program for Intensive Care Medicine.

Phil suggested that in future it would be valuable for the Group to review one College Policy Document at each meeting to ensure community need and interests have been considered.

7. Next meeting
The next meeting of the Group will be held in April 2015.

The meeting was closed at 15:50.

APPENDIX 3

DEFINITION OF AN INTENSIVE CARE SPECIALIST

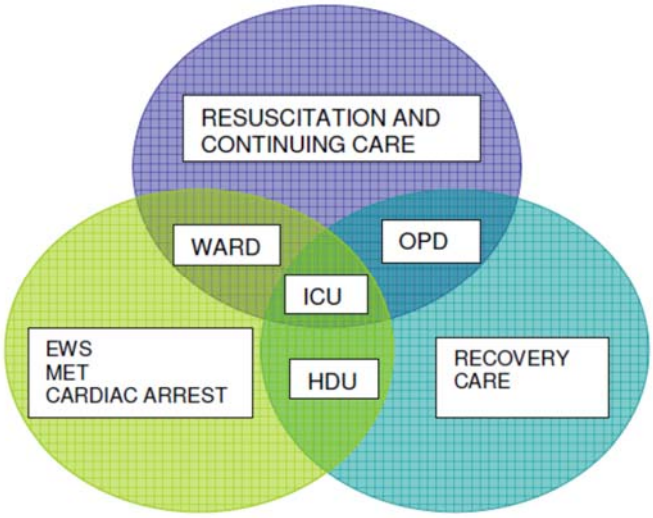
An Intensive Care Specialist is a medical specialist trained and assessed in the comprehensive longitudinal clinical management of critically ill patients. These patients are at variable points in their critical illness and therefore include patients at risk of deterioration to severe illness and those recovering from such illness.

The Specialist is trained to recognise and manage disturbances associated with severe medical or surgical illness. This includes but is not limited to:

- Care of patients using invasive and non-invasive diagnostic, monitoring and treatment techniques for haemodynamic, respiratory and renal support
- Care of patients using specific treatments and monitoring only available in the intensive care unit (ICU). These include the modalities of Continuous Renal Replacement Therapy, specialised respiratory support (e.g. complex multimode ventilators, High Frequency Oscillation and Prone Ventilation), control of intracranial dynamics guided by specialised monitoring (e.g. brain tissue PO2) and invasive haemodynamic monitoring (e.g. continuous cardiac output measurement) and cardiorespiratory support (e.g. ECMO).
- Organisation and participation in early warning systems to anticipate and prevent further deterioration of patients.
- Assistance in the care of or managing sick patients in settings outside ICU, including: the emergency department, hospital ward and high dependency unit.
- Transport of acutely ill patients within, to and between hospitals.
- Assistance with the continuing care of patients recovering from acute illness with specific needs related to that illness, e.g. tracheostomy, respiratory, nutrition, and psychological and neuromuscular problems.

The Specialist is also involved in activities, which support the clinical care of critically ill patients:

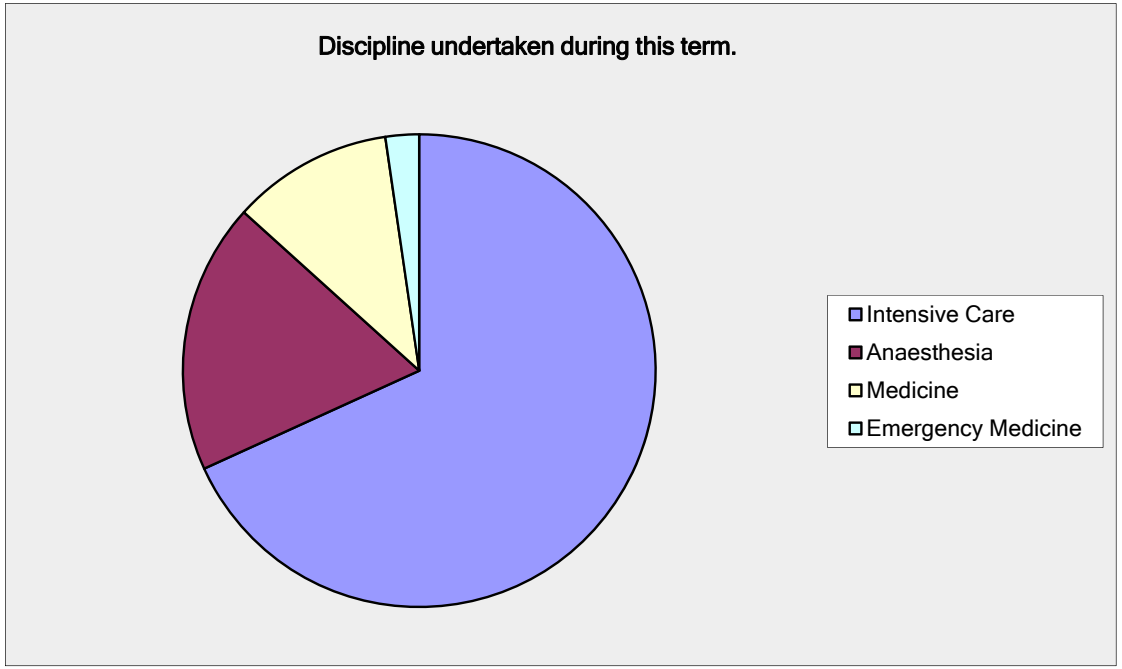
- Research into critical illness and all aspects of its management
- Education on all aspects of the management of critically ill patients
- Administrative tasks related to the management of critically ill patients and ICUs
- Quality improvement in the management of critically ill patients.



APPENDIX 4

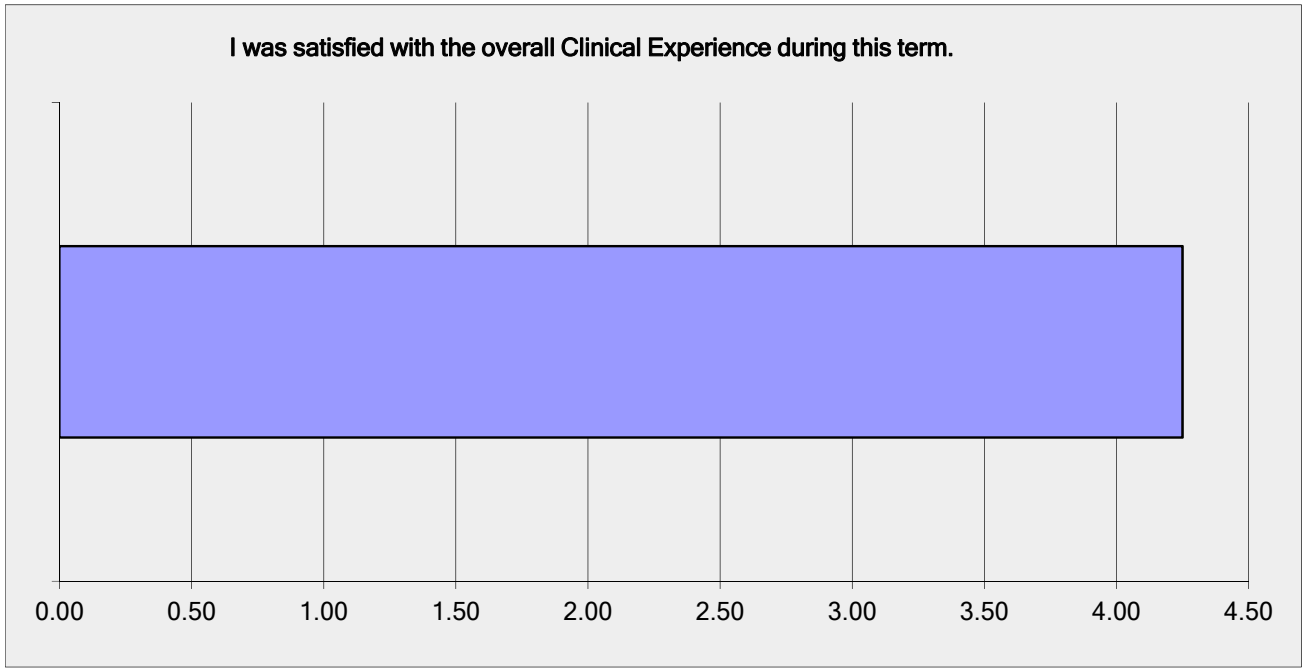
TRAINEE SURVEY RESULTS

Q1. Discipline undertaken during this term.		
Answer Options	**Response Percent**	**Response Count**
Intensive Care	68.2%	118
Anaesthesia	18.5%	32
Medicine	11.0%	19
Emergency Medicine	2.3%	4
Other (please specify)		3
answered question		173
skipped question		0

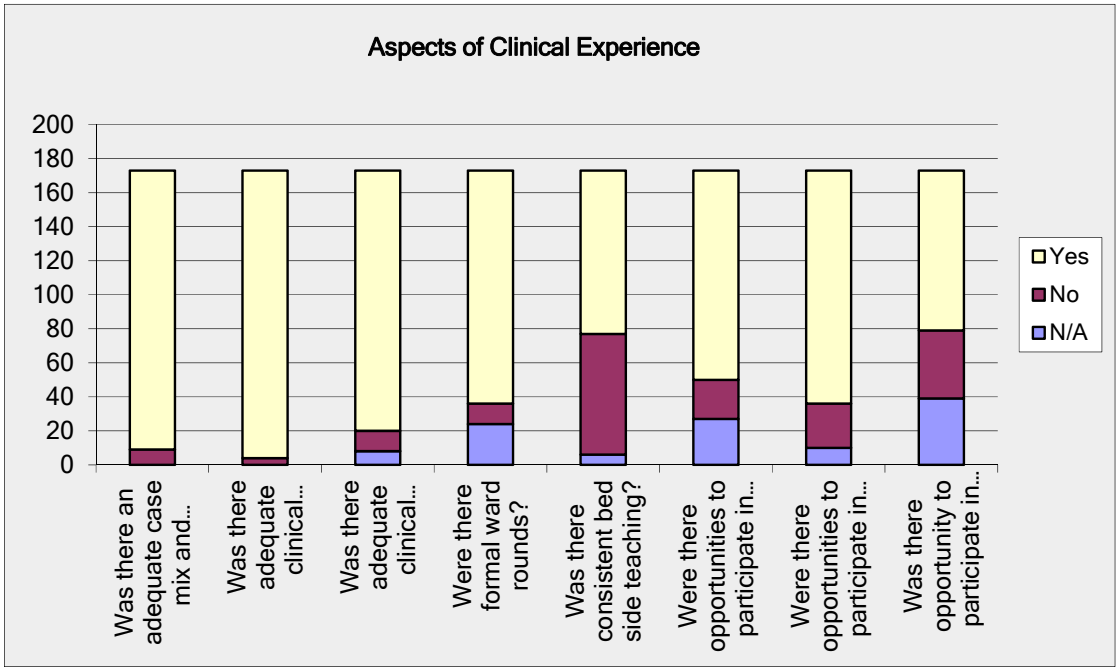


Q2. I was satisfied with the overall Clinical Experience during this term.

Answer Options	Completely Disagree	Disagree	Neutral	Agree	Completely Agree	Rating Average	Response Count
	1	6	8	91	67	4.25	173
						answered question	173
						skipped question	0

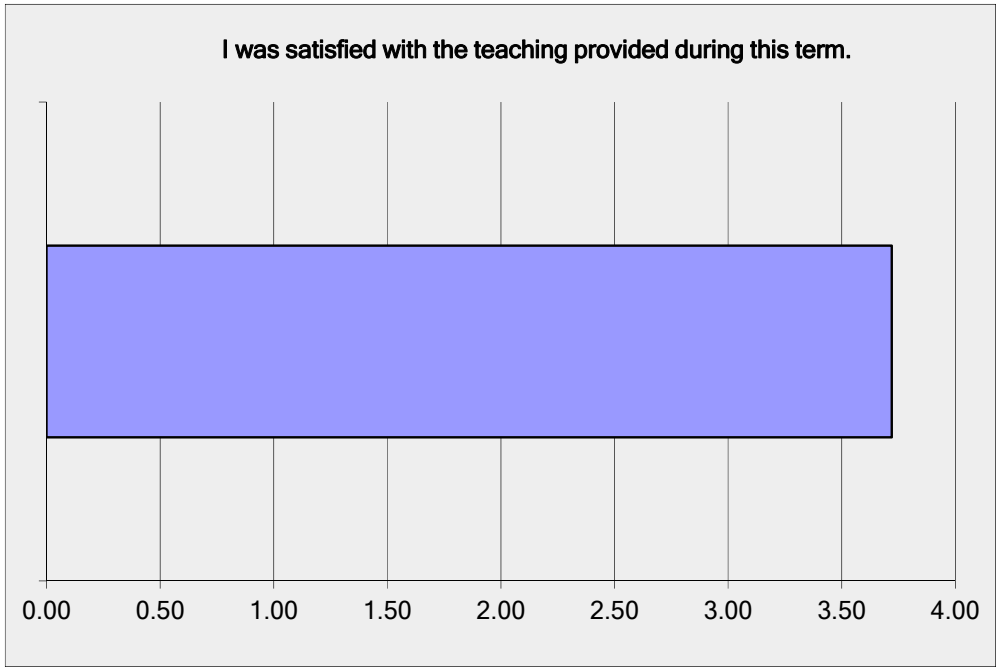


Q3. Aspects of Clinical Experience				
Answer Options	**Yes**	**No**	**N/A**	**Response Count**
Was there an adequate case mix and number of patients?	164	9	0	173
Was there adequate clinical supervision in hours?	169	4	0	173
Was there adequate clinical supervision out of hours?	153	12	8	173
Were there formal ward rounds?	137	12	24	173
Was there consistent bed side teaching?	96	71	6	173
Were there opportunities to participate in patient case presentations on ward rounds?	123	23	27	173
Were there opportunities to participate in patient case presentations in clinical meetings?	137	26	10	173
Was there opportunity to participate in patient case presentations for exam preparation?	94	40	39	173
Any other comments (please specify)				27
			answered question	**173**
			skipped question	**0**



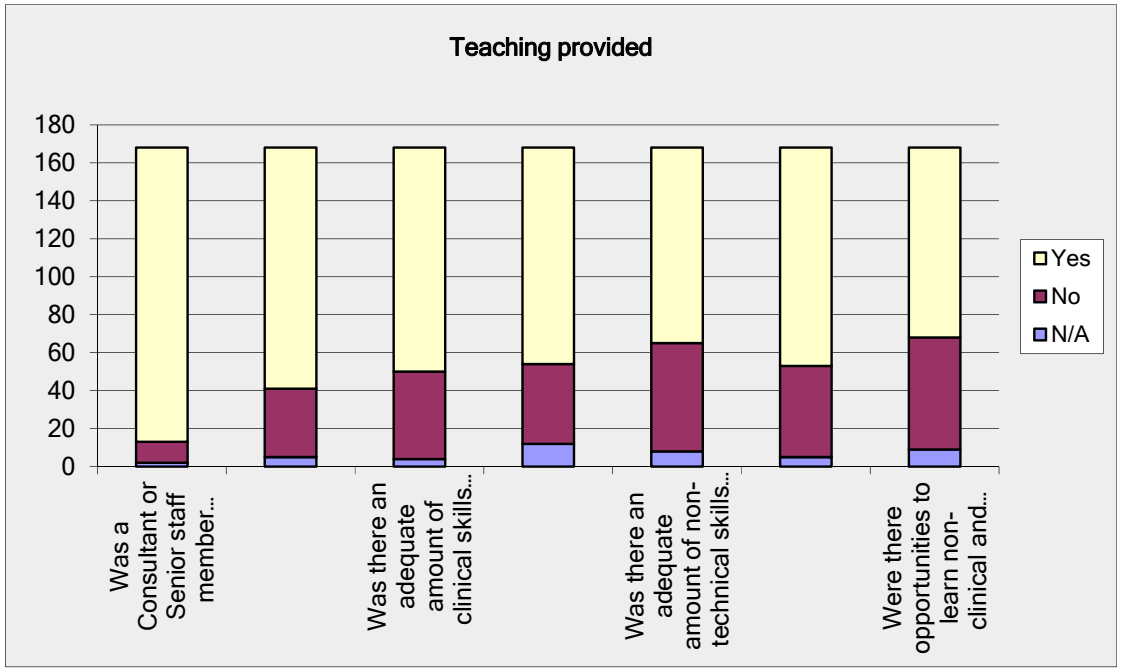
Q4. I was satisfied with the teaching provided during this term.

Answer Options	Completely Disagree	Disagree	Neutral	Agree	Completely Agree	Rating Average	Response Count
	5	20	30	75	38	3.72	168
						answered question	168
						skipped question	5



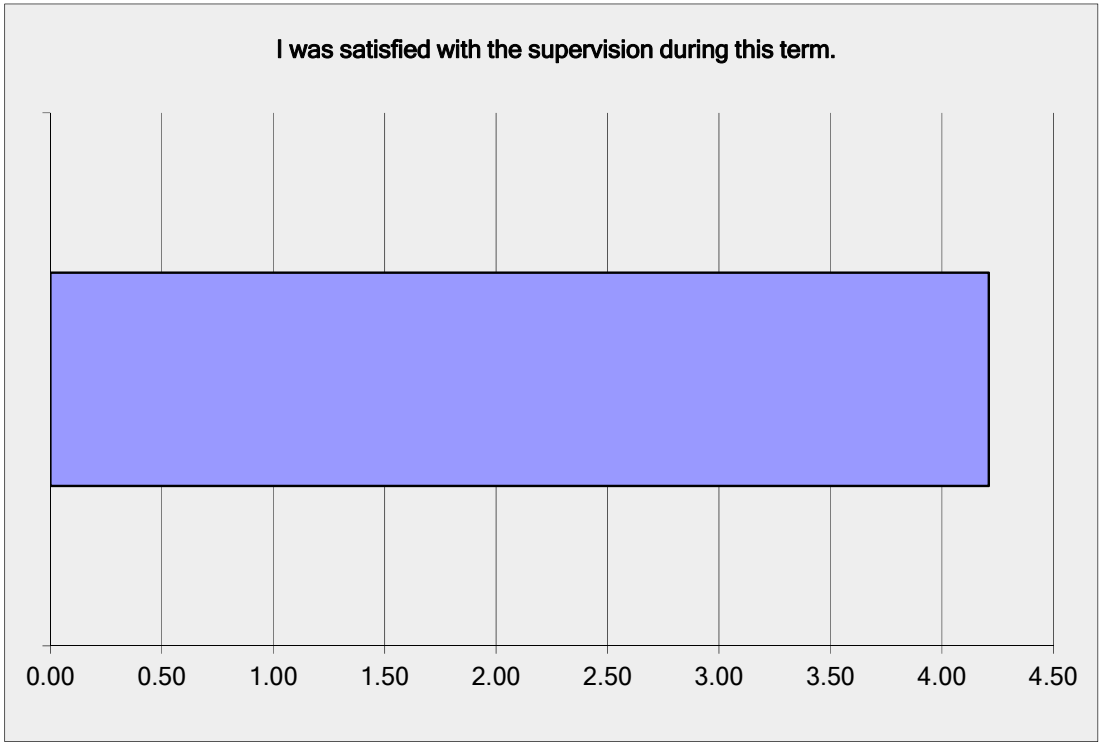
Q5. Teaching provided

Answer Options	Yes	No	N/A	Response Count
Was a Consultant or Senior staff member present?	155	11	2	168
Was there adequate subject breadth and depth?	127	36	5	168
Was there an adequate amount of clinical skills teaching?	118	46	4	168
Was there an adequate amount of procedural skills teaching?	114	42	12	168
Was there an adequate amount of non-technical skills teaching?	103	57	8	168
Were there opportunities to learn teaching skills?	115	48	5	168
Were there opportunities to learn non-clinical and management skills?	100	59	9	168
Any other comments (please specify)				24
			answered question	168
			skipped question	5



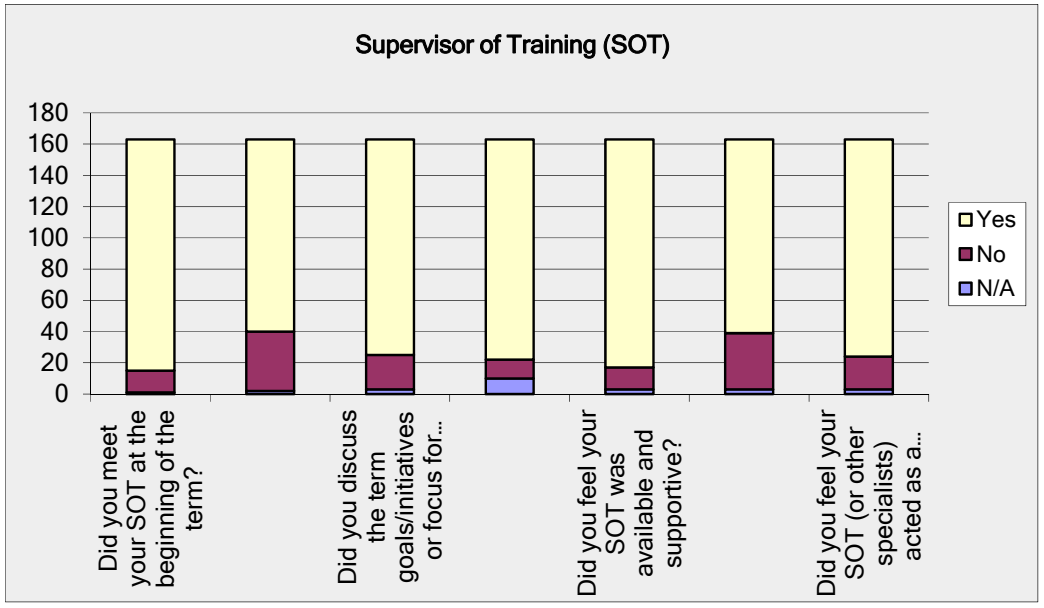
Q6. I was satisfied with the supervision during this term.

Answer Options	Completely Disagree	Disagree	Neutral	Agree	Completely Agree	Rating Average	Response Count
	3	3	10	88	59	4.21	163
						answered question	163
						skipped question	10



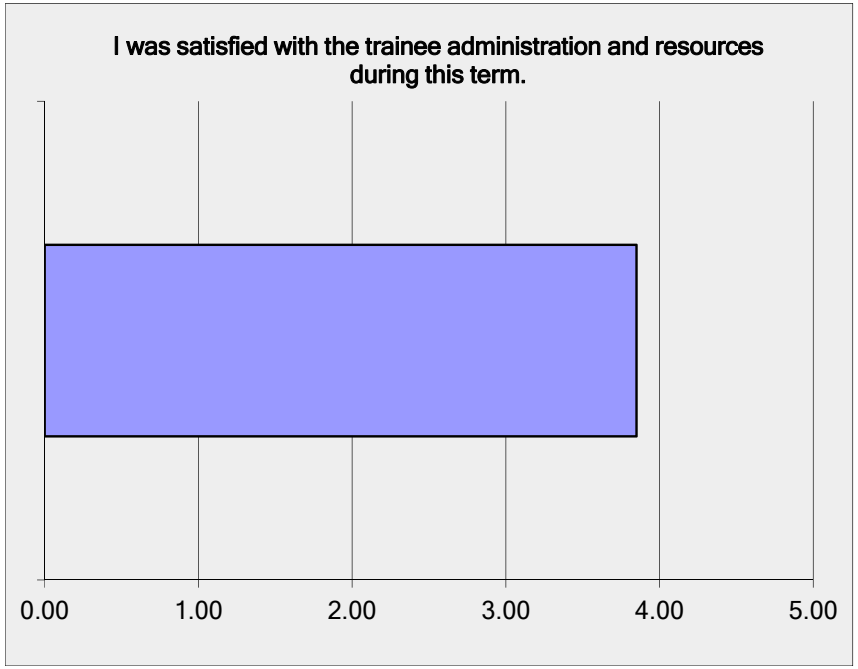
Q7. Supervisor of Training (SOT)

Answer Options	Yes	No	N/A	Response Count
Did you meet your SOT at the beginning of the term?	148	14	1	163
Did you have regular meetings with your SOT during the term?	123	38	2	163
Did you discuss the term goals/initiatives or focus for your development during this term?	138	22	3	163
Was your end of term assessment constructive?	141	12	10	163
Did you feel your SOT was available and supportive?	146	14	3	163
Was there a formalised feedback process during your term?	124	36	3	163
Did you feel your SOT (or other specialists) acted as a mentor?	139	21	3	163
Any other comments (please specify)				19
			answered question	163
			skipped question	10

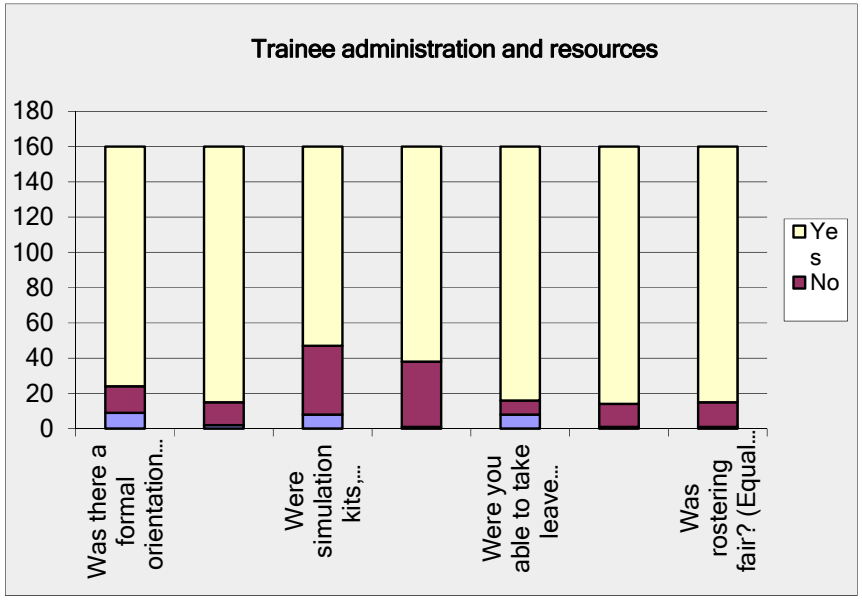


Q8. I was satisfied with the trainee administration and resources during this term.

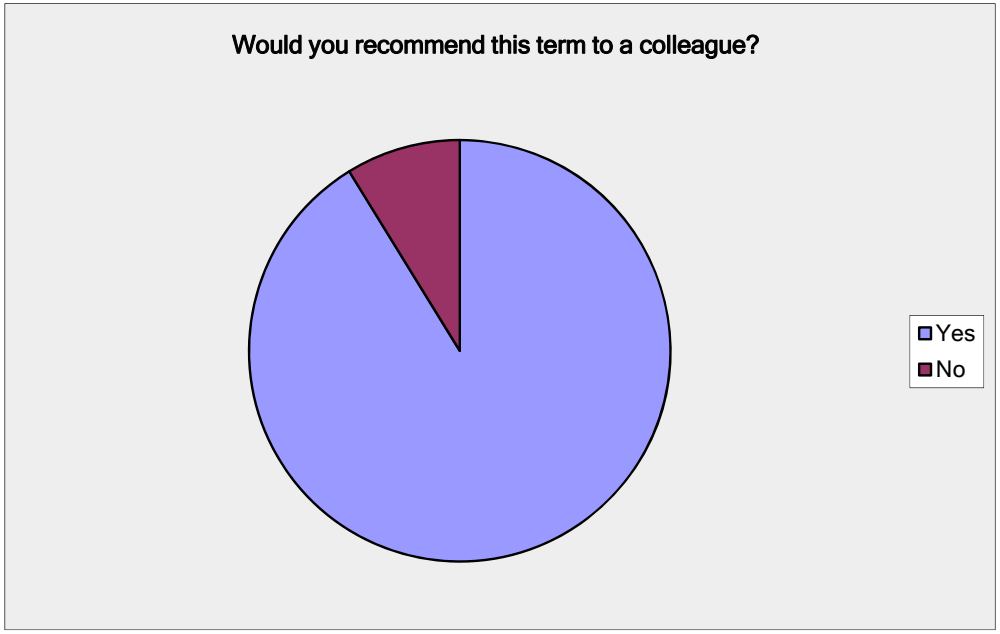
Answer Options	Completely Disagree	Disagree	Neutral	Agree	Completely Agree	Rating Average	Response Count
	4	6	26	98	26	3.85	160
						answered question	160
						skipped question	13



Q9. Trainee administration and resources				
Answer Options	**Yes**	**No**	**N/A**	**Response Count**
Was there a formal orientation provided at the start of term?	136	15	9	160
Were there adequate resources (Books, journals, policy documents etc.) available as either hard copies or online?	145	13	2	160
Were simulation kits, education packages or other resources available to use?	113	39	8	160
Was there protected teaching or non-clinical time?	122	37	1	160
Were you able to take leave (Personal, exam preparation, etc.) as requested?	144	8	8	160
Was the workload reasonable for level of staffing and skill?	146	13	1	160
Was rostering fair? (Equal mix of in and out of hours)	145	14	1	160
Any other comments (please specify)				21
			answered question	**160**
			skipped question	**13**

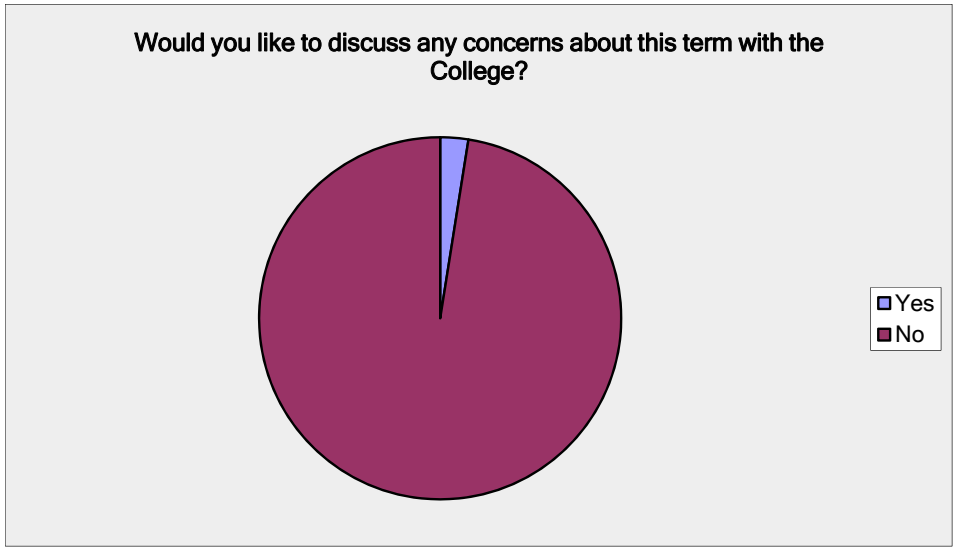


Q11. Would you recommend this term to a colleague?		
Answer Options	**Response Percent**	**Response Count**
Yes	91.3%	146
No	8.8%	14
	answered question	160
	skipped question	13



Q13. Would you like to discuss any concerns about this term with the College?		
Answer Options	**Response Percent**	**Response Count**
Yes	2.5%	4
No	97.5%	155
answered question		159
skipped question		14

Please provide your details below and a member of the College will contact you.	
Answer Options	**Response Count**
	4
answered question	4
skipped question	169



APPENDIX 5

ANALYSIS OF PERFORMANCE AND PREDICTORS OF SUCCESS IN THE FINAL FELLOWSHIP EXAMINATION OF THE COLLEGE OF INTENSIVE CARE MEDICINE

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Keywords:
Education
anaesthesia and intensive care
administration and health services
social issues
statistics, epidemiology and research design

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Objective:
To analyse the performance and predictors of success in the Final Fellowship Examination of the College of Intensive Care Medicine and to compare the outcomes of International Medical Graduates (IMG) attempting the Fellowship exam of the College of Intensive Care Medicine (FCICM) with local trainees defined as those from Australia, New Zealand and Hong Kong (ANZ-HK). The study also aimed to compare performance of IMGs from countries with comparable health care systems (CHS) to those from other countries (Non-CHS).

Design, setting and participants:
Analysis of six exam presentations collected prospectively between 2009 and 2011.

Main outcome measures:
Pass rates in the final fellowship examination.

Results:
Between 2009-2011, 233 candidates presented to the exam 334 times. 73% were IMGs. ANZ-HK trainees performed better at the exam (79% vs 46%, p <0.0001). IMG trainees from CHS performed better (60% vs 40%, p<0.01) than from Non-CHS. Any candidate completing an ANZ primary performed better (74% vs 41%, p<0.0001). IMG candidates successful at a post-graduate exam from a CHS country performed better (56% vs 34%, p=0.005). The success rate of IMGs improved to 64% on obtaining an ANZ primary. Candidates appearing for the exam while working in an Intensive Care Unit (ICU) had a pass rate of 57% as compared to 48% of candidates working in non-ICU posts (P=0.23). This was not statistically significant.

Conclusions:
A significant proportion of candidates appearing for the CICM fellowship examination are IMGs. Pass rates for trainees who have graduated from Australia, New Zealand or Hong Kong have a higher success rate in the fellowship examination. IMGs from a CHS country, or those who completed an ANZ primary have a much higher success rate as compared to other IMGs.

Introduction
The Fellowship Examination of the College of Intensive Care Medicine (CICM) is the "exit" exam for Intensive Care Medicine (ICM) specialty training in Australia and New Zealand. The exam has evolved since it was first set in 1979. It is complementary to the training program and is set according to best evidence.

The fellowship examination is sat during advanced training, and after completion of at least 12 months of core intensive care training (during the 3 years of advanced training). Successful completion of the primary exam of the CICM, or one of the other approved primary exams from other Australasian Colleges is a prerequisite to be eligible to sit for the CICM fellowship exam. For International Medical Graduates, recognition of some of the post-graduate exams held overseas has allowed individualised exemptions from an Australian primary.

The format of the fellowship examination is:

a) Written section (30% of the mark): comprising two papers, each containing 15 short-answer questions. Candidates are required to obtain a minimum mark in this section before being invited to attend the clinical and oral sections of the examination.

b) Clinical section: (30% of the mark) comprising two 20-minute hot cases (patients in an Intensive Care Unit).

c) Cross-table viva section (40% of the mark): comprising eight 10-minute stations.
The exam is not an instrument to control numbers of intensive care consultants for work force planning[1,2]. The examinations are criterion referenced, based on the input of the entire examination panel. To pass the fellowship examination, candidates must secure an overall mark of 50% and individually pass 2 of the 3 sections (written, clinical, and vivas). Failure in more than one section or a bad performance in the clinical section (<40% in the clinical section) results in an overall fail, irrespective of the total mark secured.

A curriculum review provided an opportune time to review the fellowship exam, analyse the performance of candidates and identify factors that predict success.

Recently the cohort sizes presenting to the Fellowship examination have increased, predominantly due to an increase in the number of International Medical Graduates (IMGs). Previous publications have reported differential success rates for IMGs as compared to local graduates in other

specialties.[3]. We decided to evaluate the College of Intensive Care Fellowship examination with the following aims:

1) To identify factors which may predict success for all candidates in the Final Fellowship Examination.
2) To analyze the success rates of the International Medical Graduates and compare with those of local trainees.

Methods

Participants

Six sittings of the exam between 2009 and 2011 were reviewed. The data were collated from the CICM databases to generate the following information: demographics of the candidates, country of basic medical qualification, the primary examination undertaken, the age and number of years since graduation at the time of presentation to the final fellowship exam, the clinical term the candidate was undertaking at the time of presentation (ICU or non-ICU [including medicine or anaesthesia]) and if ICU, then the Level of ICU at the time of presentation[4]. Candidate names were de-identified and a unique identifier code was used to track multiple attempts at the exam. The study was approved by the Board of the College of Intensive Care Medicine.

Statistics

Categorical variables were compared using the Chi-squared test, or Fisher's exact test as appropriate. A $P < 0.05$ was taken as statistically significant and P values were not adjusted for multiple comparisons.

Results

Between 2009 and 2011, 233 candidates presented to the exam 334 times (some candidates presenting more than once). 27% of trainees obtained their basic medical degree from Australia, New Zealand or Hong Kong ("ANZ-HK trainees"), whilst 73% were "non-ANZ-HK trainees". The geographic distribution of the country of the basic medical qualifications of the candidates is listed in Table 1. The overall results over the three years are shown in Table 2. 77% of trainees were male, and the mean age of the trainees at presentation was 38 years (range 30 to 55; **Table 2**).

Analysis of factors influencing success in the examination

a) Country of basic medical degree (Table 3)

ANZ-HK trainees performed significantly better at the exam with 79% passing the exam (in either the first or subsequent attempts) as compared to 46% for the non-ANZ-HK trainees ($P < 0.0001$). Of the non-ANZ-HK trainees, those who obtained their basic medical degree from countries which the Australian Medical Council (AMC) and New Zealand Medical Council deem to have comparable health systems (CHS) for the purpose of medical registration in Australia and New Zealand, had a pass rate of 60% as compared to 40% for trainees from other (Non-CHS) countries ($P = 0.004$).

b) Primary Exam (Table 3)

Candidates who had completed an ANZ primary (CICM primary, ANZCA primary, ACEM primary, FRACP or the RACS primary) had a pass rate of 74% as compared to 41% for candidates who had completed a non-ANZ primary examination ($P < 0.0001$). The pass rates in the Fellowship exam with Australasian primary exams were as follows: CICM 87%,: FRACP 100%, ANZCA primary 83%, ACEM primary 65% and RACS primary 22%.

IMG candidates who were successful at a post-graduate exam from a CHS country had a 56% chance of passing the FCICM as compared to 34% from a Non-CHS country ($P=0.005$). IMG candidates with an ANZ primary, had a success rate of 64% at the FCICM exam. This improvement in performance was seen in candidates from both CHS (76%) and Non-CHS (59%) systems.

Candidates appearing for the exam via the OTS (Overseas Trained Specialist) pathway had a 50% pass rate with no differences between CHS or Non-CHS countries.

c) Clinical term at the time of presentation to exam (Table 3)
Candidates appearing for the exam while working in an Intensive Care Unit (ICU) had a pass rate of 57% as compared to 48% of candidates working in non-ICU posts (P=0.23). Within the ICUs, the pass rate was higher at 58% in candidates working in a C24 unit although this was not statistically significant.

DISCUSSION
A high proportion of candidates presenting for the FCICM exam are IMGs. Candidates with basic medical qualification from ANZ-HK performed significantly better than IMGs. This has been seen in other specialities and reflects familiarity with the exam processes and assessment methods in Australia[3,5,6]. A survey of ANZCA IMGs attributed this performance to lack of effective study, time for study, and isolation from other exam-going students. Other published attributable factors include geographical isolation, variability in knowledge, insufficient orientation and difficulties with communication.[3,6]

Similar trends are observed with other postgraduate examinations. Data from the RACGP exam suggests improved performance amongst candidates who undergo a formal training program in general practice rather than a period of self-training and general practice experience. [5]. Analysis of data from the UK FRCA primary showed candidates from UK, Australia, New Zealand, South Africa, and Zimbabwe performed better than those from Egypt, Iraq, Ireland or Pakistan. [7]. Reports from the USA suggest graduates of medical schools outside the United States achieve certification over a longer period of time than local graduates[8]. Some data suggest that male students underperform in medical examinations [9]. There are differences in pass rates amongst students who belong to ethnic minorities [10] [11]. These differences may be explained in part on the basis of cultural and language similarities easing transition into a foreign working environment, lack of familiarity with local systems, and differences in access to educational resources and social support. Cultural similarities, and opportunities to improve medical education, language and communication play a vital role in settling into a foreign workforce and could explain the higher success at the exam for candidates from countries with comparable health care systems as Australia.
The improved success at the exam if attempted during an ICU term, especially from a C24 unit, may be due to exposure to a more varied case mix, and better opportunities for group study. Tutorials and case presentations with CICM examiners would also be contributory. The relatively low success rate amongst Overseas Trained Specialists (OTS) was surprising but probably reflects non-familiarity with the exam system as well as a longer gap from previous examinations.

There are limitations to this evaluation as it is over a restricted time frame of 3 years. Although the FCICM exam is well calibrated and standardised with good quality control, assessment methods used in examinations have inherent limitations.

Our study identified that a large proportion of the candidates presenting for the CICM Fellowship exam are IMGs, and emphasises the difficulties faced by these candidates. A survey to identify issues faced by them during their training would be a logical follow up to this study. This study also has implications for provision of adequate training opportunities and resources especially to IMGs. The new curriculum of the CICM has come into force from January 2014 with significant changes to the entry requirements to sit the Fellowship examination. This study will need to be repeated after the new curriculum has had a run in period to assess the impact of the new regulations on the success rates in the Fellowship Examination.

Table 1: Geographic distribution of the country of basic medical qualifications

Country	No. of Candidates	No. of presentations	Avg no. of presentations per candidate
Indian Subcontinent	83	136	1.64
Australia**	56	67	1.20
Uk & Ireland *	39	51	1.31
Western Europe *	15	24	1.60
New Zealand**	14	18	1.29
Eastern Europe	7	8	1.14
Africa	6	10	1.67
Hong Kong**	5	6	1.20
South east Asia *	4	7	1.75
Pacific countries	2	4	2.00
North America *	1	1	1.00
Middle East	1	2	2.00

* = Includes countries regarded as having Comparable Health Systems (CHS) as per AMC and NZMC guidelines for registration as a medical practitioner

** = Considered together as “ANZ-HK Trainees”

Table 2

Overall Results

Year	2009	2010	2011
Total number of presentations	116	110	108
Approved*	63	62	61
Pass Rate (%)	54.31	56.36	56.48

Demographics of candidates at presentation to exam

	Total numbers	Success at exam*	%
Age of Trainees			
30-39	223	145	66
40-49	93	37	40
>50	18	4	24
Gender			
Male	257	144	56%
Female	77	42	54%

Success at exam could be at first or subsequent attempts.

Table 3

Country of primary medical qualification

	NUMBER PASS	TOTAL PRESENTATIONS	%
ANZ-HK	72	91	79.12[1]
Non-ANZ-HK	114	243	46.9
Non-ANZ-HK from CHS	47	78	60.3[2]
Non ANZ-HK from Non-CHS	67	165	40.6

Primary exam

	NUMBER PASS	TOTAL IN CATEGORY	%
ANZ Primary	109	147	74.1[3]
Non-ANZ primary	77	187	41.17
ANZ Primary			
RACP	21	21	100
CICM	7	8	87.5
ANZCA	38	46	83
ACEM	41	63	65
RACS	2	9	22
IMGs without ANZ primary			
Comp HS	34	61	56[4]
Different HS	41	121	34
IMGs with ANZ primary			
Comp HS with ANZ Primary	13	17	76.5%
Diff HS with ANZ Primary	26	44	59.1
Either but having ANZ primary	39	61	64

Place of work at presentation to exam

ICU	161	282	57
C6	3	7	42.96
C12	16	32	507
C24	142	243	58.44
Non-ICU	25	52	48.07

1. P <0.00001 Compares pass rates of candidates with primary medical qualifications from ANZ-HK countries with those from non-ANZ-HK countries
2. P < 0.01 Compares pass rates of candidates with primary medical qualifications from non ANZ-HK countries with CHS to those from non-ANZ-HK countries with different health systems (Non-CHS)
3. P <0.00001 Compares pass rates between candidates who have an ANZ primary with those who do not.
4. P <0.005 Compares pass rates in IMGs, not possessing an ANZ primary, from CHS and Non-CHS countries.
5. P = 0.23 Compares candidates appearing for the exam from ICU posts with non ICU posts.
6. P = 0.41 Compares candidates appearing for the exam from C6 ICUs with C24 ICUs.
7. P = 0.36 Compares candidates appearing for the exam from C12 ICUs with C24 ICUs.

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APPENDIX 6

College of Intensive Care Medicine
of Australia and New Zealand
ABN: 16 134 292 103

TRAINING AGREEMENT

The College of Intensive Care Medicine (CICM) is committed to ensuring that all vocational training in Intensive Care, Anaesthesia and Medicine are undertaken in an appropriate environment and that all parties (CICM representatives and trainees) understand and are informed of their rights and obligations.

CICM training must be conducted in a manner that ensures transparency of process, assessment and decisions.

This document sets out the rights, responsibilities and obligations of each party involved in the CICM training process. A signed copy should be submitted after an applicant has been selected as a registered trainee of the College. The Chief Executive Officer will then sign it, and return a copy to the trainee.

TRAINEE RESPONSIBILITIES AND DECLARATION

1. I will endeavour to achieve the objectives of training, as set out by CICM.

2. I will develop the necessary skills, attributes, and undertake the necessary experience required, to provide safe, high quality care to patients, namely:

   Medical and technical expertise, clinical judgement and decision making, communication and collaboration skills, health advocacy, professional attitudes and behaviour to patients, colleagues and other health professionals, management and leadership skills, and a commitment to assisting trainees and colleagues with their learning and development needs.

3. To achieve these objectives, and in accordance with the principles of adult learning, I will undertake training by:

   Reflecting and building upon my own experience, identifying my learning needs, being involved in planning and documenting my education and training, and evaluating the effectiveness of my learning experiences.

4. I acknowledge that each period of training must be prospectively approved by CICM, and will be supervised appropriately. I agree, when in a CICM approved training site, to meet with my Supervisor(s) regularly and complete In-training Evaluation Reports (ITER) and prescribe assessments as outlined in the Regulations.

5. I understand that I will receive feedback on my performance, and will be advised on how best to address any areas that need improvement. I accept that training will require me to move between hospitals, and may require experience in rural and/or private practice settings.

6. I understand that CICM collects and holds personal data for the purpose of registration, for the administering of the Training Program, and for evaluating my progress. I consent to have this information used for these purposes. If I wish at any time to request access to the information I have provided, I understand that I may contact CICM and request to review it.

7. I understand that CICM documentation and/or materials will be provided to me during the course of the Training Program. I acknowledge that this material is owned by the College, is subject to intellectual property protection, and therefore cannot be used by me for purposes other than training, without the College's prior approval.

8. I agree to make all applications, complete the relevant feedback forms, and provide all information required by CICM within the time limits or deadlines stipulated. I acknowledge that it is my responsibility to ensure that all time limits and deadlines are met.

9. I agree to pay for all accredited training in order to remain an active trainee of the College, and understand that it is my responsibility to inform the College if I am undertaking interrupted training or training towards another specialty.

10. If I am not undertaking training that can be accredited toward my CICM training, I will pay the deferred training fee in order to remain an active trainee. I understand that I will become a "Non active trainee" if I do not comply with these requirements. If I cease or suspend my training I will notify the College in writing. Unless otherwise agreed, my training will be suspended if an application for training (AVT Form), ITER or other progress report is not returned to the College for 24 months.

11. I acknowledge that it is my responsibility to be fully informed and aware of all requirements of CICM, particularly the Regulations and guidelines in relation to the Training Program and to observe all relevant CICM policies in relation to training.

12. I acknowledge that regulations, guidelines and policies in relation to the Training Program may change over time.

13. I agree that if I have concerns regarding my training, it is my responsibility to seek to have these concerns addressed. I acknowledge that I can approach and seek appropriate guidance from my Supervisor of Training or relevant CICM Staff.

14. I agree and acknowledge that, whilst I may seek advice from my Supervisors and relevant CICM Fellows in relation to aspects of my education and training, my Supervisors are not authorised to vary the rules and guidelines for the Training Program, or the policies of CICM in relation to the Training Program. Requests for any change or variation of these conditions, guidelines or policies or any extension of time must be made to the CICM Censor and be confirmed to me in writing by CICM.

15. I understand that if I do not reach work-related performance standards I may be required to undertake a further period(s) of training as recommended by the CICM Censor.

16. I agree to participate, if required, in CICM's review processes in relation to unsatisfactory performance or progress in the Training Program, including a Trainee Performance Review (TPR). Refer to T-13 "Guidelines for Assisting Trainees with Difficulties" and T-14 "Trainee Performance Review". I also understand that I can initiate the TPR if I feel that I have been unfairly assessed or treated. I am aware that if I disagree with any decision made about my training, CICM has a formal Reconsideration and Review process that precedes the final Appeals Process. I agree to abide by the final decision of the Appeals Process.

17. I release CICM (and its representatives) from all claims or liability arising from advice or assistance given in good faith.

18. I certify that I am free from substance abuse disorder, and have no illnesses or other conditions which my treating physician(s) advise(s) will preclude the safe practice of intensive care medicine.
I undertake to inform the College if I develop any of these conditions.
I acknowledge that if I develop a substance abuse disorder, and/or any condition which my treating physician(s) advise(s) will preclude the safe practice of intensive care medicine; this may result in the suspension or termination of my training at any time, and prevent my admission to Fellowship of CICM.

19. I undertake to notify the College if conditions are placed on my medical registration.

CICM DECLARATION AND RESPONSIBILITIES

CICM agrees to provide support to its representatives (Supervisors of Training) to provide the trainees with appropriate resources and support in the following areas:

1. Assisting the trainee to achieve completion of all Training requirements (including courses, work-placed based assessments, examinations and the formal project).
2. Reviewing the trainee's learning objectives for each term, to ensure that they are realistic, achievable, and within the scope of the learning opportunities available.
3. Advising the trainee, as requested, on resources available to assist the trainee in achieving the objectives.
4. Ensuring appropriate supervision.
5. Encouraging a climate conducive to learning and training.
6. Meeting regularly with the trainee (at least every three months) for the purposes of support, feedback and assessment, to review the trainee's progress, and to provide feedback on performance (while the trainee is in a CICM-approved training site).
7. Completing the Supervisor's Report component of the ITER and other assessments in a timely fashion, and discussing its contents with the trainee, before sending it to CICM.
8. Encouraging the trainee to keep copies of his/her ITER and other assessments.
9. Assisting the trainee to be able to attend any appropriate educational sessions.
10. Encouraging the trainee to make appropriate time allowance for learning needs.
11. Encouraging the Department to roster trainees fairly, and to ensure an appropriate balance between training, service, rest and study time.

CICM and its representatives agree to use reasonable endeavours in the following areas:

12. Supporting an appropriate, fair, and transparent selection process of trainees.
13. Providing access for trainees to educational material related to the Training Program.
14. Ensuring that any information held by the College on a trainee is stored in a manner in which ensures confidentiality.
15. Ensuring that any information supplied by the trainee cannot be disclosed to third parties except as required by Law.
16. Answering in an accurate and timely manner any queries the trainee may have on the
    Training Program, clinical assessments, the examinations process, and reporting requirements.
17. Responding in a timely manner to applications for approval of individual training positions requiring prior approval.
18. Responding to any other enquiries in a timely manner.
19. Endeavour to communicate to the trainee any changes to the Regulations, guidelines or policies in relation to the Training Program that may change over time in a timely manner.

ACCEPTANCE BY TRAINEE AND CICM

We accept the rights and responsibilities of our respective positions in this Agreement.

Signed:

……..	……
Trainee	Name in block letters
Date:	
……	……..
Chief Executive Officer	Name in block letters
Date:	

This Agreement will be reviewed five years after the date of signing.

APPENDIX 7

College of Intensive Care Medicine
of Australia and New Zealand
ABN: 16 134 292 103

RECOMMENDATION TO OTS COMMITTEE – PRELIMINARY ASSESSMENT

Applicant name:	

Qualifications	**Yes**	**No**
Primary medical degree completed		
Specialist Qualification completed		

Examination and Registration	**Yes**	**No**
Completed a specialist exit examination with a written and clinical component		
Evidence of Specialist Registration		

Clinical Practice	**Yes**	**No**	**Duration**
Evidence of practice as a Specialist			
Evidence of Anaesthesia training			
Evidence of Medicine training			

Additional information	**Yes**	**No**
Curriculum Vitae Submitted		
Do you (CICM Staff Member) believe the applicant is suitable for a face to face interview with the OTS Committee?		

Additional Comments:

Staff member name:
Date:

APPENDIX 8

COLLEGE OF INTENSIVE CARE MEDICINE
AUSTRALIA AND NEW ZEALAND

Minutes of the meeting of the Censor's Committee held (via teleconference) on Tuesday 13th May 2014 at 12.00pm AEST

Members present: A/Prof. Rob Boots (Chair, Censor)
A/Prof. Dianne Stephens (Deputy Censor)
Dr Megan Robertson (Assistant Censor)
Dr Felicity Hawker (Director Professional Affairs)
Dr Ross Freebairn (President)
Mr Daniel Angelico (Manager, Training and Examinations)
Ms Caitlin Gheller (Admin. Officer, Training)
Ms Jennifer Condon (Admin. Assistant, Training and Online Learning)

Apology: A/Prof. Bruce Lister (Paediatric Deputy Censor)

1. Previous minutes

This was the first meeting of this Committee.

2. Accreditation of Training Positions

2.1.1 Late Application for Vocational Training (AVT) Forms

The Committee discussed developing an approach to the assessing late AVT forms. D. Angelico advised that the ITER system is reliant upon the timely submission of an AVT and that late submissions would affect trainee's online assessments.

The Committee agreed that a more firm approach is required and that trainees need to be reminded of the consequences of submitting a late AVT. D. Angelico suggested using the CICM newsletter to continue educating trainees on submitting AVTs on time. The Committee agreed that if there was no improvement, the issue would be re-discussed.

Recommendation:

The Training Department will remind trainees of the consequences of submitting a late AVT. If the issue has not been rectified, it will be brought back to the Committee for re-discussion.

2.1.2 Locum Positions

The Committee discussed accrediting Locum positions as elective training. R. Boots advised that it is difficult to classify Locum positions due to the variety and the absence of a designated supervisor. The Committee agreed that for Locum positions to be accredited; the duration would be the minimum requirement of 10 weeks, FTE and supervised. Trainees would also be required to submit a position description.

Recommendation:

Locum positions can be accredited as elective training only. Applications must include a position description and the position must be the minimum duration of 10 weeks, on a regular roster and include an appropriate supervisor.

2.1.3 Relieving Positions

The Committee discussed accrediting relieving positions during a 12 month Clinical Internal Medicine rotation. M. Robertson advised that trainees in relieving positions may have minimal contact with a supervisor and that relieving is not automatically accredited for RACP training. She went onto to outline the minimal supervision received by a relief trainee on night duty. R. Freebairn stated that trainees are often contracted into relieving positions. R. Boots advised that relief can expose trainees to longitude care.

Recommendation:

Relief terms may be accredited as minimum blocks of one month when done in a medicine subspecialty rotation. The Committee also agreed that no night relieving terms would be accredited.

2.1.4 Accreditation of General Practice

The Committee discussed classifying General Practice rotations as elective rather than non-training time. The Committee was concerned that General Practice rotations were too difficult to monitor.

Recommendation:

General Practice rotations will continue to be classified as non-training time.

2.1.5 Neonatal Intensive Care Unit (NICU)

The Committee discussed accrediting NICU rotations for trainees on the paediatric pathway. R. Boots said that NICU has previously been accredited for as Elective training and is accredited by the RACP. R. Boots also advised that NICU should not be accredited for Foundation training as it is not a requirement of CICM Intensive Care Training. The Committee discussed B. Lister's previous comments supporting 6 months of NICU accredited for Core Training.

The Committee then discussed accrediting NICU for trainees who registered prior to the 2014 Regulations. F. Hawker and R. Boots discussed that if pre-2014 trainees were to request a review of NICU training time, the request would be considered on an individual basis. D. Angelico suggested speaking with B. Lister (Paediatric Deputy Censor) to get his opinion prior to finalising the recommendation.

Recommendation:

The Committee agreed that NICU training would be accredited for Core Training only however will consult B. Lister prior to finalising the recommendation.

2.1.6 Emergency Department / Acute Medical Positions

The Committee suggested the need for a list of approved ED / Acute Medicine positions for post-2014 trainees. R. Boots asked if units approved by ACEM and RACP would be the requirement or if it needed to be individually based. D. Angelico advised that the AVT form has been updated to automatically request a job description from trainees applying for medicine positions. The College will begin to develop a list of approved positions and units that would not be published.

The Committee also discussed whether the new approval of ED / Acute Medicine positions for post-2014 trainees would be unfair to pre-2014 trainees as previously, all ED positions were accredited as Elective training only. R. Boots advised that if a trainee requested a review of their medical training, it would be considered on an individual basis.

Recommendation:

The College will develop an internal list of approved ED / Acute medicine positions to assist the Committee. The Committee also agreed that if a pre-2014 trainee requested a review of their medical training, it would be considered on an individual basis.

2.1.7 8 and 10 Week Terms

The Committee discussed the approval of 8 and 10 week terms when giving recognition of prior learning. This has become increasingly common when the Censor is assessing letters of service for new registrations. F. Hawker and M. Robertson suggested that the Censor needs to look at the entire year of training in order to make a decision.

Over a 12 month period, if a 10 week term was done in a single discipline, it could be accredited as a 3 month block. If the term was spent in multiple disciplines, each discipline would be considered in weeks. Over a 12 month period, if an 8 week term was done in a single discipline, it could be would be considered in weeks and then converted to months.

In both cases, any leave during this time would need to be considered before making a decision. It must be noted that if multiple 10 weeks are approved it is possible to accredit more than 12 months.

Must submit details of any leave also. Letters of service MUST include leave. Update the website.

Recommendation:

Over the course of one year, 10 week terms in a single discipline may be accredited as 3 months of training. If there were multiple disciplines during the term, it must be counted in weeks.

The Committee agreed to accredit 8 week terms only if there are multiple terms in the same discipline. The trainee's entire year would be reviewed.

If multiple 10 weeks are approved, the Censor must not accredit more than 12 months.

The College will update the website and relevant documentation accordingly.

3. Hot Case Assessment Form

The Committee discussed changing the submission date for hot case assessment form. M. Robertson advised that the current rules are difficult to administer and suggested changing the submission date to the exam closing date. The Committee agreed it would be appropriate to inform the Second Part Examination Committee of the proposed change. D. Angelico discussed strengthening the wording of feedback letters and hot case submission information.

Recommendation:

All exam applications must be accompanied by the completed hot case assessment form by the exam closing date.

4. Fellows of Hong Kong College of Physicians with a specialisation in Critical Care Medicine (HKCP)

The Committee discussed adopting a flexible approach when assessing trainees who are Fellows of Hong Kong College of Physicians with a specialisation in Critical Care Medicine (HKCP). F. Hawker suggested retrospectively approving Core Intensive Care training for HKCP if they have received a First Part exemption. The Committee agreed that a summary of Hong Kong trainees who may fit into this category was needed.

The College will collate the data and feedback to the Committee as soon as possible.

The Committee also discussed CICM/HKCP trainee Dr Shek Yin Au's request to change to the OTS pathway. The Committee agreed that S. Au does not meet the requirements for OTS pathway.

Recommendation:

The Training Department to produce a summary of HKCP trainees for review by the Censor's Committee.

5. Task List

Task	Action required	Staff	Completed
2.1.1	Post information in the E News regarding the late submission of AVTs.	C.Gheller	
2.1.6	Create an updated internal list of approved acute medicine training positions.	J. Condon	
3	Ensure Hot case instructions are updated on the form and website.	F. Keo	
4	Produce a summary of HKCP trainees for the Committee to review. Write to S. Au advising the outcome of the OTS Pathway request.	C. Gheller	

R. Boots thanked the Committee for their time and closed the meeting at 13:35 pm.