

2010

AMA SPECIALIST TRAINEE SURVEY

REPORT OF FINDINGS

October 2011



AMA

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FOREWORD

The AMA Council of Doctors-in-Training (AMACDT) is the peak representative body for junior doctors, with strong links to all trainee representative groups. It plays a key leadership role within the AMA and provides junior doctors with an effective voice that is helping to shape the future delivery of medical education and training in Australia.

The 2010 AMA Specialist Trainee Survey (STS) has been several years in the making, but that is the nature of something worth doing. It was developed through extensive consultation with medical colleges and trainee organisations and it provides an honest insight into specialty training through the eyes of trainees.

The results of the STS will provoke discussion within the profession and not everyone will necessarily agree with all of the findings. That said, it is important for the AMA to speak frankly about such issues and ensure that the feedback of trainees is heard and acted upon. Over the last ten to fifteen years we have seen significant improvements to college training programs and these have been achieved through collaboration and the development of a better mutual understanding among colleges and trainees alike.

The significant rise in medical graduate numbers, a changing medical workforce demographic, a focus on safer working hours and changing lifestyle choices all have the potential to impact on the depth and quality of vocational training positions. The STS compels us to think about the delivery and support for specialist training in the future, bearing in mind these challenges.

Utilising the rich information provided by the STS, the AMA looks forward to building upon the already positive and productive relationships it has with the colleges and their respective trainee associations as we work together to enhance the quality of specialist training for all doctors.



Dr Steve Hambleton
President, Federal AMA



Dr Michael Bonning
Chair, Federal AMA Council
of Doctors-in-Training

EXECUTIVE SUMMARY

Australians have access to a world class health system that is the envy of many other countries. According to the Australian Institute of Health and Welfare, life expectancy in Australia is among the highest of all the Organisation for Economic Co-operation and Development countries.¹ One of the keys to the success of the Australian system is that patients have access to a highly skilled and motivated medical workforce working in general practice, community and hospital settings. This is, in part, the product of a strong medical education system.

Fundamental to the quality of medical education in Australia are the medical colleges, who are responsible for the rigorous training standards and arrangements that set the benchmark for specialist practice. The AMA fully supports this role for the medical colleges within the broader accreditation framework established by the Australian Medical Council (AMC).

The role of medical colleges in assuring the quality of medical training will become even more critical in coming years. Since 2004, the Commonwealth has responded to medical workforce shortages by taking steps to significantly increase the number of medical school places across the country. By 2014, the number of domestic graduates from medical schools will grow to 3108pa, compared with 1287pa in 2004.² Taking into account international full fee paying students, the total number of graduates from Australian medical schools in 2014 will be 3786.³

These changes have resulted in a rapid escalation of the number of pre-vocational and vocational trainees. The AMA, like other professional organisations in medicine, has been concerned that this growth might compromise the quality of clinical training delivered in Australia's health system.⁴

In this context, the AMA developed the 2010 Specialist Trainee Survey (STS) to provide medical colleges with important trainee feedback about key training issues, as well as other aspects of their operation. Regular evaluation and appraisal is essential for the ongoing delivery of high quality specialty training.

This survey captured a point-in-time impression of training and conditions from the hospital-based trainee perspective. It took the form of an on-line, confidential, self-reporting questionnaire and was conducted between 9 April and 2 May 2010. Questions were developed with regard to the AMC's standards for specialist medical education and training,⁵ and covered 11 key areas including overall satisfaction, selection processes, training and educational activities, supervision, assessment, flexibility and cost. There were

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- 1 Australian Institute of Health and Welfare. Australia's Health 2010. Canberra: AIHW, 2010. (AIHW Cat. No. AUS 122.)
 - 2 Commonwealth of Australia. Medical Training Review Panel Thirteenth Report. Canberra: Commonwealth of Australia, 2010.
 - 3 Commonwealth of Australia. Medical Training Review Panel Thirteenth Report. Canberra: Commonwealth of Australia, 2010.
 - 4 Australian Medical Association, Australian Medical Students' Association, Medical Deans Australia and New Zealand, Confederation of Postgraduate Medical Education Councils. Joint Statement: Action on Medical Training. AMA Medical Training Summit. 2010 Sep 29; Canberra, Australia.
 - 5 Australian Medical Council. Accreditation of Specialist Medical Education and Training and Professional Development Programs: Standards and Procedures. Canberra: AMC, 2010.

538 respondents, which meant that the survey was sufficiently powered for results to be reported with a 95% confidence level for population estimates within plus or minus 5% of the survey estimates.

The survey revealed that colleges and health services are performing well in many areas of vocational training. These include:

- Transparency of selection processes;
- Alignment of clinical experience with training objectives;
- Access to supervision; and
- Adherence to safe hours guidelines.

Overall, there was a high level of satisfaction with work and training, as well as broad support for the provision of educational resources and activities. There were, however, significant areas of dissatisfaction, including:

- Access to effective appeals processes;
- Capacity to raise concerns without fear of recrimination;
- Recognition of prior learning;
- Provision of feedback and remediation;
- Responsiveness to cases of bullying and harassment; and
- Value for money, and overall cost of training.

This last area attracted the most negative weighted average score of all questions.

These results will be of value to colleges and health services in reflecting on their performance against the AMC standards for specialty education and training. It is hoped that this report will prompt institutions to internally review their education and training policies, with a particular focus on the areas of trainee dissatisfaction.

It is critical that quality in specialty training is maintained in the face of escalating trainee numbers. For this reason, the AMA plans to repeat this survey in four years so as to provide a further point-in-time perspective. Comparison of the two results will identify areas where quality may have been diluted.

BACKGROUND

Quality in patient care is highly dependent on quality in medical education. One of the reasons Australia enjoys a high-standard of healthcare is that it has a strong system of clinical training.

The medical colleges play a pivotal role in this system; their rigorous standards set the benchmark for specialist training and practice in Australia. The AMA fully supports this role of the medical colleges within the broader accreditation framework managed by the AMC.

The responsibility of the colleges in assuring quality specialist training will become even more critical in coming years. Since 2004, the Commonwealth has responded to medical workforce shortages by taking several steps to significantly increase the number of medical school places across the country.⁶ By 2014, the number of domestic graduates from medical schools will grow to 3108pa (from 1287pa in 2004).⁷ Taking into account international full fee paying students, the total number of graduates from Australian medical schools in 2014 will be 3786.⁸ The down-stream effects of increased prevocational and vocational trainee numbers are now materialising, which will invariably place further pressure on the colleges to deliver quality clinical training.

The AMA Council of Doctors-in-Training (AMACDT) is specifically tasked by AMA Federal Council to provide feedback on the views of junior doctors in Australia, from interns to senior registrars. There has been overwhelming feedback from medical students and junior doctors across the country that access to a high-quality training environment and educational resources is an issue of great importance to them.

The AMACDT is acutely aware that vocational trainees must be appropriately supported and supervised during their specialty training years. Their training must adequately prepare them for independent medical practice. Colleges play a critical role in facilitating this.

There are obstacles, however, to the collection of trainee opinion on these issues. Despite the value in doing so, obtaining confidential program feedback from trainees who fear identification can be difficult for colleges and other providers of clinical education.^{9,10,11}

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- 6 Australian Medical Association, Australian Medical Students' Association, Medical Deans Australia and New Zealand, Confederation of Postgraduate Medical Education Councils. Joint Statement: Action on Medical Training. AMA Medical Training Summit. 2010 Sep 29; Canberra, Australia.
 - 7 Commonwealth of Australia. Medical Training Review Panel Thirteenth Report. Canberra: Commonwealth of Australia, 2010.
 - 8 Commonwealth of Australia. Medical Training Review Panel Thirteenth Report. Canberra: Commonwealth of Australia, 2010.
 - 9 Kogan JR, Shea JA. Course evaluation in medical education. *Teaching and Teacher Education* 2007; 23 (3): 251-264.
 - 10 Afonso N, Cardozo LJ, Mascarenhas OAJ, Aranha ANF, Shah C. Are anonymous evaluations a better assessment of faculty teaching performance? A comparative analysis of open and anonymous evaluation processes. *Fam Med* 2005; 37 (1): 43-47.
 - 11 Nash-Stewart C. Medical training providers obtaining feedback from their trainees: what is best practice? Presentation to the Australian Medical Council (AMC) workshop: Training Program Evaluation and Trainee Feedback; 2010 Nov 13; Sydney, Australia.

For these reasons, the AMA developed the 2010 Specialist Trainee Survey (STS) to provide medical colleges with trainee feedback about key training issues, as well as many other aspects of their operation. Given the rigour of the AMC-led accreditation process for specialty training colleges, the content for the survey was based on the AMC's standards for specialty training.¹² These standards should be read alongside this report.

The AMA is planning to conduct the STS every four years. Monitoring trends in vocational training is critical to ensuring that the increasing number of trainees does not dilute the quality of clinical training and, by extension, the standard of care afforded to Australian patients.

¹² Australian Medical Council. Accreditation of Specialist Medical Education and Training and Professional Development Programs: Standards and Procedures. Canberra: AMC, 2010.

METHODOLOGY

METHODS

The AMA Specialist Trainee Survey was a confidential, self-reporting questionnaire conducted between 9 April and 2 May 2010. Questions were developed with regard to the AMC's standards for specialist medical education and training,¹³ and covered 11 key areas:

- Overall satisfaction;
- Selection processes;
- Training and educational activities;
- Supervision;
- Assessment and examinations;
- Cost;
- Recognition of prior learning;
- Environment;
- Flexibility; and
- Safe hours and doctors' health.

COMMUNICATION

There were 55 primary items and each utilised a five-point Likert scale (strongly disagree, disagree, neither agree nor disagree, agree and strongly agree). The Likert scale is widely used in survey-based research.

The survey was only available on-line. It was hosted on the AMA Federal Secretariat's website and the link distributed electronically to approximately 8000 hospital-based trainees, including both AMA members and non-members. Trainee committees (from each of the specialty colleges) were also asked to distribute the survey via their own internal email networks. Respondents were presented with an explanatory statement on the aims and objectives of the survey and participation was voluntary.

General Practice trainees were surveyed separately. Results from that questionnaire are not reported here.

¹³ Australian Medical Council. Accreditation of Specialist Medical Education and Training and Professional Development Programs: Standards and Procedures. Canberra: AMC, 2010.

ANALYSIS

For the purposes of this report, results have been expressed as:

- The percentage of those in agreement or strong agreement; and
- A weighted average score.

The weighted average score (WAS) is based on a 'vote value' where strongly agree equals 1.0, agree equals 0.5, neither agree nor disagree equals 0.0, disagree equals minus 0.5 and strongly disagree equals minus 1.0. It is determined by dividing the cumulative vote value by the number of respondents. The WAS, therefore, theoretically ranges from 1.0 if 100% of respondents strongly agree to minus 1.0 if 100% of respondents strongly disagree.

No college-specific data was analysed, and only grouped results are presented here.

SAMPLE

There were 538 respondents. As is very common with voluntary surveys, not all respondents answered each question; the majority attracted between 510 and 520 responses. Based on a total hospital-based trainee population of 10,649,¹⁴ the survey is sufficiently powered for the results to be statistically significant (with population values within plus or minus 5% of the survey estimates) at a confidence level of 95%.

DEMOGRAPHICS

Respondents were training in 18 different clinical disciplines. The demographic profile was as follows:

- 85% completed their primary medical degree in Australia;
- The average time period enrolled in a training program was 3 years;
- The average period of training remaining was 2.8 years;
- Over half were advanced;
- The average age was 33;
- 52% were male, 48% female;
- 91% were in a full-time training program, 94% in a public hospital;
- 79% report the main location as metropolitan;
- Two thirds have not undertaken any training in the community sector;
- 30% are single, 68% married or de facto; and
- 66% have no children, the balance averaging 1.7 children each.

14 Commonwealth of Australia. Medical Training Review Panel Thirteenth Report. Canberra: Commonwealth of Australia, 2010.

KEY FINDINGS

OVERALL SATISFACTION

For trainees, overall career satisfaction is determined by a number of factors, including quality of training and workplace conditions. Respondents were asked about their overall impression of their training program and career choice, with the results outlined in Table 1 below:

Table 1

	Percentage agree or strongly agree	WAS
I am satisfied with my training program	68%	0.29
I am happy with my career choice	88%	0.66

It is encouraging that the vast majority of trainees are satisfied with their career choice. That said, the implied dissatisfaction rate is not insignificant. This may relate to the negative findings considered elsewhere in this report.

These results are comparable to those in other recent studies. Survey results from wave 1 of the longitudinal MABEL study showed that 85% of doctors enrolled in a specialist training program were very or moderately satisfied with their work.¹⁵

SELECTION PROCESSES

Colleges individually determine how junior doctors apply for entry into their training programs. There is marked variation in their approach to trainee selection, within the overall standards framework established by the AMC. Trainees were asked to give their response to the statements in Table 2 below:

Table 2

	Percentage agree or strongly agree	WAS
The selection processes for entry into the training program are fair and transparent	69%	0.34
The selection criteria for entry into the training program are clear and explicit	70%	0.33

¹⁵ Joyce CM, Schurer S, Scott S, Humphreys J, Kalb G. Australian doctors' satisfaction with their work: results from the MABEL longitudinal survey of doctors. *Med J Aust* 2011; 194 (1): 30-33.

There was quite strong approval of college selection processes, which no doubt reflects the adoption over time of more transparent, structured and consistent arrangements for trainee selection (in accordance with the relevant AMC accreditation criteria). This is a pleasing result, given that the college application processes have traditionally been a source of great anxiety for doctors-in-training.

TRAINING AND EDUCATIONAL ACTIVITIES

Training and educational activities are integral to quality clinical tuition. There are numerous elements to quality teaching, including curriculum, breadth of clinical exposure, provision of feedback and assessment. The STS posed a range of statements in this area, with the responses outlined in Table 3.

Table 3

	Percentage agree or strongly agree	WAS
I am satisfied with the standard of training I receive	71%	0.31
The college-recognised educational activities offered are relevant and meet my training needs	64%	0.23
The college-recognised educational activities offered are of good quality	68%	0.29
The college has a clear curriculum to guide my learning	65%	0.25
My training posts provide the necessary clinical experience to meet the objectives of my training program	75%	0.36
I am able to access training in the private or community sector as part of my college training program	42%	0.00
Mandatory rotations are adequately flexible to accommodate the personal circumstances of trainees	37%	-0.05
I feel isolated in my training location	15%	-0.38
The college utilises technology effectively in delivering its training program	46%	0.03
The college communicates effectively with trainees about exams, including exam results	63%	0.23
The college provides all candidates with detailed feedback about their exam performance	29%	-0.14
The college provides unsuccessful candidates with appropriate remediation	16%	-0.14

	Percentage agree or strongly agree	WAS
There are sufficient exam places to accommodate all eligible candidates	67%	0.36
The exam is run frequently enough to progress through training without undue delay if I am unsuccessful at the first attempt	54%	0.08
I pay for education and training in addition to that provided by my college training program, in order to meet my training needs	74%	0.42

While there was reasonably strong approval for many aspects of the training programs (with the first five questions all gaining over 60% agreement), mandatory rotations, access to feedback and provision of remediation were all net negatives.

Concern about flexibility in mandatory terms reflects the significant upheaval that some trainees go through to meet training requirements (which often mandate frequent moves between hospitals, towns and states). Some of these concerns could be ameliorated by greater adherence by employers to the AMA's relevant position statements, including Accommodation and Appointment Standards for Community Placements¹⁶ and Workplace Facilities and Accommodation for Hospital Doctors.¹⁷

Absence of sufficient feedback is an ongoing issue, with this also being identified in the AMA 2009 Junior Doctor Training, Education and Supervision Survey Report.¹⁸ Feedback is critical to learning and, in its absence, growth in knowledge and skill is likely to be inhibited. It is important that colleges give significant weight to the results here, and actively work with supervisors to communicate results and provide feedback to trainees in a more constructive way.

The AMC has defined standards to guide the specialist colleges, and in turn hospitals, in the attainment of supervisor assessments and reports, as well as rights of review.¹⁹ It is critical that programs adhere to these guidelines.

SUPERVISION

Quality supervision is critical for learning, efficiency in service delivery and patient safety. Trainees were asked to respond to a number of statements, as outlined in Table 4.

16 Australian Medical Association. AMA Position Statement. Accommodation and Appointment Standards for Community Placements 2007. Canberra: AMA, 2007.

17 Australian Medical Association. AMA Position Statement. Workplace Facilities and Accommodation for Hospital Doctors 2006. Canberra: AMA, 2006.

18 Australian Medical Association. AMA Junior Doctor Training, Education and Supervision Survey. Report of Findings. Canberra: AMA, 2009.

19 Australian Medical Council. Accreditation of Specialist Medical Education and Training and Professional Development Programs: Standards and Procedures. Canberra: AMC, 2010.

Table 4

	Percentage agree or strongly agree	WAS
I am satisfied with the level of supervision I receive	84%	0.46
I am satisfied with the mentoring I receive	69%	0.31
I receive appropriate feedback which is useful in guiding my ongoing performance	72%	0.34
Regular or interim appraisals and/or assessments are routinely conducted	82%	0.43

Pleasingly, all aspects of supervision received strong approval. This is consistent with data from the AMA Junior Doctor Training, Education and Supervision Survey,²⁰ which showed that registrars had the highest level of satisfaction with respect to supervision of all medical trainees. That study found that prevocational doctors were at particularly high risk of sub-optimal supervision, and recent reports from the UK have found similarly.²¹

These results likely reflect the individual commitment that clinical supervisors have to trainees in their discipline. With rapidly escalating trainee numbers, the AMA has concerns that could easily change particularly given that total time dedicated to supervision activities may have plateaued.²² It is critical, therefore, that health service providers and governments continue to support initiatives in this area. Effective recruitment and retention strategies must be put in place, with a particular focus on the next generation of supervisors.

It is hoped that the Health Workforce Australia Clinical Supervision Support Program,²³ as well as other initiatives in this area, will assist senior doctors to develop the skills and knowledge required to become talented and enthusiastic supervisors. It is equally important that registrars are encouraged to develop their teaching and supervision skills. Initiatives such as Teaching On The Run²⁴ and the Professional Development Program for Registrars²⁵ have been well-received for this reason.

ASSESSMENT AND EXAMINATIONS

Assessment is one driver of learning, and it is critical that workplace-based assessment processes, as well as examinations, are relevant to clinical practice. Table 5 outlines trainee responses to a number of statements in this area.

20 Australian Medical Association. AMA Junior Doctor Training, Education and Supervision Survey. Report of Findings. Canberra: AMA 2009.

21 Collins J. Foundation for Excellence – An Evaluation of the Foundation Programme. London: NHS Medical Education England, 2010.

22 Joyce C, Piterman L, Wesselingh S. The widening gap between clinical, teaching and research work. *Med J Aust* 2009; 191 (3): 169–172.

23 Health Workforce Australia. Clinical Supervision Support Program Directions Paper. Adelaide: HWA, 2011.

24 University of Western Australia. Teaching on the Run (TOTR). The Education Centre, Faculty of Medicine, Dentistry and Health Sciences.

25 Confederation of Postgraduate Medical Education Councils. Professional Development Program for Registrars.

Table 5

	Percentage agree or strongly agree	WAS
The exam content is set at an appropriate level for the trainees being assessed	58%	0.22
The written exam content is relevant to clinical practice	52%	0.12
The oral exam content is relevant to clinical practice	55%	0.26
The other exam content is relevant to clinical practice	46%	0.07
I have confidence in the validity of the oral exam as an assessment tool	48%	0.16
The college provides exam candidates with adequate access to educational materials to prepare for exams	45%	0.00

Respondents were, on average, only slightly approving when it came to assessment and examination issues. While trainees were generally satisfied that exams were set at an appropriate level, results were only marginally positive in regards to clinical relevance. Results were also less positive with respect to the validity of oral examinations as an assessment tool.

Of concern, this data illustrates a disconnect between overall access to educational opportunities (with which trainees were generally satisfied) and the provision of educational material in advance of examinations. The WAS of 0.0 suggests that colleges need to work harder to ensure sufficient preparatory tools are available to trainees in the lead up to assessments. This is likely to be particularly important for basic science examinations, where the links to everyday clinical practice are likely to be less apparent.

COST

While there will always be expenses associated with the administration of training and assessment programs, costs to trainees should be fair and appropriate. Trainees were asked whether their program represented value for money (Table 6).

Table 6

	Percentage agree or strongly agree	WAS
The costs of the college training program represent value for money	23%	-0.30

There was a clear majority view that the costs of the college training program did not represent value for money. In data not tabulated here, 40% of respondents reported that the cost of the training program had caused them financial hardship. Other items revealed that the estimated average cost per trainee in 2009 was \$5,700 (with 2% of respondents reporting costs of more than \$20,000) and the cumulative cost up to and including 2009 averaged \$11,600 (with 21% of respondents reporting costs of more than \$20,000).

These findings are concerning, particularly given that the sequelae of study debt can be significant.²⁶ Vocational training should represent value for money, and trainees should not suffer financial hardship in the process of completing their fellowship. Trainees must also be made more aware of what their fees cover and colleges must make this information freely available.

These findings have implications for both colleges and jurisdictions. The former must evaluate the transparency of their fiscal arrangements, as well as actively demonstrate how training fees are apportioned. Overall, a better equilibrium must be found between registrar income and training costs.

RECOGNITION OF PRIOR LEARNING

The medical workforce in Australia is undergoing great change, with an increasing proportion of female doctors, growing numbers of overseas trained doctors, evolving technologies and different values and priorities among those individuals entering the profession.^{27,28} The challenges for the delivery of training in this environment are significant and require a system that is flexible but does not compromise standards of care.

A common theme among junior doctors is that the ability to move between training pathways is restricted by insufficient recognition of prior learning (RPL). Trainees make significant decisions about their career at a very early stage and, in practical terms, are virtually 'locked in' to this choice for the rest of their working life.

Recognition of these challenges is a fundamental step towards ensuring that the training system is compatible with the needs and aspirations of the future medical workforce. Most importantly, provided that standards are not compromised, changes to the way that training is delivered and assessed is in the interests of patient care. The adoption of more sophisticated systems of RPL is an important and necessary component of any response to the challenges outlined above.

Respondents were posed a series of statements with respect to RPL, as detailed in Table 7.

26 Moore J, Gale J, Dew K, Davie G. Student debt amongst junior doctors in New Zealand. *New Zealand Medical Journal* 2006; 119 (1229): 20-28

27 Mahady SE. Adding flexibility to physician training. *Med J Aust* 2011; 194 (9): 460-462.

28 Brooks PM, Lapsley HM, Butt DB. Medical workforce issues in Australia: "tomorrow's doctors —too few, too far [letter]. *Med J Aust* 2003; 179 (10): 556.

Table 7

	Percentage agree or strongly agree	WAS
The college has clear guidelines on recognition of prior learning policies and processes	34%	0.03
The college grants appropriate credit (recognition of prior learning) for relevant prior training and experience	25%	-0.09
The lack of recognition of prior learning offered by my college has impacted negatively on my career progression	14%	-0.22

This set of questions attracted a relatively high share of “not sure” responses (30% to 43%). Otherwise there was a roughly even split in the approval and disapproval ratings of college RPL. There was, however, strong evidence that a lack of RPL had impacted negatively on trainee career progression.

These figures speak to long-held views that medical education systems fail to adequately recognise prior learning (particularly at the vocational level). There are numerous reasons for this, including a lack of integration between college pathways and stages of training. A failure to award advanced standing to sufficiently-qualified trainees has implications for individuals as well as the health system. In the absence of RPL, training progression is inefficient and unnecessarily costly. It is important, therefore, that all sectors of medical education work together to streamline training pathways and, where appropriate, award recognition of prior learning.

ENVIRONMENT

Workplace conditions and industrial entitlements impact on access to quality education and training. Although balancing service delivery and training is challenging, finding an equilibrium is essential. Access to educational activities was assessed as per Table 8.

Table 8

	Percentage agree or strongly agree	WAS
I am able to attend regular college-recognised educational activities	58%	0.11
I am given protected time to attend educational activities	55%	0.08
I am able to access adequate conference and study leave to meet my training needs	60%	0.15

Respondents were more approving than disapproving on these questions, with about half choosing to “agree”. Relatively few respondents expressed strong approval or strong disapproval.

While interpretation of this data is difficult at a national level (owing to different awards in each jurisdiction), the relatively low weighted averages with respect to this question set are disappointing.

The results align with anecdotal evidence that some trainees face hurdles in securing professional development (PD) leave, particularly as a result of cumbersome and bureaucratic application processes. The large ambivalent result may suggest that communication processes in hospitals are inadequate. In many hospitals, a major barrier is the hospital administration’s willingness and capacity to arrange appropriate cover arrangements.

Conferences, workshops and seminars are essential in maintaining a skilled and talented workforce that is abreast of the latest advances in medical science and technology. Ultimately, limiting access to professional development opportunities will come at a cost to patient care.

Beyond PD requirements, quarantined time for learning is essential for trainees, who often face significant clinical pressures; learning opportunities are easily foregone in the face of service delivery requirements. Education and learning time needs to be protected from the competing pressures of service delivery to ensure that the quality and effectiveness of learning are not compromised.

Protected teaching time is a key component of clinical support time provisions in most State and Territory industrial agreements, and the AMA has strong policy in this area.²⁹ Hospital administration and senior staff must be diligent in ensuring that their employees have quarantined time for professional development – especially if contractual obligations exist. The provision of learning opportunities should be seen as core business and incorporated into the rosters for trainees as well as their supervisors.

FLEXIBILITY

Flexible work and training arrangements are critical particularly given the changing demographic of the medical workforce and the growing desire for better work life balance among doctors of all ages and gender. These can lead to high levels of job satisfaction and less fatigue without compromising continuity of care.³⁰ Access to flexible work arrangements was assessed by the statements in Table 9.

29 Australian Medical Association. AMA Position Statement. Clinical Support Time for Hospital Doctors 2009. Canberra: AMA, 2009.

30 Mahady SE. Adding flexibility to physician training. *Med J Aust* 2011; 194 (9): 460-462.

Table 9

	Percentage agree or strongly agree	WAS
The college offers appropriate flexible training options e.g. part-time and interrupted training	56%	0.17
I feel the college supports those trainees who require access to flexible training options including parental leave	42%	0.05
The training program's limits on time to complete training adequately accommodates those trainees who access flexible training options	33%	0.02
Accessing flexible training options would not disadvantage my career progression	38%	0.02

On issues of flexibility, the responses ranged from marginal approval to neutrality. A third or more were “not sure”.

It is likely that these findings reflect training demands as well as employer attitudes. There is anecdotal evidence that while colleges may allow flexibility in training, matched positions in public hospitals are rarely available. Where workplace policies on flexible employment arrangements do exist, they are not always widely publicised.

A significant amount of research has established that junior doctors are in favour of flexible work arrangements. For instance, the 2007 AMA work-life flexibility survey of public hospital doctors³¹ showed that junior doctors (including vocational trainees) had the greatest demand for flexible working hours.

More responsive rostering is essential if the public hospital sector is to engage and retain the current generation of medical trainees. Recent jurisdictional reports, including from Victoria³² and New South Wales,³³ have established that low morale and professional dissatisfaction are major issues for public hospital employees – with significant flow-on effects to patient care. Part of the solution is to encourage hospitals to offer flexible work arrangements to their staff, which will help address these issues and better support the delivery of high-quality care.

31 Australian Medical Association. AMA Work Life Flexibility Survey: Report of Findings. Canberra: AMA, 2008.

32 Department of Human Services Victoria. Ministerial Review of Victorian Public Health Medical Staff. Report of the Review Panel. Melbourne: Department of Human Services Victoria, 2007.

33 Garling P. Final Report of the Special Commission of Inquiry: Acute Care Services in NSW Public Hospitals. Sydney: NSW Dept. of Premier and Cabinet, 2008.

SAFE HOURS AND DOCTORS' HEALTH

Junior doctors are the engine room of the public hospital system, providing frontline clinical and diagnostic care 24 hours a day, seven days a week, every day of the year. They deliver high quality patient-centred care in a system that has many pressures placed upon it. The AMA survey report on junior doctor health and well-being revealed much about how those pressures affect, and are endured by, these dedicated professionals. It showed they are concerned about the impact of excessive workloads on their patients, as well as their own health and that of their colleagues.³⁴ Table 10 provides some insight into the support they get from colleges in this regard:

Table 10

	Percentage agree or strongly agree	WAS
My college training requirements are compatible with safe working hours	69%	0.26
The college promotes and supports trainee health and well-being	46%	0.09
The college has a clear policy on dealing with bullying and harassment	27%	0.03
The college responds in a timely and appropriate manner to cases of bullying and harassment	11%	-0.04

There was net support for the proposition that college training requirements are compatible with safe working hours. Otherwise, the responses were broadly neutral.

The most worrying finding here is in relation to the colleges' capacity to respond to claims of bullying and harassment. There is good evidence that bullying and harassment of doctors occurs in the workplace and colleges need to ensure that they respond effectively to this. One Australian study found that 50% of Australian junior doctors had been bullied in their workplace, and recent New Zealand research reported that 50% of doctors had experienced at least one episode of bullying behaviour during their previous three or sixth-month clinical attachment.^{35,36}

34 Australian Medical Association. AMA Survey Report on Junior Doctor Health and Well Being. Canberra: AMA, 2010.

35 Rutherford A, Rissel C. A survey of workplace bullying in a health sector organisation. *Aust Health Rev.* 2005; 28 (1): 65-72.

36 Scott J, Blanshard C, Child S. Workplace bullying of junior doctors: a cross sectional questionnaire survey. *NZMJ Digest* 2008; 121 (1282): 13-15.

It is critical that colleges have well-defined and transparent processes for dealing with these matters, which can impact significantly on trainee well-being. In their absence, trainees, supervisors and the colleges themselves remain vulnerable. The AMA position statement Workplace Bullying and Harassment (2009) highlights this issue and calls on colleges to have tailored anti-bullying/harassment policies.³⁷

The results for safe working hours are encouraging. It is hoped the long-term fashion of registrars working inappropriate hours is slowly changing. The AMA safe hours audit of 2006³⁸ identified persisting issues in this area, and a more recent study of surgical trainees concluded that while by international standards Australasian trainee working hours are around average, some rosters still leave trainees at risk of fatigue.³⁹

In regards to doctors' health issues more broadly, the AMA has a suite of resources to guide colleges and health services in addressing issues of well-being and rostering, which are available at <http://ama.com.au/doctorshealth>.

COMMUNICATION

Free-flowing communication between colleges, supervisors and trainees is critical to effective adult learning. These issues were considered by the statements in Table 11.

Table 11

	Percentage agree or strongly agree	WAS
The college communicates well with trainees regarding issues that affect their training	56%	0.13
The college gives trainees the opportunity to provide feedback on the training program and any proposed changes	54%	0.14
I am confident that I will not be disadvantaged if I raise issues of concern with my college	31%	-0.04
The college actively seeks trainee input on training issues	63%	0.25
The college responds to trainee concerns appropriately	31%	0.02
The college effectively promotes the trainee representative and/or group	56%	0.23
I am aware of how to contact my trainee representative group	67%	0.27
The college has an effective appeals process	16%	-0.03

37 Australian Medical Association. AMA Position Statement. Workplace Bullying and Harassment 2009. Canberra: AMA, 2009.

38 Australian Medical Association. Safe Hours = Safe Patients. AMA Safe Hours Audit 2006. Canberra: AMA, 2006.

39 O'Grady G, Loveday B, Harper S, Adams B, Civil ID, Peters M. Working hours and roster structures of surgical trainees in Australia and New Zealand. *ANZ J Surg* 2010; 80 (12): 890–895.

The response to this group of questions was variable. There was, however, more approval than disapproval with only two questions returning a slightly negative score. Unfortunately, these were both in critical areas.

These results confirm anecdotal evidence, which suggests that trainees are reluctant to raise concerns with their college. They also highlight a lack of faith in appeals processes.

These issues were recently highlighted in an AMC workshop on trainee feedback, which was supported by a comprehensive literature review.⁴⁰ A number of themes emerged from presentations and discussions including:

- the importance of closing the feedback loop;
- the difficulties of communicating with trainees who are dispersed over many locations;
- that some colleges have good systems and there is no reason to re-invent the wheel;
- that recognition that long term sustainability of trainee feedback and program evaluation requires high levels of responsibility and time commitments;
- the importance of clear, transparent processes, particularly in relation to the management of concerns and complaints; and
- the need for strategies to improve anonymity of feedback from trainees to reduce perceived consequences.

Best practice models of appeals processes do exist. These characteristically ensure natural justice, have clear processes and criteria and seek to avoid the potential for litigation. It is critical that colleges strive to operate appeals processes that conform to these principles.

There was strong support for college promotion of the trainee representative and/or group. Two thirds were aware of how to contact their trainee representative and/or group. This is an encouraging result, given the pivotal role that trainee committees fulfill as a conduit for feedback and communication between trainees and the college.

40 Nash-Stewart C. Medical training providers obtaining feedback from their trainees: what is best practice? Presentation to the Australian Medical Council (AMC) workshop: Training Program Evaluation and Trainee Feedback; 2010 Nov 13; Sydney, Australia.

CONCLUSIONS

The 2010 AMA Specialist Trainee Survey has revealed that colleges and health services are performing well in many areas of vocational training, including:

- Transparency of selection processes;
- Alignment of clinical experience with training objectives;
- Access to supervision; and
- Adherence to safe hours guidelines.

Overall, there was a high level of satisfaction with work and training, as well as broad support for the provision of educational resources and activities.

There were, however, significant areas of dissatisfaction. These included:

- Access to effective appeals processes;
- Capacity to raise concerns without fear of recrimination;
- Recognition of prior learning;
- Provision of feedback and remediation;
- Responsiveness to cases of bullying and harassment; and
- Value for money, and overall cost of training.

This last area attracted the most negative WAS of all questions (-0.3), with only 23% agreeing that their training program represented value for money.

It is also of some concern that only 46% of respondents believe that their college promotes and supports trainee health and well-being. The medical profession is often perceived as being very poor at caring for its own, and this is borne out in the trainee perceptions reported here. Junior doctors experience specific pressures related to their professional stage and development and can be at risk of poor health.⁴¹ The AMA believes that colleges have a leadership role to play in this area and has called for appropriate supports to be put in place.⁴²

Notwithstanding the limitations of its methodology, the results of this survey should be a useful aid for colleges and health services reflecting on their compliance with the AMC standards for specialty education and training. It is hoped that this report will prompt relevant institutions to internally review their education and training policies, with a particular focus on the areas of trainee dissatisfaction.

41 Markwell AL, Wainer Z. The health and wellbeing of junior doctors: insights from a national survey. *Med J Aust* 2009; 191 (8): 441-444.

42 Australian Medical Association. AMA Position Statement. Health and Wellbeing of Doctors and Medical Students 2011. Canberra: AMA, 2011.

The AMA provides many resources that will guide colleges and health services in implementing solutions to the issues identified here. Many of these have been referenced throughout the report, and include position statements on clinical support time, appointment standards, training in private settings, workplace bullying and harassment and safe working hours as well as guides to safe rostering, work-life flexibility and hand-over.

It is critical that quality in specialty training is maintained in the face of escalating trainee numbers. For this reason, the AMA plans to repeat this survey in four years to provide a further point-in-time perspective. Comparison of the two results will identify areas of progress by colleges and also those where quality may have been diluted.

In the mean time, the AMA will continue its work in advocating for the prioritisation of resources for clinical teaching. A highly-skilled workforce is critical to an effective health system, which is in the interest of all Australians.







AMA

42 Macquarie Street Barton ACT 2600
Telephone: 02 6270 5400 Facsimile: 02 6270 5499
www.ama.com.au