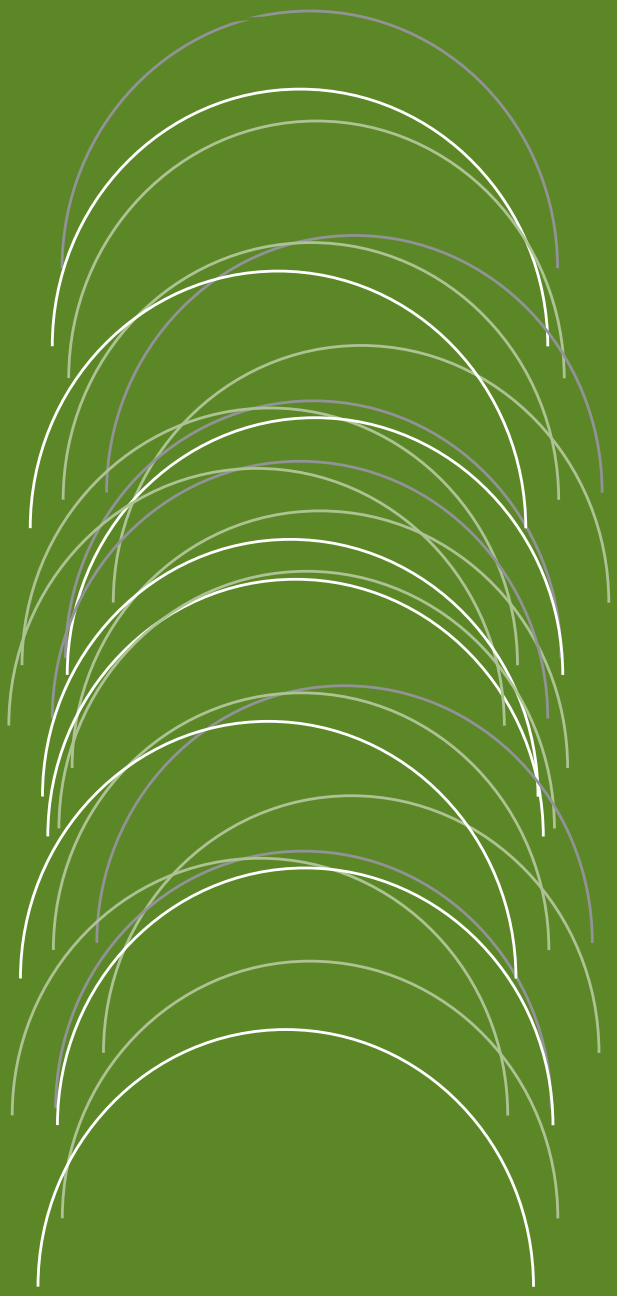

John B Reid Theatre, AGSM Building,
The University of New South Wales, Sydney
Saturday 13 November 2010

Contents

Executive Summary

On 13 November 2010, the Australian Medical Council held a Workshop on Confidential Trainee Feedback Mechanisms.

The workshop was an initiative of the Specialist Education Accreditation Committee, which oversees the process for assessment and accreditation of Australian specialist medical education programs and professional development programs. In reviewing progress reports by accredited specialist medical colleges, the Committee had noted that a number of colleges were having difficulty addressing recommendations made in AMC accreditation reports concerning the accreditation standards relating to Monitoring and Evaluation, and in particular accreditation standard 6.1.3, which states, 'Trainees contribute to monitoring and to program development. Their confidential feedback on the quality of supervision, training and clinical experience is systematically sought, analysed and used in the monitoring process. Trainee feedback is specifically sought on proposed changes to the training program to ensure that existing trainees are not unfairly disadvantaged by such changes.'

The workshop, in which 75 trainees, college staff and jurisdictional representatives participated, provided an opportunity to discuss current processes for trainee input into program monitoring and evaluation within colleges, as well as processes for addressing complaints and appeals.

The Australian Medical Council also commissioned a literature review and survey of appropriate institutions, which was provided to workshop participants, to determine good practice for conducting trainee feedback on their training experiences, with particular focus on confidentiality. This research was then incorporated into the program evaluation.

This report summarises the workshop's sessions and presentations. It also captures the outcomes of the workshop's small group and panel discussions.

Introduction and Context

Since the AMC established the process for assessing and accrediting specialist medical training programs ten years ago, it has recognised the importance of providing opportunities for those completing programs of study, the doctors in training, have opportunities to contribute to the assessment of these programs. Similarly, in setting its accreditation standards, it has recognised that trainees are affected by the way in which the education providers, the colleges, manage their training program and also the role trainees play in AMC's own processes and committees. Over this period, recognition of trainee issues within the colleges has changed, as have the AMC's accreditation standards in regard to these matters. The AMC monitors colleges program against the accreditation standards and the AMC Workshop for Training Program Evaluation and Trainee Feedback, held on 13 November 2010 at the University of New South Wales, Sydney, was developed to assist organisations, including specialist colleges, deal with trainee issues, and to inform possible changes to the AMC accreditation standards.

The workshop addressed two themes:

- Obtaining feedback from trainees, with a focus on improvement.
- Trainee concerns, complaints, and appeals.

The workshop aimed to be useful, educative and useful at a practical level, to form a sense of whether current practices are sufficient. The workshop was structured into sessions including presentations, small-group discussions, and a panel discussion. This report captures the outcomes of the sessions.

Presentation Sessions

The workshop included four presentation sessions with seven presenters from a variety of disciplines. This section presents a brief summary of each session. Biographies of presenters are included in Attachment 4 and full presentation slides for each topic are available in Attachment 5.

AMC standards and accreditation findings

This session was presented by Associate Professor Jill Sewell AM, chair of the AMC Specialist Education Accreditation Committee.

Presentation

Associate Pr

- Anonymity, especially in smaller training programs. In these situations, trainees fear being branded troublemakers if they give negative feedback.
-

connection (see slides, Attachment 5), including taking on trainees as associate fellows and spending time in hospitals with trainees. The most important principle is to **close the loop** – make sure trainees understand what is done with data collected. Dr Klein commented that under this principle, they have posted survey results and proposed actions on student websites, and have kept response rates >90%.

Dr Klein outlined the long history and evidence base of participatory evaluation. The method chosen (survey, direct methods, focus group, etc.) depends on the questions being posed, the available sources of data, and people and time resources. Sh

Presentation

Mr Gorton presented the legal perspective on trainee complaints. He reflected that for every

considered in these circumstances, because then college may have obligation to report the trainee to the medical board.

supervision; the possibility of a national tool; the culture of workplaces and connecting curriculum with clinical work, teaching, and assessment. Suggestions were made to have external mediators (or tools) assist with term evaluation.

- Finally, the need for colleges to have a process for and show they can 'close the loop' on feedback. Survey design has a role in making sure the trainee knows their feedback will result in change.

Question 3*: In what circumstances is it more appropriate to seek feedback from groups of trainees (such as a trainee committee)? When is it more appropriate to seek feedback from individual trainees?*

The group responded that:

- Where information was sought on curriculum/assessment or related issues of change, feedback should be sought from a group (training committee etc).
- Where information was sought on effectiveness of attachments or delivery of training, feedback should be from individuals, ensuring they are de-identified.
- Induction or guidelines to assessment are needed for trainees providing individual feedback (including limitations and privacy legislation).

Question 4: *What is the role of an effective trainee feedback process in program evaluation and improvement? What are the consequences of not collecting and addressing trainee feedback effectively?*

The group listed their key points for effectiveness of trainee feedback in evaluation and improvement were:

- Structure of the evaluation to determine what happens to the feedback.
- Demonstrating a change/outcome.
- Involving trainees early (not just as respondents) to identify the issues and feedback purpose, and to design questions.
- Closing the loop – acting on results, targeting information to relevant groups, and promoting the changes.

Key consequences for not addressing feedback effectively were:

- AMC dissatisfaction 372.53 Tm[actin)14(g </MCID 9/(i)5(de)3(l)5(i)5(ne)3(s)-4(t)-4(o)13( )-4(asse)3(ss)

- Trainee agreements and charters (e.g. RACP developed in response to AMC recommendations, RACDS) or memoranda of understanding (e.g. ACEM, RANZCOG). Need for a supervisor charter was also raised.
- Encouraging trainees to participate in the college, including on review committees.
- Supervisor training courses and supervisor accreditation.
- Educating both trainees and supervisors on feedback expectations, and using common feedback forms.
- The use of an ombudsman for independent review.

Through the discussion, the groups recognised challenges in this area, including:

- Dispersed supervision making communication more difficult.
- Delineating the responsibilities of the college and the employer not always easy – these 'jurisdiction' issues are complex and can lead to duplication or miscommunication.

Questions asked by the groups included:

- Why can't colleges work together to achieve common goals and outcomes?
- Do we need to educate trainees and supervisors in the expectations for feedback?

Question 2: *In your experience, what are the characteristics of effective mechanism for dealing with complaints and/or reviews in educational institutions such as the specialist colleges? What characteristics of ineffective mechanisms have you experienced?*

The groups discussed a number of characteristics of systems that effectively deal with complaints of reviews:

- A clear, open, and transparent process, including documentation and excellent communication to the trainee. The clarity of the process also includes knowledge of who to contact, which affects expediency. One group specifically cited that a single point of contact is needed.
- Ensuring the responsibility is passed (or delegated) to the most appropriate level in the organisation, and, equally, providing informal mechanisms prior to the a formal complaint, such as mentors or advocates. This can be a challenge in a decentralised environment and highlights importance of communication.
- Clearly defined grounds for complaint (objective criteria) and demonstration of natural justice.

Ineffective mechanism characteristics discussed included:

- Poor communication between the college and the 'periphery'.
- Impacts on the trainee for raising a complaint.
- Non-empathetic processes.

Question 3*: What role does an effective process for dealing with trainee complaints/reviews of decision play cohhsistifor h(e-4)5(n t)-(7he)3(aCID 4ang (en-GB)(w)15(ay)oCID 4a(l)5(y)1ua)ion be?(4)(b)atrola*

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- Financial (and other) consequences for the trainee.
- Invoking legal avenues.

The groups noted:

- No formal process in most colleges.
- Much is resolved at the local level and never known to the colleges.
- Appeal information and outcomes need to be de-identified.

The groups queried:

- Is there a role for an external body to provide a third party avenue?
- Are databases/registers of complaints reviewed and used for broader trend analysis?

Question 4: *What can organisations such as the specialist colleges do to minimise complaints and/or reviews of decisions?*

Consistent themes in group discussion were:

- Good communication with employer, supervisor, and trainee (misinformation is an issue).
- A good process which is clear and is always followed.
- Empowering trainee representation (including committees) in governance structures, for example, ability for trainee committees to table agenda/policy for consideration.
- Having mechanisms in place for trainee feedback, including on governance structures. Both formal (e.g. focus groups) and informal processes of value.

Other discussion reflects a need for:

- Change management to minimise issues and to sell the change.
- Ensuring link between educational objectives and assessment.

Panel Discussion

The panel discussion took questions both generated from the small-group discussions and direct from the audience. The panel members were: Professor Barry Baker, Dr Linda MacPherson, Dr Andrew Perry, Associate Professor Jill Sewell and Associate Professor Tim Shaw.

Question 1: *Tim mentioned specialist training has an impact on patient care – do you think patients have a stake in the traineeeq 4 TEBT1 0 1 5 1.51 1 8 Tm [(do)3-4(you)1 4(ss)12(m)-1(EBT1)-6 5(msa)1([(C)5(ha)*

Question 3: *I got a sense from Dr Perry's talk that concerns can arise and founder at the sub-specialty level and that this level can call the shots despite the college having overriding authority. How much of a problem is the sub-specialty group with trainee concerns?*

Within large colleges, the subspecialties not always knowing the college processes can be a problem, including in areas such as selection, training location, and natural justice principles. The AMC is aware of and discussing this issue. The panel commented that structures in the larger colleges have changed a lot. The panel clarified the AMC holds the overall college accountable to the standards, and expects the college would ensure standards through its subgroups, but has recognised a need to address this further.

Question 4: *One of the group ideas was trainee agreements – almost quasi-contracts – comments?*

The panel discussed their individual experiences, including trainee agreements where both trainees and the college sign for what they will and will not do. RACP is drawing up a training charter to recognises trainee and college expectations. The panel discussed the role of the hospital in charters. The panel experience is where the hospital signs to say they will provide the listed facilities. The panel also suggested further discussion on agreements with supervisors, and the audience commented that agreements may disadvantage some trainees if their college cannot negotiate particular conditions that another college can. Overall, the panel recognised the actual implementation of the on-paper agreement is the key.

Question 5: *What is the general feeling about how communication to trainees is done on the purpose of evaluation and expectations for trainees?*

Communication is difficult where people are distributed. In a university model, trainees could be addressed as a group but a college model, this is difficult. New technologies and approaches may provide some answers, but information overload has to be avoided. The face of the college is the supervisors, and if they do not understand the processes, then the

Attachment 1

AMC Standards and Accreditation Process

Attachment 2
Literature Review

Abstract

Continuous evaluation and improvement in modern medical education requires trainees to give feedback on their supervision and training programs. Feedback approaches vary: methods include surveys (paper-based or electronic), interviews, focus groups and direct peer reporting. Feedback may be taken by the training provider or a third party, and may be anonymous or open. Despite the frequency and the variety of approaches, published literature contains no clear consensus on what constitutes best practiceThis paper reviews the literature and presents a summary of best practice knowledge on obtaining feedback from medical trainees. This is

6.2.2 Supervisors, trainees, health care administrators, other health care professionals and consumers contribute to evaluation processes.

7.2 Trainee Participation in Training Organisation Governance

7.2.1. The training organisation has formal processes and structures that facilitate and support the involvement of trainees in the governance of their training.

8.1 Supervisors, Assessors, Trainers and Mentors

8.1.3 The training organisation routinely evaluates supervisor and trainer effectiveness including feedback from trainees and offers guidance in their professional development in these roles.

8.1.5. The training organisation has processes to evaluate the effectiveness of its assessors/examiners including feedback from trainees, and to assist them in their professional development in this role.

The meaning of feedback has been discussed in published literature, but usually definitions are given in the context of feedback to trainees.[10] This review focuses on the complementary situation: trainees giving feedback on their training experiences. The definition of feedback in this setting, however, is essentially the same: feedback is specific information comparing observed performance [of a training program, supervisor, etc.] to a standard, given with the intent to improve performance [of the training program, supervisor, etc.]. As such, high quality feedback in clinical education settings:

1. covers observable tasks and competencies

what is presented in this paper is a summary of consensus, and agreement between many researchers in the absence of rigorous testing may constitute only most common practice, rather than best practice. Despite this, the review identified some key papers that contain excellent summaries of relevant research, or extensive details of feedback tool development. These, listed below, are advised as further reading:

10. Maniate,[12] detailing the development of the Canadian resident program evaluation (RPE) surveys.

11. de Olivera Filho,[13] detailing reliability and validity processes for survey development.

12. Bienstock et al,[14] summarising giving feedback to trainees, a subject complementary to this paper.

13. Kogan and Shea,[15] summarising current knowledge in medical course evaluations, including feedback.

14. Alfonso et al,[16] one of the first studies of anonymous vs. open evaluations.

15. Beckman et al,[17,18] who summarise available feedback tools and comment on validity.

16. Porter et al,[19] who reviews literature related to 'survey fatigue'.

Methods

To obtain material for this review, PubMed, Medline, Google Scholar, and Web of Science databases were searched for articles with various combinations of: trainee OR student OR postdoct* OR learner OR apprentice OR cadet AND feedback OR evaluat* OR opinion OR judgement AND confidential* OR anonymous OR secret OR closed

Paper references were also examined and highly relevant papers were checked for prospective citations using Web of Science. The AMC also contacted two overseas organisations known to conduct large-scale trainee surveys ² The London Deanery, whose surveys are now used nationally in the UK, and the Royal College of Physicians and Surgeons of Canada (RCPSC) ² for their input.

Discussion

Best practice in selecting or designing a feedback tool

Published literature shows a variety of qualitative and quantitative methods for taking trainee feedback, including surveys/questionnaires, interviews (independent or with trainers), focus groups and direct reporting.

Surveys and questionnaires

Surveys/questionnaires are the most common feedback method and are used both to answer one-off research questions[4,6,9,16,20-23] and to measure changes.[3,7,12,24-26] Surveys are highly flexible: they can be small- or large-scale; on paper or electronic; and can measure quantitative ratings (e.g. Likert scales: strongly disagree, disagree, neither agree nor disagree, agree, strongly agree) or collect qualitative data (e.g. open questions).[20] Electronic surveys allow rapid data processing (including for 'red flag' issues), flexibility to change information flow,[2] may reduce administration cost,[26] and allow tracking of respondents while preserving confidentiality.[26] The reviewed literature does not evaluate whether taking feedback

electronically or on paper changes response quality, however efficiency gains for large-scale surveys make the electronic format part of current best practice. Examples of existing, large-scale surveys of medical trainees include:

17. Canadian resident program evaluations (RPEs) used in the RCPSC and College of Family Physicians of Canada (CFPC) programs.[12] Both were developed using input from residents

describe the LPS survey development; and Roff et al,[8] who describes the development of the

Substantial research has considered how to increase response rates, though most studies are not specific to feedback from trainees.[59]

process report, rather than a research study. No studies addressing these issues were found in the surveyed literature.

Administering the feedback tool

Confidentiality

Research shows preserving confidentiality for trainees giving feedback is critical for data integrity. Trainees exist in a power imbalance with their supervisors, and research suggests negative experiences are less likely to be reported if the trainee can be readily identified.[15,16,23,32,62,68,69] Meta-

tri-annual basis for small specialties with just one trainee per unit [64]. This may defeat the need

level of success. The paucity of these details makes determining best practice in incorporating feedback difficult. In fact, Willett[32] found medical students held the opinion that feedback does not lead to program change, and other surveys suggest this opinion may be widespread.[75] Willett called for investigation of this perception. Among those who do describe action taken, Jasper[70]

Lessons from other professions

Kogan and Shea[15]

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41.

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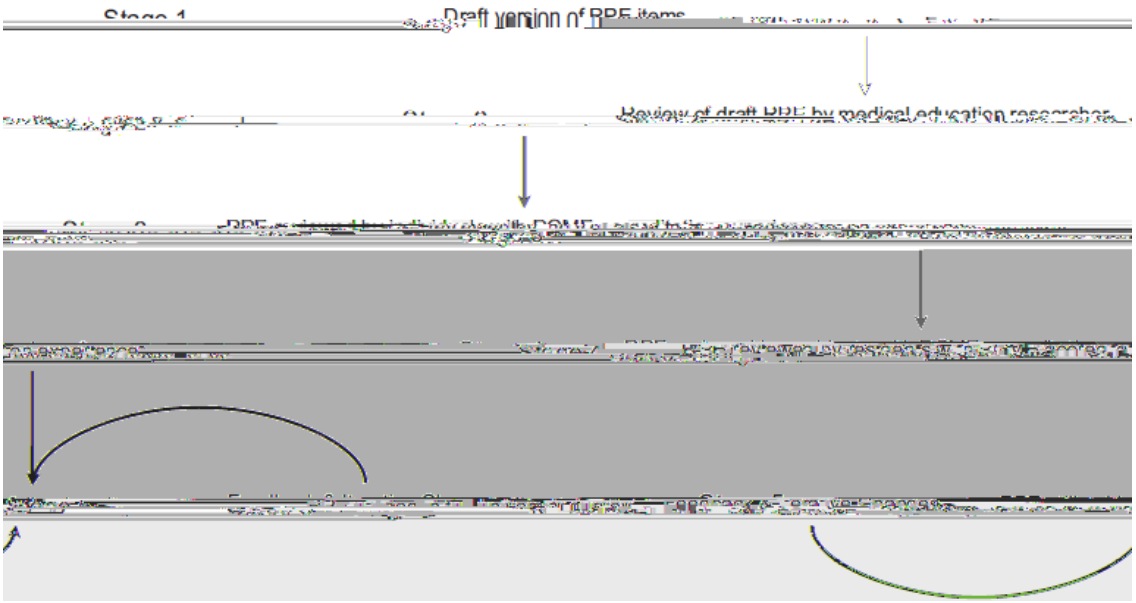
73.

Table 1: Methods to change response rates to postal and electronic questionnaires [62].

Postal/Paper		**Electronic**	
Method	Odds Ratio	Method	Odds Ratio
Teaser of benefit on envelope	3.08	Including a picture in the email	3.05
More interesting topic	2.00	More interesting topic	1.85
Monetary incentives	1.87	Shorter questionnaires	1.73
Recorded delivery	1.76	Non-monetary incentives	1.72
Shorter questionnaires	1.64		

Figure 1: Process of survey development for the Canadian RPEs. From Maniate (2010)[12]



Attachment 3
Recommended Reading

The following papers offer a selection of research in the field:

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.

Beckman TJ, Cook DA, Mandrekar JN. What is the validity evidence for assessments of clinical teaching? J Gen Intern Med. 2005;20:1159-1164.

Beckman TJ, Ghosh AK, Cook DA, Erwin PJ, Mandrekar JN. How reliable are assessments of clinical teaching? J Gen Intern Med. 2004;19:971-977.

Bienstock JL, Katz NT, Cox SM, Hueppchen N, Erickson S, Puscheck EE, et al. To the point: medical education reviews - providing feedback. Am J Obstet Gynecol. 2007 Jun;196(6):508-513. This paper is a review on giving feedback to trainees, a subject complimentary to the workshop.

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Porter SR, Whitcomb ME, Weitzer WH. Multiple surveys of students and survey fatigue. New Directions for Institutional Research. 2004;121:63-73.

Attachment 4
Presenter and Panel Member Biographies

Professor Barry Baker

Professor Barry Baker became a Director of Professional Affairs for ANZCA in July 2006. He graduated MBBS from the University of Queensland in 1963 and with a Doctor of Philosophy from Magdalen College, Oxford University, in 1971. He has held a number of academic positions in Australia and New Zealand as well being active in academic publications.

He has served on a number of boards and councils including as Dean of the Faculty of Anaesthetists of the Royal Australasian College of Surgeons (FRACS), which later became the Faculty of Intensive Care, ANZCA. He is the author of more than 200 publications in the academic and scientific literature on anaesthetic, physiological and historical topics, and the recipient of a number of distinguished awards including the Ben Barry medal.

Mr Michael Gorton AM

Michael Gorton currently is a Principal of Melbourne-based law firm Russell Kennedy. Michael provides advice in health, administrative and intellectual property law and in company, contract and commercial law.

He holds a Bachelor of Laws and Bachelor of Commerce from the University of Melbourne. Mr Gorton holds an Honorary Fellowships of the Royal Australasian College of Surgeons and the Australian and New Zealand College of Anaesthetists. He is the Chairperson of the Victorian Equal Opportunity and Human Rights Commission and a Board Member of Melbourne Health (Royal Melbourne Hospital). He is also past President of the Health Services Review Council, former Chair of the Victorian Biotechnology Ethics Advisory Committee and currently Deputy Chair of the Infertility Treatment Authority.

Dr Linda Klein

Dr Linda Klein is a Senior Lecturer in Evaluation at the Office of Medical Education at Sydney Medical School, a position she has held since 2008.

She graduated with honours and a Bachelor of Science from the University of Iowa in 1975, a Master of Science from the School of Psychology, University of New South Wales in 1989, and a PhD from the School of Public Health and Community Medicine, University of New South Wales in 2009.

Linda has held a number of research and teaching positions at the University of New South Wales. She also serves as a freelance consultant in research/evaluation methods and data analysis for the public and private sector, and for honours and postgraduate students. She is a registered Psychologist with the NSW Psychologists Registration Board, and a Member of the Australasian Evaluation Society.

Ms Mary Lawson

Mary Lawson is the ANZCA Director of Education and leads educational projects within the ANZCA Education Development Unit (EDU). She has worked in the field of medical education for almost 20 years, at both the undergraduate and postgraduate levels. Her research and work interests in this area have included emphasis on curriculum redevelopment and the development of clinicians as educators.

Prior to her role at ANZCA Mary held a senior position at Monash University where she developed a suite of postgraduate programs in health professional education and has coordinated national research projects in both the UK and Australia.

Dr Linda MacPherson

Australia in January 2005, for services to child health and is Chair of the Alfred Health Quality Committee.

Associate Professor Tim Shaw

Attachment 5
Small-group Discussion Questions

Session 4 Obtaining feedback to enable program improvement

- In practice, what information should medical colleges be seeking from trainees in order to assist with program evaluation and improvement?
  - Of this information, what is most important?
  - Which type of information is most difficult to gather?
- In your experience, what have been the more effective methods for gaining feedback from trainees/students on their education programs?
  - What were the key elements that made these methods effective?
  - What factors make feedback methods less effective, and how can these be addressed?
- In what circumstances is it more appropriate to seek feedback from groups of trainees (such as a trainees committee)? When is it more appropriate to seek feedback from individual trainees?
- What is the role of an effective trainee feedback process in program evaluation and improvement? What are the consequences of not collecting and addressing trainees' feedback effectively?
- Trainees are one of many groups/stakeholders interested in contributing to feedback on training programs. In your experience, is more or less attention given to trainees' feedback than from other stakeholders? Is it more or less difficult to obtain?

Session 6 College review and complaints procedures

- Given the number of trainee/supervisor or trainee/college interactions that may lead to complaints or reviews of decisions, how does a college prepare supervisors/colleges and trainees, including informing them of their rights and responsibilities?
- In your experience, what are the characteristics of effective mechanisms for dealing with complaints and/or reviews in educational institutions such as the specialist colleges? What are the characteristics of ineffective mechanisms that you have experienced?
- What role does an effective process for dealing with trainee complaints/reviews of

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