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

ACCREDITATION SUBMISSION
TO THE AUSTRALIAN MEDICAL COUNCIL

JANUARY 2011
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<td>Australian Donor Awareness Programme</td>
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<td>AMC</td>
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EXECUTIVE SUMMARY

Introduction

The College of Intensive Care Medicine of Australia and New Zealand (CICM) was formed on 1 January 2010 and is now the body in Australia and New Zealand responsible for the training, certification and continuing professional development of intensive care medicine specialists. The six-year training program has grown out of programs commenced in 1977 by the Royal Australasian College of Physicians (RACP) and the Faculty of Anaesthetists of the Royal Australasian College of Surgeons (FARACS) and now culminates in Fellowship of the College of Intensive Care Medicine of Australia and New Zealand (FCICM). An endorsement in Paediatric Intensive Care Medicine is also available through CICM after a specific six-year program in that sub-specialty, containing many common elements with the general training program.

The College is responsible for the maintenance of standards within the profession, and its Fellows participate in a range of activities that promote and enhance the science and practice of intensive care medicine. The College has a close relationship with the Australian and New Zealand Intensive Care Society (ANZICS) and by agreement shares and divides the particular roles which support the specialty (refer Appendix 11).

The College assists in the review of the credentials of international medical graduates on behalf of the Australian Medical Council (AMC).

The College has developed from the Joint Faculty of Intensive Care Medicine (JFICM) over the last two years. JFICM had been the outcome of co-operative discussions and collaboration between the Australian and New Zealand College of Anaesthetists (ANZCA) and the RACP, and had existed within the corporate structure of ANZCA since 2002, although a joint faculty of ANZCA and RACP.

Since the successful establishment of a separate College of Intensive Care Medicine and transfer of funds and intellectual property, the College is moving rapidly to review its processes and assure openness, fairness, validity and reliability in all areas of responsibility. The initial priorities of the new College have been maintenance of the highest standards of training and education in intensive care medicine (ICM), while considering the needs of our Trainees and Fellows and the public at large. Special care has been taken to ensure that no existing Trainee was disadvantaged by the move to the new College.

Recent Events in Establishing CICM

The new College was incorporated as a body limited by guarantee in November 2008 and the inaugural meeting of the CICM Board was held in February 2009. At this meeting office-bearers were elected and a Constitution was accepted, which is very similar to that of the previous parent bodies, ANZCA and the RACP. This process was initiated by a survey of Fellows of JFICM in 2007 that showed strong support for establishment of a new College and a vote at the May 2008 JFICM Annual General Meeting that revealed 90% of Fellows were in favour of formation of a new College.
ANZCA Council conducted a plebiscite of its Fellows, in which the motion was to support the transformation of JFICM into the new College of Intensive Care Medicine, and to provide seed funding. Over 90% of ANZCA Fellows supported the motion.

Members of the JFICM Board were appointed to the Interim Board of CICM and this allowed both Boards to operate in parallel, with a gradual transfer of functions from the JFICM Board to the CICM Board, so that a smooth transition was effected.

A working party of representatives of ANZCA and JFICM was established to work through separation issues and a Memorandum of Understanding regarding the new College was developed between JFICM, ANZCA and RACP. Discussions proceeded smoothly, with the focus on a smooth transition of the training program to the new body. In March 2009 the relevant statutory bodies and related organizations were informed of the establishment of the new college. All state, territory and national health care services were informed of the development of the new College of Intensive Care Medicine and CICM will continue to have representation on the appropriate national, territory and state health organizations.

A review of all JFICM policies, procedures and guidelines was completed in 2009, and these provide a solid platform for the new College. Regulations governing the detailed operation and structure of the College were finalised and the Human Resources, Finance and Information Technology (IT) requirements of a separate college were developed. New premises were found in Prahran, (Vic), and all the existing JFICM staff transferred to the new body.

Criteria for Foundation Fellowship were agreed, and invitations forwarded, with admission of the new Fellowship completed in late 2009 with all but ten Fellows of JFICM transferring to CICM.

The business plan and timeline for transfer were maintained, and, because of a great deal of energy and enthusiasm from staff, Fellows and the parent colleges, no obstacles or delays were encountered. In particular, ANZCA and RACP were very helpful in assisting with arrangements for the new body. The responsibility for the training and education of intensive care specialists officially transferred to the new College on 1st January 2010. The history of the College is discussed further in Section 2.

**Previous AMC accreditation, recommendations and resultant action**

The precursor training body of CICM, JFICM, was inspected and accredited by the AMC along with ANZCA in 2002. The formation of JFICM had recognised the evolving nature of intensive care practice and was achieved in a positive and collaborative manner, so the structure and content of many of JFICM’s processes were shared or inherited from ANZCA and the RACP.

JFICM also submitted its own annual reports following the original inspection, and the latest report was the seventh, in 2009.

The overall report of the AMC Team in 2002 was very positive but a number of items that
would require additional attention were recognised. The recommendations included that JFICM should:

- establish an Education and Training Committee;
- clarify the formative and summative nature of In Training Assessments (ITAs);
- encourage Trainees to gain rural experience;
- do more about recruiting Trainees;
- consider a less rigorous regimen of training and assessment;
- establish a more liberal attitude to retrospective training;
- gain systematic feedback from Trainees and
- ensure greater uptake of the Continuing Professional Development (CPD) program and encourage alternative pathways to meet individual needs eg. an individualized CPD process.

Many changes have occurred since this review; some in response to AMC recommendations and others resulting from a continual process of internal review and renewal. The review and renewal have not been interrupted by the formation of the new College.

**Major developments relating to training, education and CPD**

Since the original accreditation review, major changes have been made to the training program. Some of these have been documented in annual reports to the AMC. They include:

- development of an outcomes-based curriculum in intensive care medicine with linked assessments. The program consists of three years of basic training and three years of advanced training;
- establishment of an Education and Training Committee to address issues relating to the advanced training program and the welfare of Trainees;
- establishment of a Trainee Committee within JFICM;
- attracting increased numbers of JFICM Trainees, including in the paediatric area;
- revision and improvement of ITA processes, customising the criteria to specific term needs and increasing responsibility of Trainees;
- change to summative assessments, including the development of the Intensive Care Primary Examination. Trainees can still use Basic Training and the Primary Examination of other vocational programs (ie. the ANZCA, ACEM or RACP) to enter CICM Advanced Training;
• expansion of the number of hospitals accredited for training in intensive care medicine;

• adoption of broad criteria for accreditation of Intensive Care Units (ICUs) for Basic Training and acceptance of rotations to smaller ICUs. This should encourage Trainees to gain experience in rural ICUs;

• establishment of a stand-alone Annual Scientific Meeting of JFICM (in 2005) and CICM (in 2010). This high-quality, single-themed 2½ day conference has become the premier intensive care medicine conference in Australia;

• establishment of an annual New Fellows Conference, specifically for JFICM/CICM Fellows, in association with the ASM;

• development of a new format for the Fellowship Examinations;

• modification of the Trainee database so that it accurately reflects the numbers of Trainees currently in active training and their passage through the program;

• establishment of a Hong Kong Committee to assist training in that region, and

• establishment of a CPD development team to design a contemporary professional development program under the oversight of the Fellowship Affairs Committee.

Challenges

Intensive Care Medicine is a rapidly evolving specialty. With the aging population and more efficient medical care provided in the hospital environment, hospitals are now caring for increasingly sick patients, with complex co-morbidities, in an environment of heightened expectations by jurisdictions, consumer groups and families. Therefore demands on intensive care specialists are increasing, particularly for their skills in caring for greater acuity patients in the general wards. Expectations of the role of intensive care specialists are changing.

Intensive Care Units are expanding in size and specialists are increasingly required to attend to a greater number of responsibilities outside the ICU. The terms ‘mega-units’ and ‘outreach work’ have crept into the lexicon and become accepted as core intensive care work in many institutions and health care systems. Early Warning Systems (EWS), Medical Emergency Teams (MET) and programs to teach detection, diagnosis and treatment of deteriorating ward patients, as well as running the daily processes of ICUs are endeavours invariably led by intensive care specialists.

The challenges are to educate for the future and effectively train and maintain the ongoing professional development of today’s highly skilled and flexible specialist workforce. Tomorrow’s intensive care specialists should be capable of using increasingly sophisticated technology (such as echocardiography and ultrasound), working in large or small ICUs, dealing with organ donation and end of life issues and also able to interact co-operatively with many other specialties.
Summary of strategy and initiatives for 2011 and beyond

A Strategic Plan was developed over the first six months of 2010 (refer Appendix 7) Over the next few years the Board has decided to prioritise:

- development of a CPD program that meets the needs of individual practitioners more flexibly and in a positive and supportive way, as an alternative to the "lowest common dominator" points-based MOPS system;

- strengthening the Supervisor of Training (SOT) role by ensuring access to workshops, stand-alone courses and lobbying for protected time for non-clinical work;

- development of a database web-based interface that will enable improved access for Trainees to view their training status and needs, and other general information (currently Trainees make contact personally when seeking an update on their training progress);

- improving educational and training resources with expansion of teaching and in-training assessment tools including:
  - exploration of opportunities to assess further a range of clinical skills before completion of training;
  - consideration and trialling of new methods of trainee assessment;
  - increasing use of simulation in both training and assessment. These are important strategies in the face of increasing trainee numbers and diminishing public hospital in-patient services;

- increasing approval of training posts in rural, regional and private hospitals to expand the available number of training settings, particularly for the anaesthetic component of training;

- focusing on feedback and other coaching skills in supervisor training activities;

- development of distance education materials;

- extending Trainee participation in the governance of their training by including a Trainee representative on the Board, relevant committees and hospital accreditation review teams;

- incorporating professional educational expertise into the College’s processes;

- developing further collaboration with other institutions;

- increasing interaction with the health sector;

- developing policies and modules on cultural competence within the ICU, within the broader national cultural perspective and for overseas doctors coming to Australia;

- establishing a pool of appropriate persons for consumer representation, and

- engaging non-Fellows by being more inclusive with the College’s education activities, particularly CPD.

These initiatives are expanded upon within the body of this Submission.
Training organisation details

Contact details

College of Intensive Care Medicine of Australia and New Zealand

Suite 101
168 Greville Street
PRAHRAN VIC 3181
Telephone: (03) 9514 2888
Email: cicm@cicm.org.au

Chief Executive Officer:
Mr Philip Hart

Officer to contact concerning the accreditation submission:  Mr Philip Hart
Telephone number:  (03) 9514 2800
Email: philh@cicm.org.au

Training programs offered

Fellowship of the College of Intensive Care Medicine of Australia and New Zealand (FCICM)

and

Fellowship of the College of Intensive Care Medicine of Australia and New Zealand (FCICM), endorsed in Paediatric Intensive Care Medicine
1 The Context of Education and Training

1.1 Governance

AMC accreditation standards

1.1.1 The training organisation’s governance structures and its education and training, assessment and continuing professional development functions are defined.

1.1.2 The governance structures describe the composition and terms of reference for each committee, and allow all relevant groups to be represented in decision-making.

1.1.3 The training organisation’s internal structures give priority to its educational role relative to other activities.

Governance Structure

The College is governed by an elected Board, which operates within the Objects of the College, defined within the Constitution. The Constitution (Appendix 1) defines the composition and election of the Board and Executive, and the election of Office Bearers. The Objects of the College detail its education and training functions.

The College Regulations (Appendix 2) expand upon the functions of the College, detailing the duties of office-bearers and the number and composition of the various subcommittees and Regional and National Committees. The Regulations also detail the requirements of the training and assessment program. The Maintenance of Professional Standards Program Manual (Appendix 3) outlines the College’s current MOPS program.

Board: composition, membership and duties:

There are eleven members of the Board elected by the Fellowship. One of these is identified as the “New Fellows” representative, specifically to represent the interests of Trainees and recently admitted Fellows (within 3 years of admission to Fellowship) in the governance of the College. From 2011, there will be a Trainee representative on the Board, who will be a co-opted observer for a trial period. There is provision to co-opt Fellows to represent those geographic regions that do not have an elected Member. The Presidents of the related intensive care society (ANZICS) and the ANZCA and RACP are official Observers at Board meetings.

The College encourages representation of special intensive care interest groups and has the authority to co-opt a representative if not represented following an election. An example of this might be a Fellow with experience in paediatric intensive care, or the rural sector.

The positions of Office-bearers and Chairs of the Committees are permanent ‘portfolios’ and other portfolios are established on an ad-hoc basis. Senior officers are the President, Vice-President, Censor, Education Officer and Treasurer (refer Job Descriptions, Appendix 4). An Executive Committee (comprising the President, Vice-President, Treasurer and CEO) is a standing committee of the Board that has delegated authority to review urgent matters
between scheduled Board meetings.

Figure 1.1: Governance Structure
Board members as at January 2011

Elected

Professor John Myburgh President
Dr Ross Freebairn Vice President, Censor, Chair, Fellowship Affairs Committee
Professor Bala Venkatesh Treasurer, Chair of Examinations Affairs Committee
Dr Charlie Corke Education Officer
Dr Michael Anderson Assistant Education Officer
A/Professor Rob Boots Assistant Censor, Research Officer
Professor Gavin Joynt CPD Officer, International Liaison Officer
Dr Amod Karnik Chair, Hospital Accreditation Committee, Regional Officer
A/Prof Bruce Lister Communications and Journal Officer
Dr Peter Morley Deputy Chair, Hospital Accreditation Committee
Dr Liz Steele New Fellows Representative, ASM Officer

Co-opted Representatives

Dr Peter Sharley (South Australia) Assistant CPD Officer
Dr Mary Pinder (Western Australia) Co-Deputy Chair of Examinations

Invited Observers

Professor Kate Leslie ANZCA President
A/Professor John Kolbe RACP President
A/Professor Michael O’Leary ANZICS President

Directors of Professional Affairs

The College has employed a number of former Board members to assist the Board.

Dr Felicity Hawker
A/Professor Richard Lee
Dr Megan Robertson

Changes to Board Structure

Since the AMC review in 2002, a number of changes to the structure of the Board have occurred in line with increasing activities.

- The responsibilities of the Chair of Examinations have expanded in line with changes to the administration of the Examinations (refer 1.2 below).
- A New Fellow has been appointed to the Board to represent both New Fellows (within three years of graduation), and Trainees. In 2011, a Trainee observer will be co-opted to the Board.
• New portfolios for Rural Intensive Care, International Liaison and Continuing Professional Development and Fellowship Affairs have been established.
• The Assistant Education Officer is responsible for supporting the Supervisors of Training.
• The Assistant Censor provides support to the Censor.

Committees

The College has a number of principal committees whose composition and terms of reference are described in Section 2 of the Regulations. More detailed terms of reference have been established where required. The Chair of each committee is normally a member of the Board.

Since the previous AMC review of the JFICM in 2002, the committee structure has expanded in line with the increasing workload and responsibilities.

A Trainee Committee was established in 2005. It consists of a Trainee representative from each Region and is chaired by the New Fellows representative on the Board. If more than one representative is nominated from a region, an election is held in that region.

The former Fellowship Examination Committee has evolved to become an overarching Examinations Committee, with responsibility for each examination delegated to the relevant subcommittee: the Primary Examination Committee, the General Fellowship Examination Committee, and the Paediatric Fellowship Examination Committee.

In preparation for the establishment of the new College, two committees were established in 2009, an Executive Committee and a Finance, Audit and Risk Management Committee.

A Fellowship Affairs Committee was established in 2010 to fulfil the observed need for a committee to oversee CPD, recertification, credentialing, the Annual Scientific Meeting and welfare of Fellows.

Principal Committees of the Board

Refer Figure 1.1.

• Executive Committee (also acts as Finance Audit and Risk Management Committee)
• Education Committee
• Examinations Committee
• Fellowship Admissions Committee
• Hospital Accreditation Committee (HAC)
• Overseas Trained Specialists Committee (OTS)
• Finance, Audit and Risk Management Committee (FARM)
• Fellowship Affairs Committee
Separate terms of reference are attached where applicable (Appendix 5) or are included within the Regulations.

Other Subcommittees which report to these Principal committees:

- Trainee Committee
- Primary Examination Committee
- General Fellowship Examination Committee
- Paediatric Fellowship Examination Committee
- Conjoint Rural Committee (joint committee formed in 2004 with ANZICS)
- Formal Projects Panel

Regional Representation

Each geographic region, with the exception of the Northern Territory and ACT, has a Regional Committee or in the case of New Zealand a National Committee, whose structure and function is described in Regulation 3 (Appendix 2). Members are elected by Fellows in that region. Board Members are ex-officio members of their respective Regional or National Committee, and act as a conduit for communication to and from the Board. A representative of the ACT Fellows sits on the New South Wales Regional Committee and a Northern Territory Fellow sits on the South Australian Committee.

New Fellows and Trainee representatives sit on the relevant Regional or National Committee. Committees may co-opt other representatives as required.

A list of current members of the Regional and National Committees is attached as Appendix 6.

Review of the Governance Structure

Since the AMC review in 2002, there has been ongoing review of governance issues in the development towards independence and a separate College. In October 2005, a dedicated planning workshop identified key issues, such as creating an Executive and reviewing Board composition, portfolios, meetings of the Board and risk management. The resultant initiatives have all been adopted in the following years.

A major restructure was undertaken during 2009 as part of the development of the Constitution and Regulations for the new College. A workshop held during the Board meeting in June 2010 approved future goals and a formalised Strategic Plan (Appendix 7) and a Tasklist (Appendix 8) for the next two years.

Strengths and Challenges

A key strength of the College is its governance. Having evolved from a faculty of two separate colleges, the College has inherited a robust governance structure developed over many years from both its parent colleges. Because the formation of the College has been so recent, the Constitution and Regulations were reviewed in 2009 and are current and
relevant. As with ANZCA and RACP, the Organisational Structure and Regulations demonstrate the emphasis given within the organisation to education and training activities. The majority of CICM staff are employed in the areas of education and training.

As an associate member of the CPMC from 1999, the Faculty of Intensive Care, JFICM and now CICM (as a full member from 2009) have participated in forums of mutual interest to all medical colleges. With the establishment of the new College, the Board is determined to maintain collaboration with other medical colleges and the CPMC.

The intensive care training program, and its related policies and procedures have been subject to ongoing development for the past three decades. The gradual and deliberate evolution towards an independent training body has ensured minimal disruption.

As an independent College, the CICM does not have access to the resources of parent colleges as did JFICM but a measured approach to the ‘separation’ has allowed for preparation for replacing resources such as educational expertise, finance and IT and communication facilities.

An aim is to secure engagement with other relevant medical and intensive care related authorities. A Strategy Taskforce was established by the Board in February 2010 and is considering priorities for 2010 - 2012. The Strategy Taskforce is currently auditing its representation on external bodies, both centrally and regionally.

The evolution of a new College is a significant change and therefore it is anticipated that the structure of the Board and its Committees will require constant review to keep pace with evolving responsibilities. The AMC Accreditation process will also provide the College with opportunities to consider new innovations and practices.

1.2 Program management

**AMC accreditation standards**

1.2.1 The training organisation has established a committee or committees with the responsibility, authority and capacity to direct the following key functions:

- planning, implementing and reviewing the training program(s) and setting relevant policy and procedures
- setting and implementing policy and procedures relating to the assessment of overseas-trained specialists
- setting and implementing policy on continuing professional development and reviewing the effectiveness of continuing professional development activities.

1.2.2 The training organisation’s education and training activities are supported by appropriate resources including sufficient administrative and technical staff.

Most of the College’s Committees are involved in training and assessment of Trainees and Fellows:

- Education Committee
- Hospital Accreditation Committee
- Trainee Committee
The Governance Chart at Figure 1.1 illustrates the reporting mechanism of each Committee.

The following Figure demonstrates how trainees are administered within the College.

Figure 1.2: *Administration of training*

The Education Committee is the body responsible for overall educational strategy. The Education Officer, Assistant Education Officer and the Administrative Officer (Education) drive the activities of the Committee. The Censor is predominantly responsible for the review and approval of individual training.

Generally the ongoing development of the training and examination program by the relevant committees enables oversight of any changes that may impact upon the College’s resources. Additional staff members were appointed in anticipation of the establishment of the new College, two of whom are solely supporting training and examination functions. IT expertise is outsourced, and a new database for Fellows and Trainees has been introduced.

The Fellowship Affairs Committee has been recently established and it is envisaged further staff and resources will be required as the new CPD program is rolled out.

The College employs eight full-time administrative staff, two part-time staff and three part-time Directors of Professional Affairs, who are Fellows of the College (refer Staffing Structure, Appendix 9). In addition to this, technical support in areas such as IT and
finance/accounting is outsourced to appropriately skilled contractors.

The Censor and the Education Committee are responsible for oversight of training resources. Looking to the future, it is anticipated that additional resources may be required including:

- employing professional educational expertise;
- drawing further on Fellows who have educational qualifications;
- increasing staffing for anticipated growth in Trainees and exam candidates, particularly OTS;
- subcontracting for development of online educational facilities;
- reviewing the training program; consideration of competency based training, modular training, post fellowship year, and the changing roles in practice of intensive care medicine;
- developing the new Continuing Professional Development program.

1.3 Educational expertise

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<th>AMC accreditation standards</th>
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<tr>
<td>1.3.1 The training organisation uses educational expertise in the development, management and continuous improvement of its education, training, assessment and continuing professional development activities.</td>
</tr>
<tr>
<td>1.3.2 The training organisation collaborates with other educational institutions and compares its curriculum, training program and assessment with that of other relevant programs.</td>
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Development of the original training program in intensive care medicine for the Faculty of Anaesthetists was led by Professor G.A. Harrison in 1976 as part of his Master of Medical Education Thesis, in association with a team of experienced specialists. Since that time, his expertise and that of educationalists sourced through AMC and CPMC workshops have helped to develop assessment processes in particular. With the establishment of the JFICM, professional educational expertise from the parent colleges, ANZCA and RACP was used. Ongoing links have been maintained with ANZCA’s Director of Education and the Chair of the ANZCA Education Committee, who attend the College’s Education Committee. The CICM Education Committee also has representation on the RACP College Education Committee and the ANZCA Curriculum Authoring Group.

More recently, educational consultants have been contracted to undertake specific tasks relating to the current curriculum review and to suggest improvements to the training program. The Monash University Curriculum Unit (Gippsland Medical School) has agreed to supply educational expertise, under the direction of a Curriculum Review Taskforce. Dr Liz Molloy of Monash University’s Educational Unit has been co-opted to the Education Committee and will undertake specific tasks, including re-designing SOT workshops.

The College will continue to rely on input from its Board, Committees, Fellows and Trainees to refine and review the education, training and CPD activities of the College.
Collaborations

In 2004 the JFICM Education Committee provided input to the European Society of Intensive Care Medicine (ESICM) curriculum and competencies development process, and in return an ESICM representative gave a presentation to the JFICM Board in 2005.

The Examination Committee has provided external examiners for the Hong Kong College of Anaesthetists examinations and helped with establishing their program modelled on the JFICM (and now) CICM processes.

There has also been informal dialogue with representatives of the Irish Board of Intensive Care Medicine, who are following a similar process of evolution as CICM.

Representatives of the Education Committee have participated in a number of CPMC workshops related to assessment and curriculum development. JFICM representatives were involved in extensive reviews by both ANZCA and the RACP and gained useful insights from participating in these reviews.

1.4 Interaction with the health sector

<table>
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<th>AMC accreditation standards</th>
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<tbody>
<tr>
<td>1.4.1 The training organisation seeks to maintain constructive working relationships with relevant health departments and government, non-government and community agencies to promote the education, training and ongoing professional development of medical specialists.</td>
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<tr>
<td>1.4.2 The training organisation works with healthcare institutions to enable clinicians employed by them to contribute to high quality teaching and supervision, and to foster peer review and professional development.</td>
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The College has representatives on many federal and state health department bodies in Australia and contributes to health policy through membership of CPMC, and more directly by making appropriate submissions to government, and reporting for example to the Medical Training Review Panel (MTRP). The College has established a working relationship with the new Medical Board of Australia with regard to the registration and credentialing of specialists working in the area of Intensive Care Medicine. In New Zealand, the National Committee has a good relationship with the Medical Council of New Zealand, the Ministry of Health, Standards New Zealand and other bodies. It is the Branch Advisory Body for Intensive Care Medicine.

The College has representation on a wide range of groups within the health sector at national, regional and local levels. In Australia, these include the Organ and Tissue Donor and Transplantation Advisory Council and the Institute of Medical Education and Training among others. 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. The CPMC is the main forum for the College to address national health issues that may affect its ability to deliver
the training program. 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, via its hospital accreditation process (outlined in Section 8).

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.

The College requirement for intensive care specialists to be involved in teaching, training and supervision of Trainees and their own CPD, and the need for non-clinical time to achieve these requirements is set out clearly in Documents IC-1, IC-2, IC-3 and IC-4 (Appendices 15 - 18). Trainee and specialist rosters are always examined during hospital accreditation reviews to ensure these requirements are met. College policy also requires that there is College representation on specialist appointments committees.

1.5 Continuous renewal

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<th>AMC accreditation standards</th>
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<tr>
<td><strong>1.5.1</strong> The training organisation reviews and updates structures, functions and policies relating to education, training and continuing professional development to rectify deficiencies and to meet changing needs.</td>
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The Board and Committees of the College actively review and identify necessary changes as part of ongoing strategic review and in response to changes within the community, the health sector and the health workforce. In addition, the College has a formal process of consultation for review of its policies. Every five years, policy documents are circulated to relevant groups (Fellows, Regional and National Committees and other bodies as appropriate). Feedback is then assembled by the relevant committees responsible for reviewing functions and policies relating to their particular area of concern.

One example of an avenue for trainee feedback and renewal is the New Fellows’ Conference. This meets each year in June prior to the Annual Scientific Meeting to focus on a themed program. Its purpose is to give fresh insight from New Fellows and Trainees into how the College is run and the changing demands on Trainees. Its recommendations are then considered and if appropriate, incorporated by the Board.

Inter-collegiate and government forums relating to broader issues (such as processes for Overseas Trained Specialists and the Health Workforce) also impact on the review of education and training policy.
Examples of current initiatives, which impact on training and education include:

- instigation in 2010 of a major review of the Training program as a result of the changing nature of intensive care practice;
- provision of increased support for Supervisors of Training;
- review of cultural competence and how it is addressed within the College structure;
- establishment of Trainee representation on College committees;
- establishment of a Fellowship Affairs Committee which will oversee CPD, recertification, credentialing and welfare (terms of reference are attached as Appendix 5);
- review of policies and documentation relating to hospital accreditation;
- review of consumer representation / involvement of external stakeholders, and
- completion of a workforce survey of Fellows in 2010 seeking views on aspects of training and future employment opportunities.
Purpose of the training organisation and outcomes of the training program

2.1 Purpose of the training organisation

AMC accreditation standards

2.1.1 The purpose of the training organisation includes setting and promoting high standards of medical practice, training, research, continuing professional development, and social and community responsibilities.

2.1.2 In defining its purpose, the training organisation has consulted fellows and trainees, and relevant groups of interest.

History of the College of Intensive Care Medicine

The College of Intensive Care Medicine of Australia and New Zealand was formed on 1st January 2010 but was over thirty years in evolution and maturation. The current programs and processes have been continuously reviewed and adjusted over that time to set high standards of clinical practice, provide education based on sound principles, support research, stress quality improvement and CPD, in an environment of changing organisational structure, community expectations and needs and knowledge base.

A Section of Intensive Care within the Faculty of Anaesthetists, Royal Australasian College of Surgeons (FARACS) was established in 1975 and a similar committee was established by the Royal Australasian College of Physicians (RACP) during the 1970s to organize the new specialty of intensive care medicine. Training programs followed.

Therefore in Australia and New Zealand, training programs in intensive care medicine have been available since 1977 through either the RACP or FARACS. The concept of a joint training scheme in intensive care involving a joint diploma of both the College and the Faculty was discussed in the early 1970s. However, this did not eventuate and each body went its own way for approximately 25 years. Their programs changed and matured during this period.

In 1992 the Faculty of Anaesthetists separated from the Royal Australasian College of Surgeons to form the Australian and New Zealand College of Anaesthetists (ANZCA), from which the Faculty of Intensive Care (FICANZCA) evolved in 1994. The Faculty was responsible for all matters relating to intensive care medicine within ANZCA. At that time there was some debate as to whether a separate college should be formed, but it was considered that the numbers of Fellows and Trainees were too small, the costs would be too high, and that there was a risk that a third training program in intensive care medicine would be created if ANZCA and RACP continued with their existing training programs. Meanwhile, the RACP continued its intensive care training program.

In 1996, a Joint Specialist Advisory Committee for Intensive Care (JSAC-IC) was formed as a conjoint committee of FICANZCA, RACP and the Australian and New Zealand Intensive Care Society (ANZICS), to unite the two pathways for intensive care training into a single
training scheme, jointly supervised. JSAC-IC continued the training and examination processes in line with that which had been established by the Section of Intensive Care and FICANZCA.

JSAC-IC was also given the task of developing a discussion document: ‘Development of a Single Body for Intensive Care Certification and Standards’, published in the ANZCA Bulletin in August 1998. This discussion document was circulated to all Fellows of FICANZCA in July 1998 along with a survey. The survey showed that the vast majority (89%) respondents supported the formation of a separate College of Intensive Care Medicine within ten years, although others had strong views that this should not happen immediately and that FICANZCA should continue. The RACP proposed a third option at the eleventh hour - a Joint Faculty of Intensive Care Medicine (JFICM) of both ANZCA and RACP. This option was ultimately adopted and JFICM was established in 2002 by agreement between the ANZCA and the RACP. JFICM was housed and set up within the corporate structure of ANZCA.

Foundation Fellowship included Fellows of FICANZCA and RACP. The two training programs were formally integrated, although in geographical, financial and legal terms, JFICM remained incorporated within ANZCA.

During its eight-year history, JFICM made steady progress towards a stand-alone training body. Major refinements continued to be made to the training program and assessment processes that were first developed in the 1970s. These included:

- development of a Primary Examination to complement the Fellowship Examination;
- establishment of a stand-alone Annual Scientific Meeting (ASM), first held in 2005;
- establishment of a New Fellows Conference;
- adoption of the Journal *Critical Care and Resuscitation*, and
- progression towards financial independence.

The results of a further questionnaire in 2007 indicated that 66% of Fellows supported the immediate formation of an independent college of intensive care medicine. The question was put to a vote at the Annual General Meeting at the 2008 ASM where the vote was overwhelmingly in favour of independence. The College of Intensive Care Medicine was formed as an entity soon after.

Negotiations then began between the Board of the Joint Faculty and the Councils of ANZCA and RACP to begin the separation process. Both Colleges were extremely supportive of this move. A constitution was developed, Foundation Fellows were identified and the Joint Faculty of Intensive Care Medicine completed its evolution into the College of Intensive Care Medicine on 1st January 2010.
Over this time the College has worked collaboratively with ANZICS and formalised this through a Cooperation Agreement signed in 2006 and updated in 2010 (refer Appendix 11). The agreement details the respective roles of the Society and the College to facilitate education, research, accumulation of accurate patient outcomes and workforce data, clinical trials, journal publication and guideline development.

**Training in Intensive Care Medicine in Other Countries**

Although the first ICUs were developed in Scandinavia, the USA and New Zealand during the post-war polio epidemics, Australia and New Zealand were the first countries to develop Intensive Care Medicine (ICM) as a separate specialty with a specific training program, now the CICM program. Overseas, ICM is usually a subspecialty, predominantly of anaesthesia or internal medicine, most often respiratory medicine. Training in ICM has only existed in other countries for a relatively short time, and some of these programs e.g. the Hong Kong College of Anaesthetists and the Irish program are modelled on the Australian program. No overseas training program in intensive care medicine is as comprehensive in content and assessment as the College program. Consequently a large number of Trainees of the College have a primary medical qualification from outside of Australia.
Details of specific overseas training programs are shown in Table 5.4, Section 5.4.

Purpose of the College and Range of Roles it undertakes

The College of Intensive Care Medicine of Australia and New Zealand is the body that oversees training of intensive care specialists and sets and promotes high standards of medical practice in the specialty of Intensive Care Medicine in this region.

The Objects of the College are contained in the Constitution. They are to:

1. promote excellence in healthcare services and cultivate and encourage high principles of practice, ethics and professional integrity in relation to intensive care medicine practice, education, assessment, training and research;

2. promote and encourage the study, research and advancement of the science and practice of intensive care medicine;

3. determine and maintain professional standards for the practice of intensive care medicine in Australia and New Zealand;

4. advocate on any issue which affects the ability of College members to meet their responsibilities to patients and to the community;

5. establish the status of Fellowship and other membership of the College and to admit appropriately qualified members of the College to that status;

6. conduct and support programs of training and education leading to the issue of Fellowship or other certification attesting to the attainment or maintenance of appropriate levels of skills, knowledge and competencies commensurate with specialist practice in intensive care medicine in Australia and New Zealand;

7. promote recognition of the College as the pre-eminent body in Australia and New Zealand and internationally for the establishment of training and education programs and the development of professional standards in intensive care medicine;

8. disseminate information and to advise on any course of study and training designed to promote and ensure the fitness of persons who wish to qualify for recognition by the College;

9. conduct and coordinate examinations and other assessment processes and to grant registered medical practitioners specialist recognition in intensive care medicine, either alone or in cooperation with other relevant bodies or institutions;

10. hold or sponsor meetings, lectures, seminars, symposia or conferences, within or outside of Australia and New Zealand, to promote understanding in medicine and related subjects and professional relations among members of the College, members of other health professions, scientists and the community in general;

11. facilitate the advancement of specialist education and training in intensive care medicine through the conduct of projects and research;
12. ensure College members undertake continuing professional development and participate in effective, ongoing professional activities and learning;

13. foster and promote cooperation and association with organisations which have objectives similar to the College in Australia and New Zealand as well as in the wider international arena, including particularly Asia and the Pacific region;

14. advance public education and awareness of the science and practice of intensive care medicine;

15. provide authoritative advice, information and opinion to other professional organisations, to governments and to the general public;

16. work with governments and other relevant organisations to achieve the provision of adequate, well-qualified, experienced and capable workforces in Australia and New Zealand and to improve public health services;

17. facilitate medical education and medical aid support to developing nations;

18. monitor issues affecting the interests of the College or the professional interests of its members and to take all such actions as may be deemed necessary for the protection of those interests;

19. provide advice and support to members to assist them in establishing and maintaining an appropriate work / life balance and to meet effectively the challenges of their professional life.

To summarise, the major roles of the College are training, setting of standards, CPD and research. The training program is outlined elsewhere in this submission (Section 3).

Policy Documents (1C-1 through to IC-15) are expressions of the College’s role in setting standards. They are diverse and include documents that set out the minimum standards for intensive care units (IC-1, currently under review), a statement on the ethical practice of intensive care medicine (IC-9) and statements on patient transport (IC-10 and PS-39). The policy documents are included in the appendix and can be viewed on the College website. Hard copies are available to Fellows, Trainees or other interested parties on request.

The College has a commitment to research. The role of research in the Training Program is detailed in Section 3.3.

The College runs a continuing professional development program that is available free of charge to all Fellows and at a cost to non-Fellows who practice some intensive care medicine. The existing MOPS program is under review, and a new CPD program will be launched in 2012 (refer Section 9).

The College acknowledges that it has social and community responsibilities to protect the public/minimise community risk by:

- training high quality specialists through the training program;
• ensuring Trainees acquire communication skills through the compulsory Medical Australian Donor Awareness Program (ADAPT) course;
• assessing the competence of OTS and AON specialists and providing appropriate top-up training and experience;
• ensuring Fellows’ knowledge and skills are kept up to date though the MOPS program;
• promulgating standards documents to ensure that facilities, staffing and equipment are safe;
• promoting translation of high quality research into best clinical practice;
• developing leaders in resuscitation, particularly by setting guidelines in collaboration with the Australian Resuscitation Council (ARC);
• promoting organ donation through its representatives on appropriate committees, and
• educating the public in understanding the concept of intensive care medicine and the range of outcomes of an intensive care admission (eg. Document IC-14 “Statement on Withholding and Withdrawing Treatment”).

The purpose of the College was reviewed in 2009 when the Constitution for the new body, CICM was written. It was circulated for comment to all Fellows and promulgated widely.

Fellows and Trainees were consulted extensively during the genesis of the College, including contribution to the symbolism embodied in the design of the College’s Coat of Arms and motto.

How the College Communicates its Purpose and Roles:

The College website www.cicm.org.au is available to Fellows, Trainees, any relevant groups of interest and members of the general public. The “About Us” page explains the role of the College as the peak body for intensive care medicine specialist training and education in Australia and New Zealand. Further it outlines the relevance of the College for Fellows, Trainees, research, the community at large and for International Medical Graduates and those in Area of Need (AON) positions. There is also a short history of intensive care training in Australia and New Zealand, and descriptions of the role of an intensive care specialist and the specialty of intensive care medicine. This information on the purpose and roles of the College is publicly available. Other avenues for communication include:

• Policy Documents (1C-1 through to IC-15) are expressions of the College’s role in setting standards.

• The Annual Report is posted on the College website.

• The President provides a detailed report to Regional and National Committees, and Fellows and Trainees after each Board Meeting.

• An electronic newsletter is sent by email to all Fellows and Trainees every six weeks.
• The Annual Scientific Meeting (ASM). Various meetings are held with Fellows and Trainees at the ASM, particularly the Annual General Meeting.

• Input from Trainees is received via the Trainee Committee and through the Trainee feedback component of Hospital Accreditation visits. Both Fellows and Trainees are encouraged to bring any matters concerning the College to the attention of the Regional/National Committees.

• The President visits each Region during his or her term to meet Fellows and Trainees and discuss topical issues including the roles and purpose of the College.

The College has no formal, organised means of dialogue with the community at large but gathers information indirectly through discussion with the community representatives and Fellows and Board members interfacing with patients and families in their daily ICU work. The College website explains the role of the College to the public and is a potential avenue for community enquiry. It is felt generally that members of the community do not think about ICUs or wish to influence their management until an unexpected and often devastating, illness or injury intervenes. In that case, the College website would be a useful resource to establish standards and quality of care.

How the College Responds to Feedback from Hospitals and/or Jurisdictions

The College monitors feedback regarding knowledge, behaviours and skills of Fellows through discussions with hospital management at the Hospital Accreditation visits. The reports of the visits are discussed at the Hospital Accreditation Committee and Board if problems are revealed. The College does not performance-manage each Fellow. This is now established in the workplace by line managers and the results are confidential.

The College receives overall feedback regarding knowledge and skills of Fellows from diverse hospital personnel during accreditation visits, including hospital CEO, Director of Nursing, Director of Medical Services and ICU managers and nurses. Assessing the effective delivery of ICU services and the training environment are the aims of the discussions. Communications from Trainees and other specialists have also been useful at this time. Intensive care specialists work in teams in hospital-based practice. They are therefore under constant peer review and assessment from other intensive care specialists, other specialty teams and healthcare professionals. Problems with individual Fellows are usually identified and reported to hospital or line managers and on occasions the College has been asked to provide a review of practice. A formal process for assessment or remediation for Fellows is in development. In the meantime, it is the practice of the College to appoint an appropriate Fellow to assist in negotiations with the hospital and to develop a remediation plan.
### 2.2 Graduate outcomes

**AMC accreditation standards**

<table>
<thead>
<tr>
<th>2.2.1</th>
<th>The training organisation has defined graduate outcomes for each training program including any sub-specialty programs. These outcomes are based on the nature of the discipline and the practitioners’ role in the delivery of health care. The outcomes are related to community need.</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.2.2</td>
<td>The outcomes address the broad roles of practitioners in the discipline as well as technical and clinical expertise.</td>
</tr>
<tr>
<td>2.2.3</td>
<td>The training organisation makes information on graduate outcomes publicly available.</td>
</tr>
</tbody>
</table>

**Description of Intensive Care Medicine**

Intensive Care Medicine encompasses the early detection, assessment, resuscitation and ongoing management of critically ill patients with life-threatening single and multiple organ failure, and monitoring of those at high risk of developing life-threatening complications. It also involves management of end-of-life care, organ donation and provision of palliative care. Clinical responsibilities are not confined to the Intensive Care Unit since intensive care specialists are also frequently required to manage medical emergency teams for the wards and attend seriously ill patients outside of the ICU for assessment and treatment, including their safe transport within and between facilities. They are also involved in the practice and teaching of out-of-hospital resuscitation and transport. Quality improvement activities, research and the active practice of evidence-based medicine are important in the intensive care specialist’s practice, to maintain the highest level of care.

This description has been updated since the last AMC accreditation to reflect changes in Intensive Care Practice. The roles of the intensive care specialist are changing because of the changing characteristics of hospital patients in terms of acuity, age and presence of co-morbidities. Outbreaks of severe illness in our region, eg. SARS and H1N1, have focused jurisdictions on the importance of intensive care medicine.

The description of Paediatric Intensive Care Medicine is identical to the above, except that it applies to children of less than 16 years. Paediatric Intensive Care Medicine is generally practiced in specialised Paediatric Hospitals. Although the principles are very similar to those of Intensive Care Medicine for adult patients, the sub-specialty acknowledges there are illnesses, clinical conditions and problems unique to critically ill children.

Intensive Care Medicine is not defined on the website of other major international bodies (The European Society of Intensive Care Medicine, (ESICM), The Society of Critical Care Medicine (USA; SCCM). Government bodies in Australia and New Zealand and the National Health Data Dictionary use definitions and classifications coined by JFICM/CICM.
Statement of Graduate Outcomes

The Objectives of Training documents are statements of the knowledge, skills and attributes that the College expects a Trainee to have achieved by the end of a component of his or her training. These documents are posted on the College website.

Since the last accreditation, the Objectives of Training documents have been comprehensively revised and expanded to include:

- Objectives of Training and Competencies for Basic Training in General Intensive Care Medicine (Document T-5, Appendix 36)
- Objectives of Training and Competencies for Advanced Training in General Intensive Care Medicine (Document T-6, Appendix 37)
- Objectives of Training and Competencies for Advanced Training in Paediatric Intensive Care Medicine (Document T-15, Appendix 38)
- Objectives of Training - The Medical Term (Document T-7, Appendix 39)
- Objectives of Training - The Anaesthesia Term (Document T-8, Appendix 40)

The Objectives of Advanced Training and Competencies describe the outcomes expected for a graduate of the general ICU training program of the College. The Objectives of Paediatric Intensive Care Training and Competencies was first promulgated in 2010 and describes the outcomes expected of Trainees taking the paediatric pathway to Fellowship of the College. Achievement of these objectives will ensure that the new graduate has advanced knowledge, skills and highly developed communication skills and other personal attributes necessary to function as a competent intensive care specialist and thus to serve the community. They are minimum standards for a graduate to be a safe independent specialist.

These objectives include clinical competencies (e.g., the approach to acute illness, therapy, monitoring, measurement and interpretation of data), technical skills, and broad roles of practitioners according to accepted (CanMEDS) categories (e.g., communicator, administrator and educator).

The major reviews of the documents in 2004, 2007 and 2010 were made to add clarification to specific terms and in response to changes in our program and the changing roles of intensive care specialists. Trainees had questioned the reasons behind mandating anaesthesia and internal medicine terms so the specific aims were set out to guide Trainees and Supervisors. With the change to a three year Basic Training and three year Advanced Training program, the specific skills to be developed during each stage were outlined in separate documents. A new paediatric document followed in 2010.

Graduate Outcomes

The College views graduate outcomes on many levels and has a holistic approach to the product of its training program. The College focuses on:

a. The skills and attributes required by each trainee by the end of the program

The skills and attributes required to be gained are detailed clearly for the trainee and the trainers in the ‘Objectives’ and the success of the process in the individual is assessed
by examination and In-Training Assessment (ITA). The Supervisor of Training signs a final ITA stating that the trainee is capable of independent practice. There is no external capability assessment.

b. The number of Trainees graduating and the relationship of that number to the community need

The College has no formal role in the selection of Trainees as this is the role of individual hospitals within employing health services. However, the number of Trainees graduating is monitored by the College and compared with workforce surveys. This process is made difficult by the changing roles of ICUs and the rapidly increasing number of Trainees. The College has recently conducted a survey specifically aimed at obtaining detailed demographic information on the ICU workforce. Approximately 60% of Fellows responded and the results are being analysed. A copy of the survey form is attached (Appendix 13).

c. The engagement of the Fellows in the ICU workforce and the many roles required as clinicians, teachers, mentors, researchers and managers

The engagement and employment of the specialists is judged by regular surveys and through the ANZICS CORE (Centre for Outcome and Resource Evaluation) reports. Each would suggest a high level of engagement in employment and roles in management, teaching, university appointments, research and clinical practice.

d. The effect on patient outcomes and the systematic outcomes of ICU admission

The effect of the training program in terms of patient outcomes is assessed by following Standard Mortality Ratios based on APACHE (Acute Physiology and Chronic Health Evaluation) III data for each ICU in College HAC data sheets and for the Australia and New Zealand ICUs as a group via the CORE outcome data for Australia and New Zealand. PIM (Paediatric Index of Mortality) scores are used for outcome prediction in Paediatric ICUs.

In each of these areas data are available to the College. CORE provides data on employment, workforce, severity of illness, length of stay and standardized mortality for severity of illness and chronic health evaluation to ICUs and jurisdictions. The College encourages submission of this data and uses it during hospital accreditation reviews. The most recent CORE report is available at Appendix 12.
3 The education and training program - curriculum content

3.1 Curriculum framework, structure, composition and duration

AMC accreditation standards

3.1.1 For each of its education and training programs, the training organisation has a framework for the curriculum organised according to the overall graduate outcomes. The framework is publicly available.

3.1.2 For each component or stage, the curriculum specifies 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.

3.1.3 Successful completion of the training program must be certified by a diploma or other formal award.

The Training Program

The training program consists of six years of structured supervised training and other requirements as detailed below. Trainees may be admitted into the program once they have completed 12 months of post-graduate general hospital experience.

The six year training program is divided into three years of Basic Training and three years of Advanced Training and includes as a minimum:

- 36 months of core intensive care training (24 months as Advanced Training)
- 12 months of clinical anaesthesia
- 12 months of clinical internal medicine or paediatric medicine

At least 12 months of the core component of Advanced Training must be undertaken in a unit classified as C24 (refer Section 8.2 for definition and classifications of ICUs approved for training) and at least 12 months must be continuous in one unit.

Trainees are also required to complete the Medical ADAPT course, and to satisfactorily complete a Formal Project. For Trainees wishing to gain Fellowship endorsed in Paediatric Intensive Care Medicine, at least 18 months of the core intensive care training component of Advanced Training must be undertaken in an approved Paediatric Intensive Care Unit.

The Medical ADAPT course has been specifically developed to provide education to intensive care Trainees in the areas of brain death and organ donation and strongly emphasises the issues around communication with families of dying patients and potential organ and tissue donors.

A detailed account of the training program is available in the College Regulation 5. This is publicly available on the College website. Figure 3.1 (following page) outlines the progression through training.
Figure 3.1: Progression through the training program

Basic Training Year 1 and Post Graduate Year 2 may be the same 12 month period.
36 months of training in Intensive Care must be undertaken during the training programme.
Trainees undertaking concurrent training with another College may have the Intensive Care training period reduced to 30 months by fulfilling:
1. All components of Basic training and the 1st year of Advanced training of the 2nd specialty
2. Satisfactory completion of an Introductory Intensive Care course such as the BASIC course
Clinical Anaesthesia, Clinical Internal Medicine and Elective training can be undertaken either in Basic or Advanced Training.
The Formal Project and the Medical ADAPT Workshop may be completed at any stage during training.
CICM In-Training Assessments are mandatory for all training.
Recent Developments

In response to changes in the working environment of intensive care Trainees and following a period of consultation and discussion, as from 1st January 2011 the period of core intensive care training has been increased from 24 months to 36 months (with 12 months to be undertaken in Basic Training) for all new Trainees. The principle rationale for this change was that the number of working hours per week of Trainees declined from 55 to approximately 45 hours per week over the last five years. In effect this reduced the amount of ‘training time’ over a five year period by approximately 12 months.

It is not anticipated that this will result in a lengthening of the overall training program for most Trainees, but will better prepare them for Advanced Training and its increased responsibilities. This change also comes as a response to feedback suggesting that some junior Trainees were entering Advanced Training with limited experience and were ill-prepared for clinical responsibilities in intensive care units.

In response to difficulties experienced in attracting and supporting intensive care specialists in rural hospitals, the Board also recently approved a proposal to accredit a three-month rotation to rural or regional ICUs that are approved for Basic Training. This may be part of the non-continuous year of Advanced Training in a C12 or C24 unit.

More recently the development of echocardiography as a routine investigation in intensive care units has led to discussion with stakeholders and consideration of the introduction of a formal requirement for training in this skill as part of the training program. A suitable course has been developed but has not yet been mandated as part of the program.

Educational Objectives

The specific educational objectives, outcomes and experience required for each stage of the training program are specified in the Objectives of Training documents. These have been discussed in Section 2 and are as follows:

- Objectives of Training and Competencies for Basic Training in General Intensive Care Medicine (Document T-5, Appendix 36)
- Objectives of Training and Competencies for Advanced Training in General Intensive Care Medicine (Document T-6, Appendix 37)
- Objectives of Training and Competencies for Advanced Training in Paediatric Intensive Care Medicine (Document T-15, Appendix 38)
- Objectives of Training - The Medical Term (Document T-7, Appendix 39)
- Objectives of Training - The Anaesthesia Term (Document T-8, Appendix 40)

Each of these documents is publicly available on the College website. They are also attached as appendices to this submission.

The Objectives of Advanced Training (Documents T-6 and T-15) give a list of the particular procedural skills required by a competent intensive care specialist. There is no current requirement for Trainees to keep a log-book or for specific assessment of competence in each individual skill, although the concept incorporating this and modular training is being considered by the Education Committee. If this is introduced, Trainees may be required to
document their experience and demonstrate their competence in specific, key areas of intensive care medicine.

The Final In-Training Assessment form requires the supervisor to confirm the Trainee’s general competence. Trainees may be assessed on specific skills as part of the Clinical or Viva components of the Fellowship Examination.

Curriculum Review

A formal review of the curriculum and training program was commenced in conjunction with the ANZCA Education Resource Unit in 2005. This review has so far led to a number of development activities overseen by the Education Committee, including the compilation of the Objectives of Training documents (2006 - 2007), the development of the Syllabus for the Basic Sciences in Intensive Care Medicine, a redraft of the In-Training Assessment form into specific forms for each term, and the development of the Primary Examination (first held in 2007). The Objectives of Training and Competencies for Paediatric Intensive Care Medicine were completed in 2010.

There has also been a review of the many courses and simulation training programs available and establishment of guidelines to define each course’s suitability as a training resource.

In June 2010 the College began an association with the Curriculum Development Unit at Monash University’s Gippsland Medical School (GMS). Associate Professor Robyn Hill, Director of the MBBS Curriculum at GMS, undertook a review of the College’s curriculum documents and will work with the College over the next two years to further develop the College’s curriculum framework and give advice on accepted best practice in this area.

Award of Fellowship

Trainees who successfully complete the specified period of training and satisfy all assessment requirements are eligible for admission as a Fellow of the College and are awarded the Diploma of Fellowship. Fellows are provided with a certificate of Fellowship and are entitled to use the post-nominal FCICM. The process for admission to Fellowship is detailed in Section 4 of the College Regulations.

3.2 Sub-specialties and joint training programs

Paediatric Intensive Care Medicine

In addition to the standard pathway to Fellowship, the College has, since 1997, made available specific training in paediatric intensive care medicine. In order to receive a Fellowship of the College through the Paediatric Intensive Care Medicine pathway, as part of their six-year training program, Trainees must have successfully completed:

- 12 months of clinical paediatric medicine;
- 18 months of core intensive care training in Advanced Training in an approved paediatric intensive care unit, and
- successful completion of the Fellowship Examination in paediatric intensive care medicine.
The training program in paediatric intensive care medicine was initially developed in response to the previous requirement for Trainees in paediatric intensive care medicine to sit an examination with an inappropriate, primarily adult focus. The Paediatric program is aimed at training and assessing specific skills necessary for the care of critically ill children.

Despite being a separate endorsement, the paediatric training program uses the framework of the general training program but requires a different knowledge base and skill set.

**Dual Training**

The College has facilitated dual training programs with ACEM, ANZCA and RACP, and many of the College’s Trainees are concurrently undertaking training with another college. Discussions have been held with ACEM, ANZCA and RACP over many years to facilitate dual training. Some elements of the College program are common to multiple programs and can contribute to completion of more than one diploma. For example, a Trainee enrolled with ANZCA and CICM can receive credit in both programs for a single 12-month anaesthetic placement. In this way allowances are made for prior learning to facilitate training in as efficient a time period as possible. The College also credits Trainees who complete ACEM training with six months internal medicine training because of the large amount of acute medicine experience acquired in Emergency Departments accredited for ACEM training.

Trainees who have completed a Basic Training program with another college (ANZCA, ACEM, RACP) are eligible to receive an exemption from sitting the College’s Primary Examination. This assists Trainees who wish to complete more than one training program. At this time the CICM Primary Examination does not gain reciprocal exemption from other colleges. However the College will continue to work towards this goal which would allow a simpler path for Trainees to complete multiple programs or transfer from one training program to another.

### 3.3 Research in the training program

<table>
<thead>
<tr>
<th>AMC accreditation standards</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>3.3.1</strong> The training program includes formal learning about research methodology, critical appraisal of literature, scientific data and evidence-based practice, and encourages the trainee to participate in research.</td>
</tr>
<tr>
<td><strong>3.3.2</strong> The training program allows appropriate candidates to enter research training during specialist education and to receive appropriate credit towards completion of specialist training.</td>
</tr>
</tbody>
</table>

Research is seen as an integral part of intensive care training either as an investigator or as an observer and assessor of the literature as demonstrated by:

- The prominence given to research in the ‘Objectives’.
- The Formal Project being mandatory for all Trainees.
• Evidence based medicine, and constructing research and statistics being extensively examined in the Primary and Fellowship Examinations.
• The Board annually appointing a Research Officer who is charged with fostering and promoting research in intensive care both inside and outside of the organisation.

The College’s Regulations permit up to 12 months of research to be approved towards the elective component of training.

The success of this focus is seen in the large number of grants and publications in high impact journals achieved by the ICM community.

**Formal Research Project**

The training program includes the requirement for all Trainees to complete a formal research project, to submit the report for publication and to present the findings at an appropriate scientific meeting. The program for the College’s Annual Scientific Meeting allocates one session for presentation of Trainees’ formal projects and awards a prize to the best presentation. Trainees are also encouraged to provide a poster presentation at the ASM.

The requirements of the formal project component of the training program are detailed in Document T-9 ‘Formal Project Requirements’ (Appendix 41). Document IC-3 ‘Guidelines for ICUs seeking Accreditation of Training in Intensive Care Medicine’ (Appendix 17) requires that accredited training sites have a program of research in which Trainees can participate.

The Queensland Regional Committee is actively monitoring project ‘uptake’ by Queensland Trainees and the Committee also conducts a one day course on research for Trainees to aid completion of Projects and foster further research. Also the ANZICS Clinical Trials Group (CTG) conducts an annual meeting which incorporates a research development day for College Trainees.

**Contribution to Research**

The College publishes a quarterly peer-reviewed scientific journal, *Critical Care and Resuscitation*, which is distributed free to all Fellows and Trainees. The Journal provides an opportunity for researchers in the field of intensive care medicine in Australia and New Zealand to have their work published. The latest issue is included as Appendix 14.

Fellows of the College actively participate in a number of research programs developed and conducted by the ANZICS Clinical Trials Group, which conducts clinical research in intensive care focused on improving patient-centred outcomes. This group has become one of the premier intensive care research consortia in the world in terms of high-impact publications and competitive grant achievement. The group has established collaborations with the ANZIC Research Centre (Monash School of Public Health) and the George Institute for Global Health that provides opportunities for mentoring and enrolment in higher post graduate degrees. A recent survey indicated that 49 Fellows have or are working towards a PhD and 31 have or are working towards an MD. The College also contributes a significant proportion of Fellowship subscription revenue to the Intensive Care Foundation, an independent not-for-profit organisation dedicated to supporting research in the field.
3.4 Flexible training

AMC accreditation standards

3.4.1 The program structure and training requirements recognise part-time, interrupted and other flexible forms of training.

3.4.2 There are opportunities for trainees to pursue studies of choice, consistent with training program outcomes, which are underpinned by policies on the recognition of prior learning. These policies recognise demonstrated competencies achieved in other relevant training programs both here and overseas, and give trainees appropriate credit towards the requirements of the training program.

Part time and Interrupted Training

The College allows Trainees to undertake training on a part-time basis, providing all required training time and training content is completed. Regulation 5.12 (Appendix 2) details the requirements for approval of part time training.

The training program allows for interrupted training (Regulation 5.13).

Table 3.1: Number of Trainees undertaking part time training, 2007 - 2010

<table>
<thead>
<tr>
<th>Year</th>
<th>2007</th>
<th>2008</th>
<th>2009</th>
<th>2010</th>
</tr>
</thead>
<tbody>
<tr>
<td>Part-time Trainees</td>
<td>2</td>
<td>7</td>
<td>0</td>
<td>2</td>
</tr>
</tbody>
</table>

Recognition of Prior Learning

Trainees entering the training program in intensive care medicine have frequently commenced training in another medical specialty (most often anaesthetics, emergency medicine or internal medicine) and have either transferred to intensive care medicine or have decided to complete multiple Fellowships. The College’s history as a Joint Faculty of ANZCA and RACP has been an important contributor to this. Consequently, the College readily grants recognition of prior learning to Trainees who have already completed Basic Training – or part thereof – with another college. Trainees who have undertaken specialist training overseas may also receive exemption from some or all of the elements of Basic Training, depending on assessment of equivalence of training by the College Censor. Regulation 5.5.2 permits a maximum of 48 months to be completed outside Australia, New Zealand or Hong Kong.

In recent years a number of Trainees have entered the program at ‘Basic Training year one’ level having just completed their first post graduate year (PGY1). Although these numbers are still small as a proportion of all new Trainees, they represent the ongoing development and recognition of intensive care medicine as a primary specialty.
The Table below shows the number of Trainees who have received recognition of prior learning over the last three years. The policy for recognition of prior learning is detailed in Regulation 5.6.

Table 3.2: Proportion of New Trainees Receiving Recognition of Prior Learning

<table>
<thead>
<tr>
<th>Year</th>
<th>Trainee Registrations</th>
<th>Number applying for RPL</th>
<th>Number Receiving RPL</th>
</tr>
</thead>
<tbody>
<tr>
<td>2007</td>
<td>176</td>
<td>176</td>
<td>176</td>
</tr>
<tr>
<td>2008</td>
<td>165</td>
<td>159</td>
<td>159</td>
</tr>
<tr>
<td>2009</td>
<td>181</td>
<td>176</td>
<td>176</td>
</tr>
<tr>
<td>2010</td>
<td>198</td>
<td>192</td>
<td>192</td>
</tr>
</tbody>
</table>

3.5 The continuum of learning

AMC accreditation standards

3.5.1 The training organisation contributes to articulation between the specialist training program and prevocational and undergraduate stages of the medical training continuum.

Although the College recognizes the importance of harmonising undergraduate and prevocational training with vocational ICM training, there is currently no formal centrally organised co-ordination. Since intensive care medicine is a hospital-based specialty many intensive care specialists have university appointments as a condition of employment. The College encourages all intensive care specialists to be actively involved with education at all levels and this remains a condition of accreditation of ICUs for training by HAC.

At a local level, many specialists have senior university appointments of associate professor and above, and disciplines of intensive care medicine have been established in several universities within the medical schools eg. Sydney University, Adelaide University and the University of New South Wales. A recent survey showed that ten Fellows have university appointments at Professor Level, and 72 (approximately 10%) have appointments as Associate Professor/Clinical Associate Professor/Senior Lecturer level.

Fellows of CICM are substantially involved in postgraduate training and give tutorials for interns, residents and junior Trainees on a range of topics at the hospital or network level. In addition, structured courses are run by CICM Fellows (eg. BASIC (Basic Assessment and Support in Intensive Care), BICMed (Basic Intensive Care Medicine), the Australian Donor Awareness Program (ADAPT) and Advanced Life Support (ALS) courses).
4  The training program - teaching and learning

4.1  Teaching and learning methods

<table>
<thead>
<tr>
<th>AMC accreditation standards</th>
</tr>
</thead>
<tbody>
<tr>
<td>4.1.1 The training is practice-based involving the trainees’ personal participation in relevant aspects of the health services and, for clinical specialties, direct patient care.</td>
</tr>
<tr>
<td>4.1.2 The training program includes appropriately integrated practical and theoretical instruction.</td>
</tr>
<tr>
<td>4.1.3 The training process ensures an increasing degree of independent responsibility as skills, knowledge and experience grow.</td>
</tr>
</tbody>
</table>

Direct Patient Care

The College training program is a hospital practice-based program involving the Trainee’s personal participation in all aspects of patient care and quality management in intensive care departments that are accredited by the College. Accreditation is a rigorous process that involves data collection, paper assessment and an onsite team review (refer Section 8.2).

The broad aims of the training program are to enable the Trainee to gain an understanding of the scientific basis of intensive care medicine practice and learn through (1) training and teaching by others, (2) self-directed learning and (3) exposure to a broad range of clinical experience. On completion of training the new intensive care specialist should be able to undertake unsupervised comprehensive practice in intensive care medicine.

The training includes periodic assessment intended to test whether the Trainee has acquired the requisite knowledge, skills and attitudes to progress at each stage and finally to practice in the specialty at an appropriate standard.

The training is centred on involvement in longitudinal direct patient care. Over the years of training the level of responsibility, the level of supervision and roles grow with the level of seniority of the Trainee. Training is practice-based, supplemented with formal teaching in the workplace and also delivered at a Regional and National level. Education, support and assessment of Trainees and accreditation of intensive care units for training are particular responsibilities of the College.

There are no requirements for completion of university or other formal award courses but there is a mandatory requirement for Trainees to attend the Medical ADAPT Course (refer Section 3.1).

The Regulations

The College training requirements are set out in Regulation 5 (Appendix 2), which are available in printed form from the College and are also detailed on the College website. These requirements are designed to allow the Trainee to fulfil all the aims of training as set
out in the specific Objectives and Competencies documents for each stage of training, and for the endorsement in Paediatric Intensive Care Medicine.

Blueprinting and matching of all curriculum objectives to training and assessment are primarily the responsibility of the Education and Examinations Committees. Feedback from the Trainees regarding the program is achieved through the Trainee Committee, by interview of Trainees at hospital accreditation visits and by regular surveys.

The training program is based around the three main documents (refer Sections 2 and 3), which particularly focus on clinical aspects of intensive care management and the CanMeds dimensions of professional behaviour:

- Objectives of Training and Competencies for Basic Training in General Intensive Care Medicine (Document T-5, Appendix 36)
- Objectives of Training and Competencies for Advanced Training in General Intensive Care Medicine (Document T-6, Appendix 37)
- Objectives of Training and Competencies for Advanced Training in Paediatric Intensive Care Medicine (Document T-15, Appendix 38)

The qualities and responsibilities (knowledge, skills and attitudes) to be achieved are based on the attributes defined in the CanMeds guidelines and also other groupings, which stress cognitive, technical, integrative, contextual, relationship, affective, moral and “habits of mind” dimensions. The aims are to ensure that the program is comprehensive and appropriately focused.

As Trainees are required to gain experience and knowledge in a twelve-month anaesthesia term and a twelve month internal medicine term the aims for each term are also clearly documented in:

- Objectives of Training - The Medical Term (Document T-7, Appendix 39)
- Objectives of Training - The Anaesthesia Term (Document T-8, Appendix 40)

A formal project provides exposure to clinical research or evidence-based medicine and the requirements are set out in

- Formal Project Requirements (Document T-9, Appendix 41)

The Regulations follow on from the Objectives and Competencies and set out the requirements for award of Fellowship of the College. The Regulations also detail the process for assessment as an Overseas Trained Specialist and for Election to Fellowship.

All Trainees must participate in the College’s in-training assessment process and comply with requests from the College for information relating to their training performance, in accordance with the processes outlined in Document IC-11 ‘Guidelines for the In-Training Assessment of Trainees in Intensive Care Medicine’.

Six-monthly assessments are required during the Advanced Training Years, with the exception of the three-month rural rotation, when an assessment must be completed at the end of the rotation. A satisfactory assessment in at least five of the six assessments, including the final assessment, is essential for the award of Fellowship and the Censor may
rule that further training is required in the event of more than one unsatisfactory in-training assessment.

At least six months of core intensive care training must be in a senior registrar position. The requirements for this position are outlined later in this Section and include appropriate responsibilities for longitudinal patient care beyond shift hours and increased management responsibility.

The basic training programs of ANZCA, RACP, ACEM and RACS are accredited by the College for training. Other programs (eg. overseas) may be accepted where deemed appropriate by the Censor, after an assessment of equivalence of training, supervision and assessment. Regulation 5.6.7 also states that the College or ANZCA Primary Examination, the RACP Written/Clinical Examinations or other approved examination should be successfully completed during the BTYs in order to satisfy the requirements for Basic Training.

Recognition of overseas training in accredited or paper-assessed ICUs also facilitates international experience. Accreditation of overseas ICUs for training is discussed in Section 8.2. Regulation 5.5.2 states that a maximum of 48 months training may be spent outside Australia, New Zealand or Hong Kong. At least 12 months of the two core ATYs must be undertaken in an intensive care unit in Australia, New Zealand, or Hong Kong accredited as C24.

Integration of Clinical and Theoretical Instruction – Teaching

The training program is based on integrated practical and theoretical instruction. This is primarily delivered in the workplace ie. hospitals and accredited ICUs. The College expects formal education to supplement practise-based training. This must include a program of regular formal teaching sessions at the Trainee’s workplace and involvement in quality assurance and improvement programs. The College documents evidence of the amount and quality of formal training and mandatory attendance at such formal training during the routine accreditation visits to training units. This hospital accreditation process ensures the delivery of effective teaching by requiring of each unit:

1. Written details of the teaching program in the hospital data sheet before site visits.
2. Interview of the ICU Director and Supervisor to determine the extent and quality of the program.
3. Interview of Trainees focusing on how the program integrates practical and theoretical instruction, whether levels of supervision are appropriate and whether the program is effectively delivered.
4. Evidence of Trainee involvement in mortality and morbidity audits and quality assurance activities to supplement formal teaching.

The College requires that Fellows who work in accredited training units include teaching among their duties (refer Document IC-2 ‘Intensive Care Specialist Practice in Hospitals Accredited for Training in Intensive Care Medicine’). This requirement for teaching and training engagement is reiterated in the Document IC-3 “Guidelines for Intensive Care Units seeking Accreditation for Training in Intensive Care Medicine”. It is a condition of accreditation for training that the employer supports the training work carried out by the
specialists, and appropriate rostered non-clinical time must be allocated to support teaching. In addition, allocation of CME points by the College for time allocated to lecturing and tutorials, demonstrates the value attributed to these educational endeavours.

The College and ANZICS run and/or endorse a number of symposia and courses that present aspects of intensive care practice and all Trainees are encouraged to attend. Presently the only mandatory course for all Trainees is the ADAPT (Australian Donor Awareness Program) Course. Trainees who have not completed at least 12 months of ICU experience in Basic Training must also complete an appropriate introductory course.

Distance education is organised on a State, regional and local basis depending on the particular needs of Trainees. For example, in Queensland a weekly program of lectures and tutorials for all Trainees in the State is organised by the major teaching hospitals. In New South Wales it is organised according to regional responsibilities eg. Royal North Shore Hospital provides a topic review lecture program to the northern region of Sydney and the State.

The College provides materials to support mentoring, examination performance and communication training. The Education Officer has developed materials, printed and electronic, that use scenarios to allow practice of communication situations that are common in intensive care practice. The College is in the process of creating an additional, formal one day course to develop communication skills that will be delivered as a pilot in 2011.

The Education Committee is reviewing a proposal to make the learning materials relating to communication and crisis management available to all Supervisors and Trainees and is considering ways of incorporating such material into mandatory training.

The College encourages development of more educational modules for use in training. It has been reviewing training courses and simulation-based teaching for incorporation into the training program at each stage. So far the Education Committee has set generic guidelines for courses using a course assessment template and has reviewed available courses.

Courses Available to Trainees During 2010

- **The Canberra ICU Course**  
  Focuses on the written examination, vivas and hot cases.

- **Data Interpretation in Acute Medicine, Brisbane**  
  Focuses on blood gas interpretation, approach to biochemistry, haematology, coagulation, microbiology, pulmonary function, ventilator waveforms etc.

- **Procedure and Communication Course in Intensive Care**  
  Focuses on communication through procedural and simulation exercises and interacting with professional actors in clinical situations.

- **Australian Intensive Care Medicine Clinical Refresher Course**  
  Focuses on the Fellowship Examination process. Specifically aimed at Trainees registered to sit the Examination, other Trainees can attend as observers.
• **The Australian Short Course on Intensive Care Medicine**
  Annual course aimed at Trainees registered to sit the Fellowship Examination, includes tutorials, vivas and hot cases.

• **Sydney Intensive Care Equipment Course**
  Focuses on the basic and advanced knowledge of IC equipment and insertion procedures, with lectures and 12 station displays.

• **The Sydney Written Course**
  Focuses on the written component of the Fellowship Examination.

**Graded responsibility with increasing trainee seniority**

The College program ensures an increasing degree of independent responsibility as skills, knowledge and experience grow. Trainees are expected to work increasingly independently under the supervision of intensive care specialists and with assistance from the Supervisor in the ICU where they are employed. In the team environment of accredited ICUs, responsibilities are shared and as the Trainee’s skills grow, greater responsibility is afforded to the Trainee. This is reinforced by the ITA forms, which are graded for the stage and year of training. The explicit wording of the forms details the aspects of professional growth expected from Trainees who are assessed in their training against a standard of increasing responsibility. There are separate ITA forms for each term and each increasingly senior period of training, as roles evolve from junior Trainee, learner and observer, to clinically responsible teacher, mentor and guide of junior doctors in the team.

For instance, the ITA form for the final six months of Core Advanced Training requires the supervisor to attest that the Trainee has reached a high level of clinical functioning and responsibility and can undertake continuing care for a group of patients, priority planning, supervision of junior doctors, mentoring and ward management.

To formalise the transition to independent practitioner, a six-month term as Senior Registrar is mandated for all Trainees (refer Regulation 5.7.7). A Senior Registrar position is a position that involves increased seniority close to the time of completion of specialist training. The Trainee must have a lesser level of supervision than junior Trainees, with greater clinical autonomy and responsibility. Rostering must be independent of junior medical officers and must include longitudinal responsibility for patient care beyond the series of single shifts (this implies a specific on-call component). The position also involves specific responsibility for supervision and training of more junior medical officers and involvement in research, education and administration.

The College encourages Trainees to use the Objectives of Training to guide their learning and recommends texts to guide learning. Access to an on-line journal collection is now available.
5 The curriculum – assessment of learning

5.1 Assessment approach

5.1.1 The assessment program, which includes both summative and formative assessments, reflects comprehensively the educational objectives of the training program.

5.1.2 The training organisation uses a range of assessment formats that are appropriately aligned to the components of the training program.

5.1.3 The training organisation has policies relating to disadvantage and special consideration in assessment, including making reasonable adjustments for trainees with a disability.

The College approach to assessment embraces both formative and summative assessments:

1. The In-Training Assessments (ITAs) throughout Basic and Advanced Training are formative, with the final In-Training Assessment being summative. Five of the six ITAs during Advanced Training must be rated as ‘satisfactory’.

2. The Primary Examination is summative.

3. The Final (General) and Final (Paediatric) Written and Viva Examinations are summative assessments for their respective training programs.

4. The Formal Project (research requirement) is a summative assessment.

The subject areas for all of the examinations are blueprinted and matched with the relevant objectives and competencies documents.

In-Training Assessment

In-Training Assessment (ITA) is the College’s predominant formative assessment tool. It facilitates the ongoing education of Trainees and complements the other forms of assessment.

The formal requirements and the process of in-training assessment are detailed in Document T-12 ‘Guidelines for the In-Training Assessment of Trainees in Intensive Care Medicine’ (Appendix 44).

The process begins with an initial interview, in which the Trainee and Supervisor set goals for the training term. Previously completed assessments, retained in the Trainee’s training portfolio can also be used at this time. The definitive assessment is completed at the end of each training term. Assessments are completed according to the length of the term (as little as three months for the rural rotation), but at a minimum must be completed every six months. Trainees complete a self assessment using Section C of the ITA Form, before each ITA interview. Assessments are completed by the Supervisor of Training based on the consensus views of the majority of senior staff in the Department. Participating staff must
have a personal knowledge of the Trainee.

When a Trainee consistently performs at a level below that considered acceptable for a developing specialist in intensive care medicine, notwithstanding repeated documented attempts at correction, the provisions outlined in the Document T-13 (2010) ‘Guidelines for Assisting Trainees with Difficulty’ are invoked (refer Appendix 45).

Whilst the ITA process has been subject to reviews, the principles remain unchanged since the last AMC review. The ITA forms have been amended to reflect changes to the training program. Progressive modifications include:

• amendment of the forms to reflect the introduction of Basic and Advanced Training (2003).
• development of a separate assessment form for Basic Training (2004).
• development of the generic ITA form for Advanced Training into separate ITA forms for each component and stage of Advanced Training (2007). This enabled a more relevant assessment targeted at each term, with increasing responsibilities. The revised forms apply to core intensive care, anaesthesia, medicine and elective training. An additional form was developed as a Final In-Training Assessment (FITA), which requires the Trainee’s last Supervisor to give a global assessment confirming the Trainee is suitable to commence intensive care specialist practice. All assessment forms are reviewed prior to admission to Fellowship.
• amendment of forms to specify and document required Trainee exposure to subspecialty areas such as cardiac surgery, neurosurgery, burns, major trauma and paediatrics (2007).

The College is focusing on improving the consistency of Trainee assessment during training through Supervisor support and education. Assessments are being diversified with simulations and courses, combined with pre-tests and post-tests proposed.

The Development of a Primary Examination in Intensive Care Medicine

In 2006, the JFICM Board resolved to introduce a Primary Examination. The impetus for this decision came from a number of factors:

• The new training program, which defined a period of Basic Training, had been established.
• Increasing numbers of Trainees were undertaking intensive care training only, and the existing Primary Examination options from other Colleges were less appropriate for this group.
• A stand-alone Primary Examination was seen as an inevitable and integral step towards the evolution of a training program in a new College.

Prior to 2006, Trainees entering advanced training were required to have completed either the ANZCA Primary Examination, the RACP Written/Clinical Examination (with completion of basic physician training), the RACS or ACEM Primary Examination, or another basic sciences examination accepted by the Censor.

In 2006, a Primary Examination Committee was established and a syllabus (Appendix 35)
and proposed format were accepted by the Board. The new syllabus was based on the Objectives of Training at the time. A Panel of Examiners was appointed, drawing on experienced Fellows who had considerable involvement in the ANZCA Primary Examination. The first Intensive Care Primary Examination was held in 2007. Initially, small numbers of candidates participated, but the numbers are increasing (refer Table 5.1 under Section 5.3). One examination was held in 2007, and since then, two sittings have been held each year. A mock examination report was provided to the first candidates and since then more detailed reports have been made available to facilitate preparation by the candidates and make the process as transparent as possible. The first Primary Examination Course for Trainees was held in 2008. This focused on structure and content of the Examination, particularly the basic sciences as they apply to intensive care medicine. A CD was made available to Trainees following the Course.

**Structure of the Primary Examination**

Candidates for the Primary Examination are required to be registered with the College and have completed at least 12 months of general hospital experience. The Examination can be sat at any time during Basic Training. Trainees cannot proceed to Advanced Training until they have successfully completed Basic Training and the Primary Examination or equivalent.

The Primary Examination tests the basic sciences relevant to Intensive Care Medicine with an emphasis on integration of knowledge across disciplines. It comprises Written and Oral Sections. The Written Section has two 150-minute papers of short answer and short fact questions, and the Oral Section involves eight 10-minute stations.

Further detail is attached within the Notes for Candidates for the Primary Examinations (Appendix 50), and the most recent Primary Examination report (Appendix 55).

In 2003, the policy permitting exemption from the Primary Examination requirement was revised to include Trainees who had passed the ACEM and RACS Primary Examinations. As a result, entry to the training program was expanded, and there was a large increase in the number of emergency medicine trainees registering for dual training. Few surgical trainees have taken up this option.

In practice, the introduction of a Primary Examination has initially been relevant to a minority of Trainees, ie. those who are not undertaking joint training with another college, or who have undertaken training overseas that is not approved by the Censor. However, this number has continued to grow.

The Board continues to support a multi-disciplinary approach to intensive care training, and there are no plans to cease recognition of the basic training and primary exams of related specialty training programs. The College is also engaging with ANZCA and ACEM to consider reciprocal recognition of the CICM Primary Examination as a means to facilitate dual training in the spectrum of “acute care” medicine.
Fellowship Examinations in General Intensive Care Medicine and Paediatric Intensive Care Medicine

The Fellowship Examination of the College of Intensive Care Medicine is the Final Examination for Intensive Care Medicine specialty training in Australia and New Zealand. It has developed from the examination that was first set in 1979 as the Intensive Care Fellowship Examination of the Faculty of Anaesthetists of the Royal Australian College of Surgeons. It has been regularly and extensively revised over the last 30 years to maintain its validity, reliability and feasibility.

The training requirements for eligibility to sit the Examination are unchanged since the last review: Trainees are required to complete Basic Training, and a minimum of 12 months of Advanced Training in core intensive care medicine, before being eligible to sit.

The subject areas for the Fellowship Examinations are drawn from the Objectives of Advanced Training and Competencies in Intensive Care Medicine (Appendix 37) or the Objectives of Training and Competencies in Paediatric Intensive Care Medicine (Appendix 38).

Overview of the Fellowship Examination

The Examination is held twice yearly. It consists of three sections; the Written Section, the Clinical Section, and the Cross Table Viva Section. Some candidates may be exempted from the written section of the Examination (eg. carrying a previous pass in that section, and some OTS candidates). Marks are structured as follows:

Both the total mark and the mark in each section are considered when determining a pass/fail decision. To pass the Examination, a candidate must:

(a) achieve a total score of at least 50% (in those sections not exempted),
(b) not fail more than one section, and
(c) perform adequately in the Clinical Section. A mark of less than twelve out of thirty (12/30) in the Clinical Section is regarded as a poor fail and will result in failure of the whole examination.

Over the years, the number of candidates sitting the examination has increased steadily and more recently, has levelled out.

Further information about the structure of the Examinations is contained in the ‘Notes to Candidates’, attached as Appendix 51. A copy of the most recent Examination Report is attached as Appendix 56.
Ongoing Review of the Fellowship Examination

A number of reviews of the Fellowship Examination process have been conducted since the last AMC review. The establishment of an Examinations Committee has provided an overarching platform for refining all examination processes.

Based on consultation with Professor Russell Jones, former ANZCA Director of Education, attendance at AMC workshops and experiences of university education initiatives, the following changes have been made to the Examination:

a) Expansion: to incorporate assessment of CanMeds skills (including communication, procedures and professional qualities).
b) Lengthening: to increase the number of exposures to examiners, to ensure reliability.
c) Quarantining of candidates: to allow the provision of a similar examination for each candidate.
d) Increasing emphasis on examiner training and standard setting.
e) Increasing feedback to candidates to improve the educational experience and guide examination preparation.
f) Blueprinting of questions to maintain validity.
g) Logistic revision to ensure feasibility for a rapidly growing number of candidates and refinement to apply modern standard setting and quality control.
A paper published in 2009 in *Critical Care and Resuscitation* ‘Evidence-based evolution of the high stakes postgraduate examination in Australia and New Zealand’, by Lee, Venkatesh and Morley (Appendix 60) details further the changes to the examination and the evidence base accompanying those changes.

**Paediatric Intensive Care Medicine Fellowship Examination**

The Paediatric Fellowship Examination has the same structure as the General Fellowship Examination (refer Document Ex-2 ‘Candidate Notes’, Appendix 51). Some of the structural changes incorporated into the General Fellowship Examination were not incorporated into the Paediatric Examination until recently. This was due to the small numbers sitting the examination initially and for logistical reasons. The formats of both are now consistent and all of the changes brought in for the General Examination have been applied to the Paediatric Examination.

**Preparation for the Clinical Section of the Fellowship Examination**

In 2008 it was noted that some candidates were presenting for the Fellowship Examination with poor performance in clinical examination of patients. As a result, it was agreed that all candidates must complete at least four clinical (‘hot’) cases with a Supervisor within six months of intending to sit the Written Section of the Fellowship Examination. Four satisfactory assessments must be completed in the workplace and signed off by the Supervisor or a nominated Assessor.

**Formal Project**

This aspect of assessment is detailed in Section 3.3.

**The Curriculum Framework**

<table>
<thead>
<tr>
<th>Content</th>
<th>The Objectives of Basic and Advanced Training in Intensive Care and for the Anaesthesia and Medical components of training form the basis for assessment by Supervisors and Examiners. These embody the CanMeds principles.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Teaching/learning strategies</td>
<td>This is undertaken at the hospital level. Supervisors and other trainers use the objectives to structure local teaching activities, supplemented by local, regional and centralised courses.</td>
</tr>
<tr>
<td>Assessment forms</td>
<td>In-training assessment is not considered a barrier assessment except that the final assessment and five of six Advanced Training ITAs must be satisfactory. However any unresolved issues might impede the trainee’s progress. The Primary, General and Paediatric Fellowship Examinations are summative. The Formal Project is summative. The Medical ADAPT Course must be attended.</td>
</tr>
</tbody>
</table>
## Evaluation processes

<table>
<thead>
<tr>
<th>The Education and Examination Committees conduct ongoing reviews.</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Education Committee assesses courses and links them to the Can Meds principles in the Objectives of Training.</td>
</tr>
<tr>
<td>Feedback is sought from Supervisors and Trainees, as well as by the Trainee Committee.</td>
</tr>
<tr>
<td>Surveys of examination candidates and Trainees are regularly undertaken.</td>
</tr>
<tr>
<td>Feedback is also received during hospital reviews.</td>
</tr>
</tbody>
</table>

Whilst the College continues to work towards a more comprehensive curriculum, the Objectives of Training provide a consistent and comprehensive point of reference for learning and assessment. Blueprinting of assessments to the Objectives continues to be a focus for the Examination Committees.

### Policies for Special Consideration During Assessment

The College Regulation 5.16.4 (refer Appendix 2) and Document Ex-3 (Appendix 52) detail the policy for examination candidates suffering from illness, accident or disability.

The Regulations allow for interrupted training in the event of disadvantage or sickness, and all requests are considered on an individual basis by the Censor. Allowance is made in training time for sickness, annual and all other forms of leave, so that a minimum of 44 weeks full time equivalent training time must be completed in order for the 12 months of training to be approved.

### 5.2 Feedback and performance

#### AMC accreditation standards

<table>
<thead>
<tr>
<th>5.2.1</th>
<th>The training organisation has processes for early identification of trainees who are under performing and for determining programs of remedial work for them.</th>
</tr>
</thead>
<tbody>
<tr>
<td>5.2.2</td>
<td>The training organisation facilitates regular feedback to trainees on performance to guide learning.</td>
</tr>
<tr>
<td>5.2.3</td>
<td>The training organisation provides feedback to supervisors of training on trainee performance, where appropriate.</td>
</tr>
</tbody>
</table>

### Trainees Experiencing Difficulty

The College’s ITA process incorporates the requirement for feedback to the Trainee and the College on the Trainee’s progress. It is the main avenue for early identification of Trainees
who are underperforming. Any score of 1 or 2 (rated out of 5, with 5 being excellent) is identified by the College’s Training Department and forwarded to the Censor for attention. The Censor will contact the relevant Supervisor and offer advice or assistance. Should problems remain during the training term, an interview involving the Supervisor and relevant staff of the Training Department is held, following which a documented plan of remedial action is agreed upon. This may include external courses or supervised tailored activities. Advice or formal counselling (possibly by a mentor), and monitoring by the Supervisor is required. This process is outlined in Document T-13 ‘Guidelines for Assisting Trainees with Difficulties’ (Appendix 45). An educational module (Document T-33 ‘Trainees Experiencing Difficulty’, Appendix 49) is also available as a training exercise for Supervisors. Outcomes may include extension of training time and the Trainee and Mentor may be called to the College for discussion of unresolved issues.

Should the problem remain unresolved, an independent review of training may be required. Document T-14 ‘The Trainee Performance Review’ (Appendix 46) provides an independent process for review which may result in dismissal of a Trainee from the training program.

No Trainees have been dismissed from the JFICM or CICM program. Three have been formally counselled. Two of the three Trainees left the training program of their own volition. One Trainee completed the program after an extension of training time and heightened supervision. Reviews and re-assessments were implemented in each case, and complementary training introduced where appropriate.

These processes reflect the principles of the more generic processes outlined in College Regulations 14 and 15 (the Review and Reconsideration process, and the Appeals process, Appendix 2).

Feedback on Training

Feedback to individual Trainees is achieved by the ITA process. At the conclusion of the assessment, Trainees must sign off that they have participated in the assessment, following which the Supervisor is permitted to write a further comment before also signing the assessment. Informal and formative feedback should be also given by the Supervisor during the training term. Other avenues for feedback include:

- Informal feedback from a variety of training courses and their associated examinations. These activities form a significant part of the formative experience of training.
- Written advice from the Chair of the Examination following an unsuccessful examination attempt (see below).
- Individual approaches by Trainees to the Training Department or Censor. The Trainee is advised how best to tailor the program to their individual needs.

Feedback Relating to the Examinations

Unsuccessful examination candidates receive a letter after the examination detailing their performance and the sections of the examination in which they failed. This consists of detailed analysis of the individual’s clinical/academic weaknesses, as well as a detailed examination report, which includes examples of questions asked, and sample answers. The candidate’s SOT is contacted by phone (usually by the Chairman of the Examination) to
discuss the candidate’s performance and plan remedial action. This discussion will relate to the examination process, conduct and performance and how best to prepare again but will not include reference to specific examination questions or answers.

5.3 Assessment quality

AMC accreditation standard

5.3.1 The training organisation has a policy on the evaluation of the reliability and validity of assessment methods, the educational impact of the assessment on trainee learning, and the feasibility of the assessment items. It introduces new assessment methods where required.

Reliability and Validity in the College’s Examinations Processes

The validity of the examination has been assessed in terms of how it appears on inspection to assess relevant knowledge (face validity), how test items are blueprinted to the Objectives of Training (content validity) and whether it predicts a sustainable career in intensive care medicine (predictive validity). On a regular basis, data are collected and analysed for measurement error and bias, and measures have been introduced to minimise them.

Comprehensive surveys in 1986, 1992 and 1998 (refer Appendix 61) have confirmed the high level of acceptance of both the examination and the training program. ANZICS data show a high level of engagement by intensive care specialists, and Australian and New Zealand ICUs are internationally recognised to have excellent patient outcomes. (Refer Appendix 12.)

There are many measures that have been introduced to assist in ensuring fairness and maintaining quality in various stages of the examinations:

- Inclusion of multiple formats – written, vivas and clinical. Each component carries a significant part of the overall mark, thus providing an opportunity for candidates to make up for a particular case or weak performance in one section.
- Inclusion of multiple stations, with exposures to multiple examiners in the Oral (vivas and clinical) sections. The examiners are blinded to the candidate’s marks in other stations and sections of the examination. The dependability coefficient of the clinical cases is currently being used to maintain reliability of this section of the examination.
- Allocation of two examiners, who mark the candidate independently, for each question in the written section, the hot case assessment and some stations in the viva examination.
- Mandatory attendance of examiners at regular examiner calibration workshops. During these workshops, questions and marking grids are reviewed and practiced between a “surrogate candidate” (usually an examiner) and an examiner, and video calibration of examiners is utilised.
- Examiners are assigned to candidates in a random, blinded fashion.
- An independent assessor reviews the performance of examiners on a regular basis whilst they are examining and assesses the conduct of the Examination.
Appointments to the panel of examiners are based not only on qualifications, experience and competence, but also on referee reports that testify to the applicant’s skills and ability to examine without bias.

In 2007 a review and comparison with other intensive care examinations was conducted and the results published, refer ‘Examinations in intensive care medicine: an international perspective’, Venkatesh, Morley, Lee, and Van Heerden, *Critical Care and Resuscitation*, 2007: Vol 9 No 3: 259-263 (Appendix 59).

Examples of statistical reports for the Primary, General Fellowship and Paediatric Examinations are attached at Appendix 55, 56 and 57. A recent Survey of Candidates sitting the Fellowship Examination is attached at Appendix 58.

**Reliability and Validity in the ITA Process**

Face validity of the ITA process is regularly assessed to align it with the skills and attributes expected of the Trainee at each stage of training. The reliability of the process is dependent on assessment by a group of intensive care specialists working within the team environment in intensive care. The College provides training in this process through Supervisor of Training Workshops.

**Training for Supervisors**

Supervisors are provided with a number of training opportunities in relation to the College’s assessment processes.

- The Supervisor of Training Support Kit (Appendix 43) details all the forms of assessment. It provides two Educational Modules and lists other resources.
- Workshops are provided and usually cover topics relating to the ITA and the examination processes. These are held either at the time of the Annual Scientific Meeting or can be held independently.
- Supervisors are encouraged to attend examinations as observers, and examination reports are circulated to all Supervisors to help them understand the examination process and help their Trainees prepare.

**Training for Examiners**

Training for Examiners has been substantially formalised since the last AMC review and is detailed later in Section 8.1.

**Pass Rates**

A workshop is held immediately following each examination to compile and consider marks. This is the first point at which trends in marking and examiner calibration are observed and discussed. Following each examination a statistical report is compiled and circulated to the
relevant examination committee, the overarching Examinations Committee, the Board, Supervisors of Training and Trainees. It provides an analysis of each component of the relevant examination. The chair of each examination and the Board Chair of Examinations are both responsible for oversight of pass rates and other causes for investigation.

Possible reasons for variations in pass rates are explored by the relevant committee and if necessary the Board, following which appropriate action is taken. Two examples of this in the past have been:

- A high failure rate in the Oral Section of the Fellowship Examination for candidates from overseas was observed. In response, in 2006 JFICM introduced a new examination preparation course, specifically targeted to these candidates. In addition, the Written and Oral Sections of the Examination were separated and candidates are now required to achieve a suitable pass in the Written Section before proceeding to the Oral Section.

- Analyses of marks indicated that candidates consistently performed poorly in the Clinical section of the Fellowship Examination. In response, the Board developed the ‘Clinical Case’ Assessment requirement, to ensure candidates were achieving appropriate exposure to clinical cases before the examination, with the help of the Supervisors.

Table 5.1: Number and percentage of candidates who sat and passed the Primary Examination 2007 – 2010, per sitting, and number of attempts.

<table>
<thead>
<tr>
<th></th>
<th>Sep-07</th>
<th>Apr-08</th>
<th>Nov-08</th>
<th>May-09</th>
<th>Nov-09</th>
<th>Apr-10</th>
<th>Nov-10</th>
</tr>
</thead>
<tbody>
<tr>
<td>Passed on 1st attempt</td>
<td>1</td>
<td>0</td>
<td>2</td>
<td>3</td>
<td>3</td>
<td>6</td>
<td>5</td>
</tr>
<tr>
<td>Passed on 2nd attempt</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Passed on 3rd attempt</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td><strong>TOTAL SITTING</strong></td>
<td>6</td>
<td>3</td>
<td>5</td>
<td>10</td>
<td>9</td>
<td>10</td>
<td>16</td>
</tr>
<tr>
<td><strong>TOTAL PASS</strong></td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>%</td>
<td>17%</td>
<td>33%</td>
<td>60%</td>
<td>30%</td>
<td>33%</td>
<td>60%</td>
<td>44%</td>
</tr>
</tbody>
</table>

*Note: The first Primary Examination was held in September, 2007.*
Figure 5.2: Total Number of candidates presenting for the Primary Examination for each year, 2007 – 2010, number invited to Oral Section and successful candidates

![Primary Examination - Pass Rate 2007 - 2010](image1)

Inc. candidates invited to orals based on the 45% rule

Figure 5.3: Pass rate of candidates presenting for the Oral Section of the Primary Examination for each year, 2007 – 2010, and overall pass rate

![Primary Examination - Oral Section Pass Rate 2007 - 2010](image2)

Inc. candidates invited to orals based on the 45% rule
Table 5.2: Number and percentage of candidates who passed the General Fellowship Examination, per sitting, 2006 – 2010 and number of attempts

<table>
<thead>
<tr>
<th></th>
<th>May-06*</th>
<th>Sept-06</th>
<th>May-07</th>
<th>Oct-07</th>
<th>May-08</th>
<th>Oct-08</th>
<th>May-09</th>
<th>Oct-09</th>
<th>May-10</th>
<th>Oct-10</th>
</tr>
</thead>
<tbody>
<tr>
<td>Passed on 1st attempt</td>
<td>N/A</td>
<td>15</td>
<td>23</td>
<td>26</td>
<td>18</td>
<td>31</td>
<td>13</td>
<td>29</td>
<td>19</td>
<td>26</td>
</tr>
<tr>
<td>Passed on 2nd attempt</td>
<td>N/A</td>
<td>4</td>
<td>4</td>
<td>6</td>
<td>6</td>
<td>4</td>
<td>2</td>
<td>8</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Passed on 3rd attempt</td>
<td>N/A</td>
<td>1</td>
<td>2</td>
<td>7</td>
<td>1</td>
<td>5</td>
<td>3</td>
<td>6</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Passed on 4th attempt</td>
<td>N/A</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>2</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Passed on 5th attempt</td>
<td>N/A</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Passed on 8th attempt</td>
<td>N/A</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>TOTAL SITTING</td>
<td>30</td>
<td>36</td>
<td>54</td>
<td>61</td>
<td>51</td>
<td>66</td>
<td>49</td>
<td>68</td>
<td>52</td>
<td>58</td>
</tr>
<tr>
<td>TOTAL PASS</td>
<td>21</td>
<td>21</td>
<td>29</td>
<td>40</td>
<td>25</td>
<td>42</td>
<td>18</td>
<td>46</td>
<td>27</td>
<td>35</td>
</tr>
<tr>
<td>%</td>
<td>70%</td>
<td>58%</td>
<td>54%</td>
<td>66%</td>
<td>49%</td>
<td>64%</td>
<td>37%</td>
<td>68%</td>
<td>52%</td>
<td>60%</td>
</tr>
</tbody>
</table>

*Note: Data on number of attempts unavailable

Figure 5.4: Total Number of candidates presenting for the General Fellowship Examination for each year, 2006 – 2010, number invited to Oral Section and successful candidates
Figure 5.5: Pass rate of candidates presenting for the Oral Section of the General Fellowship Examination for each year, 2006 – 2010, and overall pass rate

Table 5.3: Number and percentage of candidates who passed the Paediatric Fellowship Examination, 2005 – 2010 and number of attempts

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Passed on 1st attempt</td>
<td>3</td>
<td>2</td>
<td>5</td>
<td>3</td>
<td>4</td>
<td>7</td>
</tr>
<tr>
<td>Passed on 2nd attempt</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Passed on 3rd attempt</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>TOTAL SITTING</strong></td>
<td>4</td>
<td>3</td>
<td>7</td>
<td>5</td>
<td>6</td>
<td>13</td>
</tr>
<tr>
<td><strong>TOTAL PASS</strong></td>
<td>3</td>
<td>2</td>
<td>5</td>
<td>4</td>
<td>5</td>
<td>7</td>
</tr>
<tr>
<td><strong>%</strong></td>
<td>75%</td>
<td>67%</td>
<td>71%</td>
<td>80%</td>
<td>83%</td>
<td>54%</td>
</tr>
</tbody>
</table>
Figure 5.6: Total Number of candidates presenting for the Paediatric Fellowship Examination for each year, 2006 – 2010, number invited to Oral Section and successful candidates.

Figure 5.7: Pass rate of candidates presenting for the Written and Oral Sections of the Paediatric Fellowship Examination for each year, 2006 – 2010.
Number of Trainees Withdrawn from the Training Program before Completion

Several Trainees have notified the College of their intention to withdraw from the program, approximately five in the history of the program. However, a number of Trainees cease specialty training or cease dual training, do not return to our program and do not advise the College. It is worth noting that a significant number of the registered Trainees are not actively training with the College. Reasons for this could be that overseas trainees may be limited by occupational training visas, or may register for training and choose not to continue once they receive an assessment of their training requirements. Also Trainees undertaking dual training may move back to their ‘primary’ specialty, unsure whether they will return to intensive care training.

5.4 Assessment of specialists trained overseas

AMC accreditation standard

5.4.1 The processes for assessing of specialists trained overseas are in accordance with the principles outlined by the AMC and the Committee of Presidents of Medical Colleges Joint Standing Committee on Overseas Trained Specialists (for Australia) or by the Medical Council of New Zealand (for New Zealand).

Overview


The policy outlines the criteria and processes for assessment, explains how the OTS Committee and Interview Panel reach their assessments, details what is required at interview and what possible outcomes can be expected. The document also incorporates processes for OTS applications in New Zealand.

The OTS process is managed by the College Secretariat under the supervision of the OTS Committee. Overseas trained specialists may contact the Censor (Chair of the OTS Committee) via the Secretariat for advice on appropriate positions and the process. Once a position is approved, an Assessor is appointed, who provides the main avenue for immediate support and feedback. Overseas trained specialists are provided with information relating to courses and examinations if applicable to their assessment requirements. Other assistance is provided to an OTS on an as-needs basis.

The great majority of OTS assessments by the College require a period of supervised practice in a pre-approved position. The level of the position may vary depending upon the training and experience of the applicant. Requirements usually include one or more aspects of the OTS Performance Assessment, which uses components of the Fellowship Examination (General or Paediatric) as its assessment tool. Detailed feedback is provided to OTS on their performance at the Examination.
Criteria for Assessing Overseas Trained Specialists

The criteria for assessment of OTS are based on:

1. **Training in intensive care medicine.** This must be equivalent with the CICM training in its duration, structure and content, assessments and supervision.

2. **Experience as a specialist.** There should be evidence of past management of patients with adequate case mix and severity of illness, use of equipment and procedures, and compliance with standards of good practice in intensive care medicine equivalent to those promoted in College Policy Documents.

3. **Participation in continuing education and quality assurance activities** must be similar to the College Maintenance of Professional Standards (MOPS) Program. A continuous involvement in recent years is important.

The process requires a paper review of the application to determine whether the applicant has a specialist qualification and has practiced intensive care medicine as a specialist in their country of origin. There must be documentation of medical registration, specialist qualifications in intensive care medicine and details of specialist practice in intensive care medicine. Consideration is given to the *curriculum vitae*, references, and any other documents that portray the candidate’s previous practice as an intensive care medicine specialist. Stated experience and qualifications must be substantiated by statements of training and original or certified copies of diplomas from relevant bodies.

If the applicant meets these criteria, he/she is invited to an interview enquiring about previous training and experience, using a proforma based on the criteria detailed above. There have been no specific changes to these criteria for assessment since 2002.

**Review**

The College’s OTS policy has been reviewed a number of times since 2002:

- In 2003, in the section relating to the Training Program, eligibility for the Fellowship Examination and more detail regarding the format of the Paediatric Examination was included. There was also clarification that the policy applies to ‘medical practitioners who have satisfied all the training and examination requirements to practice in their field of specialty’. The requirement for the performance assessment was also amended to include the requirement to complete the Short Answer section of the Written Examination. At this point separate Notes to Candidates for the OTS Examination were developed, but these have since been incorporated into a general document for all examination candidates (Appendix 51).

- In 2004, the section outlining the training program was updated to include reference to the new training program (introduced in late 2003). Changes to the format of the Fellowship Examination were also included. A further addition was to allow OTS who have a basic medical degree from Australia or New Zealand to apply directly to Board for assessment via the OTS pathway.
Later, in 2006, the policy incorporated reference to the new Primary Examination and the mandatory requirement for Trainees to complete the ADAPT Course. The Paediatric Fellowship Examination format also changed and this was noted.

Following the recommendations of the AMC (2009) to ensure the Committee is of a reasonable size, the OTS Committee was expanded to include a new Fellow, recently admitted via the OTS pathway, and two further representatives of the Board.

In 2010 the Board agreed that OTS candidates should complete a Final ‘In Training Assessment’ at the end of their supervised practice.

In summary, the majority of these amendments reflected the changes made to the training program, resulting in the need to update the OTS Document.

There have been no formal appeals against decisions regarding overseas trained specialists. The Appeals Process of the College is detailed in Regulation 13 (Appendix 2).

The College has considered more flexible methods of recognising overseas trained specialists, taking into account the stage of their career, the nature of their practice and methods of in-service assessment of competence rather than relying in all cases on an examination. However, at this time, the majority have been required to undergo a performance assessment.

Comparison with Other Training Programs Overseas

As a relatively new specialty, there is considerable variability in the standards of intensive care training around the world and few programs are similar to that of the College. To date only one overseas trained specialist has been supported for specialist registration (and admission to Fellowship) without having to undertake any additional requirements beyond a period of adaption and supervision, a Swiss national, who had a very high level of experience and additional qualifications.

The OTS Committee has undertaken reviews of other training programs to inform its assessment process.

Qualifications of overseas programs for assessment are detailed in the following table.

Table 5.4: Overseas Intensive Care Training programs

<table>
<thead>
<tr>
<th>Canada:</th>
<th>Fellowship of the College of Physicians and Surgeons of Canada with completion of a recognised Fellowship program in Intensive Care Medicine and with training and experience in Intensive Care totalling at least 2 years full-time equivalent.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>In Canada Intensive Care specialist accreditation is based on a two-year Fellowship Program after completion of a three-year base specialty. The Royal College of Physicians and Surgeons in Canada (RCPSC) administers this and accredits the Fellowship Programs, and administers a Final Written Examination for Critical Care.</td>
</tr>
<tr>
<td>Region</td>
<td>Description</td>
</tr>
<tr>
<td>-------------------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Hong Kong:</td>
<td>Hong Kong has a training program in its infancy, modelled on the JFICM program. The major difference is a format for final summative assessment based on the previous JFICM exam format.</td>
</tr>
<tr>
<td>USA</td>
<td>In the USA Intensive Care Medicine or Critical Care Medicine, as it is called, is regarded as a sub-specialty of surgery, anaesthesia or internal medicine. Training consists of a 1 or 2 year Fellowship Program at an accredited institution after completion of a 3 or 4 year parent specialty program. There is an exit MCQ examination for the American Boards. There is no clinical examination.</td>
</tr>
<tr>
<td>Europe:</td>
<td>In Europe the most common intensive care specialist qualification is the European Diploma of Intensive Care (EDIC) supervised by the European Society of Intensive Care Medicine. It requires base specialty certification and completion of 24 months intensive care training or completion of a 5 year national program and a simple written examination and undeveloped clinical examination. It attempts to bring together training from many diverse countries, which is not centrally supervised, or in units which are not systematically accredited.</td>
</tr>
<tr>
<td>United Kingdom:</td>
<td><strong>Fellow of the Royal College of Anaesthetists, Surgeons or Physicians – FRCA, FRCS or FRCP with CCST in Intensive Care and with the European Diploma of Intensive Care (EDIC)</strong></td>
</tr>
<tr>
<td></td>
<td>In the UK, Intensive Care training is supervised by the Intensive Care Society (ICS) and the Intercollegiate Board for Training in Intensive Care Medicine. Completion of training in a core specialty (anaesthesia, surgery or internal medicine) is required, plus two years of supervised experience in Intensive Care. Success at an examination is only optional so success at the EDIC should be a mandatory accompaniment.</td>
</tr>
<tr>
<td>Ireland:</td>
<td><strong>Diploma of the Irish Board of Intensive Care Medicine (DIBICM) with full registration as an Intensive Care Specialist in Ireland.</strong></td>
</tr>
<tr>
<td></td>
<td>Ireland has a program supervised by the Intensive Care Society of Ireland. Only one year of ICM training and an examination are mandated before award of the diploma.</td>
</tr>
<tr>
<td>Republic of South Africa:</td>
<td>The College of Anaesthetists of South Africa within the College of Medicine supervises a Critical Care program. The program mandates 18 months ICM, no internal medicine or anaesthesia and no clinical final summative assessment.</td>
</tr>
</tbody>
</table>
India

In India an organised training program under the auspices of the Indian Society of Critical Care Medicine has been established for 4 years. It requires a 2 to 3 year training program in a parent specialty and 2 or 1 year(s) respectively in Intensive Care Medicine. There is currently no organised system of assessment.

Other countries with more than one intensive care program are assessed on a case by case basis.

The policy for recognition of prior learning is included in the Regulations and relevant policy documents, and for the purposes of OTS, candidates are questioned about their prior learning using a structured interview proforma, and are given credit in the assessment.

Table 5.5: Graduates of the OTS Program by Year and Region of Origin, 2006 - 2010

<table>
<thead>
<tr>
<th></th>
<th>India</th>
<th>Asia</th>
<th>UK/Ireland</th>
<th>Europe</th>
<th>N America</th>
<th>Other</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>2006</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>2007</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>8</td>
<td>0</td>
<td>1</td>
<td>11</td>
</tr>
<tr>
<td>2008</td>
<td>0</td>
<td>0</td>
<td>3</td>
<td>2</td>
<td>2</td>
<td>0</td>
<td>7</td>
</tr>
<tr>
<td>2009</td>
<td>0</td>
<td>0</td>
<td>4</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>8</td>
</tr>
<tr>
<td>2010</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>3</td>
</tr>
</tbody>
</table>

It is worth noting that a great majority of the OTS currently being assessed have less than two years of specialist experience in intensive care medicine.

Strengths and Challenges of OTS process

Maintaining knowledge of overseas training programs in order to provide fair assessments is an important challenge for the OTS Committee. The International Liaison Officer is responsible for keeping up to date with other programs. Other Board members and Fellows undertake a variety of educational projects with overseas colleges as well as accreditation visits overseas and these endeavours add to the knowledge base.

Area of Need Assessments

A separate but related policy for Intensive Care Services for Areas of Need is attached as Appendix 27, or via the College website at [http://www.cicm.org.au/policydocs.php](http://www.cicm.org.au/policydocs.php). It has not been changed since 2002, but was reviewed and adopted as a policy document by the new College in 2009. Since 2005, the College has assessed eight individuals for AON positions.
Table 5.6: *Number of Area of Need Assessments Undertaken by Region of Origin per year 2006 – 2010*

<table>
<thead>
<tr>
<th></th>
<th>India</th>
<th>Asia</th>
<th>UK/Ireland</th>
<th>Europe</th>
<th>N America</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>2006</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>2007</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>2008</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>2009</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>2010</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

**Approval of Occupational Training Visas (OTV)**

The College receives requests for approval of overseas medical officers for hospital posts for postgraduate training and experience, from Medical Boards and other statutory bodies using standardised forms adopted nationally. The College is required to state whether the medical officer is suitable for the post after consideration of the curriculum vitae of the doctor and the job description. The application is considered by the Censor, and if approved, signed off by the Censor or CEO. A fee is charged. The volume of these OTV requests reflects the high requirement for medical officers to service Australian ICUs.

Table 5.7: *Number of OTV Requests Approved per Region of Origin per year since 2006*

<table>
<thead>
<tr>
<th></th>
<th>India</th>
<th>Asia</th>
<th>UK/Ireland</th>
<th>Europe</th>
<th>N America</th>
<th>Other</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>2006</td>
<td>21</td>
<td>7</td>
<td>6</td>
<td>8</td>
<td>0</td>
<td>1</td>
<td>43</td>
</tr>
<tr>
<td>2007</td>
<td>49</td>
<td>11</td>
<td>24</td>
<td>17</td>
<td>2</td>
<td>6</td>
<td>109</td>
</tr>
<tr>
<td>2008</td>
<td>40</td>
<td>4</td>
<td>15</td>
<td>16</td>
<td>0</td>
<td>3</td>
<td>78</td>
</tr>
<tr>
<td>2009</td>
<td>15</td>
<td>5</td>
<td>4</td>
<td>7</td>
<td>0</td>
<td>3</td>
<td>34</td>
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<tr>
<td>2010</td>
<td>10</td>
<td>1</td>
<td>6</td>
<td>9</td>
<td>1</td>
<td>2</td>
<td>29</td>
</tr>
</tbody>
</table>
6 The curriculum – monitoring and evaluation

6.1 Ongoing monitoring

AMC accreditation standards

6.1.1 The training organisation regularly evaluates and reviews its training programs. Its processes address curriculum content, quality of teaching and supervision, assessment and trainee progress.

6.1.2 Supervisors and trainers contribute to monitoring and to program development. Their feedback is systematically sought, analysed and used as part of the monitoring process.

6.1.3 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.

Ongoing Review of the Program

As described in Section One, the College Education Committee is the committee tasked with monitoring, evaluation and improvement of the training program, and also the assessment and appointment of Supervisors of Training (SOTs) for each accredited training unit. In 2005 the Education Committee developed a comprehensive plan for the ongoing development of the program. Since then the Education Committee (in conjunction with other committees where appropriate) has instigated a number of changes to the program that have been discussed earlier in this document and include:

- the development of an intensive care Primary Examination (2007);
- the option of a three month rotation to a rural unit as part of the core Advanced Training;
- the redesign of the format of the Fellowship Examination (2008);
- the increase in the core intensive care training time from 24 months to 36 months for all new Trainees commencing training from 1\textsuperscript{st} January 2011, and
- the assessment and mandating of courses, eg. BASIC for junior Trainees.

The Education committee is also the body responsible for the assessment and appointment of SOTs.

Any proposal to change an aspect of the training program is systematically promulgated through the Regional and National Committees to allow input from SOTs and other Fellows involved in training. Their feedback is always analysed as part of the development of the training program.

All SOTs are invited to attend twice yearly workshops, which provide opportunities for discussion with the senior office bearers on aspects of the program and to provide feedback on issues concerning training and supervision.
Trainee Feedback

Trainee feedback on training issues and proposed changes to the program is sought through the Trainee Committee, SOT workshops and during accreditation reviews. Significant changes to the program, for example, the increase in core intensive care training time from 24 to 36 months, are implemented with lengthy lead-in times and only apply to new Trainees, so that existing Trainees will not be disadvantaged. One of the fundamental considerations of the transition from the Joint Faculty to the College was that no Trainee would be disadvantaged by that move.

The College has periodically undertaken a systematic survey of Trainees to gain their confidential feedback on supervision, assessment and other training issues. The latest of these is currently underway and results will be available shortly.

As a result of discussions following the AMC’s workshop on Trainee feedback in November 2010, the CICM Board decided to appoint Trainee representatives to most committees, including the Board and also to include a Trainee representative on hospital review teams. This should greatly improve the capacity of the Trainees to be effectively represented in College governance and training issues in general.

6.2 Outcome evaluation

<table>
<thead>
<tr>
<th>AMC accreditation standards</th>
</tr>
</thead>
<tbody>
<tr>
<td>6.2.1 The training organisation maintains records on the outputs of its training program, is developing methods to measure outcomes of training and is collecting qualitative information on outcomes.</td>
</tr>
<tr>
<td>6.2.2 Supervisors, trainees, health care administrators, other health care professionals and consumers contribute to evaluation processes.</td>
</tr>
</tbody>
</table>

Outcome of Training

The fundamental aim of the training program is to produce competent intensive care specialists, capable of providing a high standard of intensive care practice without supervision. Graduates of the program work as specialist medical practitioners, and also as leaders of multidisciplinary teams in a highly specialised environment, caring for critically ill patients.

The principal output of the training program is the number of Trainees who graduate each year to become Fellows of the College. Table 6.1 shows the number of new Fellows graduating from the general intensive care training program and the paediatric intensive care program over the last six years. (Refer also Section 2.2 for discussion of other measurable outcomes.)
Table 6.1: Number of intensive care training graduates (New Fellows) 2005 – 2010, by program

<table>
<thead>
<tr>
<th></th>
<th>General</th>
<th>Paediatric</th>
</tr>
</thead>
<tbody>
<tr>
<td>2005</td>
<td>29</td>
<td>0</td>
</tr>
<tr>
<td>2006</td>
<td>23</td>
<td>0</td>
</tr>
<tr>
<td>2007</td>
<td>36</td>
<td>2</td>
</tr>
<tr>
<td>2008</td>
<td>62</td>
<td>5</td>
</tr>
<tr>
<td>2009</td>
<td>63</td>
<td>3</td>
</tr>
<tr>
<td>2010</td>
<td>53</td>
<td>4</td>
</tr>
</tbody>
</table>

The College maintains records of all Primary and Fellowship examinations and analyses the examination results (refer Section 5.3 and Examination Reports at Appendices 55, 56 and 57).

The College, at intervals, has conducted formal surveys of its Fellows, most recently in August 2010. One of the aims of this survey was to gain information about changes in the working environment and the work patterns of intensive care specialists and to use this information to inform proposed changes to the training program. The results of the latest survey are currently being analysed. The survey form is included as Appendix 13.

Feedback from Trainees, Supervisors and Others

The College first established a Trainee Committee in 2004. Each of the states and New Zealand have a representative on the Trainee Committee, whose purpose is to represent Trainee interests in the governance and affairs of the College and to particularly contribute to matters concerning education and training.

In 2007, in order to promote a more consistent and formal communication mechanism with Trainees and recent graduates of the training program, the position of New Fellows Representative was created on the Board. The New Fellows Representative chairs the Trainee Committee and provides a conduit for communication between Trainees, new Fellows and the Board.

An interactive forum for SOTs is conducted twice each year (in conjunction with the College’s Annual Scientific Meeting and also with the ANZICS ASM) at which SOTs are invited to contribute to the ongoing development of the training program. In order to provide more focus on the role of the SOTs, a specific position of SOT liaison has been created for a Board member on the Education Committee. Surveys seeking formal feedback from Supervisors of Training have previously been carried out in 2002 and 2004.

The process of assessing hospitals as accredited College training institutions involves interviews with the senior administrative staff of the hospital, their input into relevant aspects of the training program is welcomed.
Implementing the curriculum – Trainees

7.1 Admission policy and selection

AMC accreditation standards

7.1.1 A clear statement of principles underpins the selection process, including the principle of merit-based selection.

7.1.2 The processes for selection into the training program:
   - are based on the published criteria and the principles of the training organisation concerned
   - are evaluated with respect to validity, reliability and feasibility
   - are transparent, rigorous and fair
   - are capable of standing up to external scrutiny
   - include a formal process for review of decisions in relation to selection, and information on this process is outlined to candidates prior to the selection process.

7.1.3 The training organisation documents and publishes its selection criteria. Its recommended weighting for various elements of the selection process, including previous experience in the discipline, is described. The marking system for the elements of the process is also described.

7.1.4 The training organisation publishes its requirements for mandatory experience, such as periods of rural training, and/or for rotation through a range of training sites. The criteria and process for seeking exemption from such requirements are made clear.

7.1.5 The training organisation monitors the consistent application of selection policies across training sites and/or regions.

How Trainees are Appointed

The College does not administer selection or appointment of its Trainees centrally or locally. Appointments of successful candidates are made by the local health authority or employer, using the principles detailed in the College’s Document T-1 ‘Guidelines for the Selection of Trainees’ (Appendix 32). In some circumstances a Trainee will register with the College, and then he or she will make application to approved training hospitals for advertised positions. More commonly Trainees will register with the College during an ICU term or appointment because of a developing career interest.

Although the College's guidelines for selection of Trainees are consistent with recommended standards, the implementation of these guidelines varies from region to region. The College recognises the right of hospitals to be involved in the appointment of Trainees, but given the co-ordinated nature of training rotations, it does seem appropriate that centralised processes for appointments should be achieved in each region. This has proven to be difficult to implement. Centralised appointments minimise the number of
interviews for each Trainee, simplify the appointment process and increase the probability that the best human resource principles are invoked in the appointment process. This is clearly achieved in only some States in Australia.

In 2009, a centralised appointment process was developed for Queensland Intensive Care Trainees, resourced by Queensland Health. This has streamlined appointment processes especially in a work environment where there has been a dependence upon overseas Trainees to fill positions. The advantages are a capacity to plan for appropriate training terms to minimise training time, provision of a local dataset of Trainees, as well as ensuring a consistent approach to medical board registration and immigration requirements.

The majority of Trainees respond to hospital advertisements and select their training site according to the individual needs of their own training program. Advice is available locally through the relevant Regional Committee or in New Zealand, the National Committee. Advice can also be obtained via the College Training Department and the Censor.

The College’s Trainee Selection Policy

The Guidelines for the Selection of Trainees were developed by the FICANZCA in 1998 and incorporate the principles of the document ‘Trainee Selection in Australian Medical Colleges’ published by the Medical Training Review Panel in 1999. This policy was reviewed and adopted by the new College in 2009, with no major changes.

In its standards for accreditation of training sites (refer Document IC-3, paragraph 1.4.10, Appendix 17), the College requires that:

Positions for training in intensive care units accredited by the College of Intensive Care Medicine must be advertised and the unit classification must be indicated in the advertisement. The selection process must conform to College guidelines. Selection panels for the appointment of Trainees in intensive care should include a Fellow of the College of Intensive Care Medicine.

The ‘Guidelines’ include a Statement of Principles, which aims to ensure Trainees are appointed to training positions in a fair and transparent manner. They detail how Trainees may enter the training program, the criteria for eligibility and selection, and they also provide a recommended process for employing authorities. A weighting and marking system is suggested, but not prescribed. There is a separate Appeals Process (Regulation 13, Appendix 2) for applicants wishing to register for the training program. Both the Trainee Selection guidelines and details of the Appeals process are published on the College website, and identified within the Trainee and Supervisor Support Kits.

The training program is designed to be flexible and open to Trainees from other medical disciplines. The majority of Trainees enter the Advanced Training program rather than Basic Training. Given the wide variety of entry points for Trainees, a College-run selection system would be difficult to establish and administer. For the most part, it is considered that the current selection process is adequate at present.
Requirements for Registration

Regulation 5.2 requires that prospective Trainees must have a recognised basic medical degree and have completed 12 months full time equivalent General Hospital Experience. Trainees must register within three months of commencing an Advanced Training position. Information on how to register is available on the College website at http://www.cicm.org.au/howtoreg.php.

Factors Affecting Selection of Intensive Care Trainees

A number of factors dictate why the College does not select Intensive Care Trainees for training positions. These are:

- Intensive Care training is hospital-based.
- A large number of Trainees have come from outside Australia or New Zealand.
- A proportion of Trainees are completing dual training towards another specialty, (anaesthesia, medicine, emergency medicine or surgery).
- Trainees undertaking dual training may move in and out of intensive care training positions, defer components of training in order to complete other specialty training and are less likely to complete training in the six year minimum period.
- A significant number of Trainees move geographic locations to gain differing experience.

At the time of the last review by the AMC, there was a considerable shortage of Trainees compared with positions available and therefore selection was not perceived to be a major issue (“Both intensive care medicine and pain medicine positions are relatively under subscribed, so the Team identified no clear issues concerning selection.” AMC Report 2002). Whilst there has been a significant increase in the number of Trainees registering for intensive care training, there has been an even greater increase in the number of positions available, because of larger ICUs and an increase in ICU outreach activities. There is still a relative shortage of local Trainees and a large number of Trainees from overseas seek positions on an annual basis. Table 7.1 shows that only one third of CICM Trainees have graduated from Universities in Australia and New Zealand. This is another factor which impacts on the feasibility of a central selection mechanism.

Table 7.1: Number of Intensive Care Trainees entering the program, 2007 - 2010, including those with Overseas Medical Qualifications, and Country of Origin

<table>
<thead>
<tr>
<th></th>
<th>Australia/NZ</th>
<th>India</th>
<th>Asia</th>
<th>UK/Ireland</th>
<th>Europe</th>
<th>N America</th>
<th>Other</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>2007</td>
<td>66 (33%)</td>
<td>59</td>
<td>15</td>
<td>31</td>
<td>15</td>
<td>2</td>
<td>10</td>
<td>198</td>
</tr>
<tr>
<td>2008</td>
<td>52 (30%)</td>
<td>38</td>
<td>31</td>
<td>25</td>
<td>10</td>
<td>4</td>
<td>10</td>
<td>170</td>
</tr>
<tr>
<td>2009</td>
<td>63 (31%)</td>
<td>45</td>
<td>24</td>
<td>28</td>
<td>22</td>
<td>3</td>
<td>18</td>
<td>203</td>
</tr>
<tr>
<td>2010</td>
<td>57 (34%)</td>
<td>24</td>
<td>26</td>
<td>25</td>
<td>10</td>
<td>5</td>
<td>20</td>
<td>167</td>
</tr>
</tbody>
</table>
Although selection is effectively at arm’s length, there is the opportunity for Trainees to raise any issues regarding positions during accreditation reviews. Regional Committees and the New Zealand National Committee also monitor selection at a local level in an informal manner. Fellows are normally involved in the selection process at the hospital level.

**Numbers of Training Positions**

Numbers of training positions are determined by the employing authorities and the College does not limit or directly influence the availability of positions. Prospective Trainees can identify accreditation training institutions on the College website, which details the status of each site.

**Numbers of Graduates and Workforce Implications**

In 1999, the FICANZCA took part in a review of the intensive care workforce with AMWAC and a significant report was produced, “Australian Medical Workforce in Australia – Supply and Requirements 1997 – 2008”. It projected a requirement for an increase in graduates from 16 in 1998 to 24-26 graduates per year in 2008. This requirement was met and the number of graduates has continued to rise (refer Table 6.1).

The implications of this higher than anticipated output from the training program are addressed in the recent workforce survey.

**Shortage of Anaesthetic and Medical Training Positions for College Trainees**

An ongoing issue related to Trainee selection (raised in the previous report to the AMC in 2007) is the lack of anaesthesia and internal medicine experience available to intensive care Trainees. Depending upon their experience and background, Trainees may have difficulty in securing these posts as they must compete with ANZCA or RACP trainees. A common scenario is for a Trainee to leave the required year of internal medicine training until the end of their program. They are then a senior Trainee, who may even have achieved Fellowship in another specialty, competing against the Trainees of the RACP for what may be a junior registrar position. Similar problems occur with the anaesthesia term. Historically it has been left for the Trainee’s Supervisor to negotiate with the relevant department within the training hospital. The Censor and SOT may also work together to resolve the issue at an individual level, particularly since ANZCA and RACP Trainees receive essential and valued training in ICU Departments.

To address this issue the Board has amended the training requirements so that training may be undertaken in non-accredited positions. Generally, the framework for approval of training posts is flexible and is dependent upon the training and experience of the individual Trainee.

The College has supported applications to secure funding for additional training positions for intensive care Trainees in private hospitals, particularly anaesthetic training, through the expanded settings for specialist training program (STP). In the 2010 round of funding, six positions supported by the College were granted funding for 2011.
### Appeals

The College is not aware of, and has not recorded any appeals lodged by Trainees regarding specific selection into a training position. In the first instance, the appeals process of the employing authority would be applied.

#### 7.2 Trainee participation in training organisation governance

<table>
<thead>
<tr>
<th>AMC accreditation standard</th>
</tr>
</thead>
<tbody>
<tr>
<td>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.</td>
</tr>
</tbody>
</table>

### The Trainee Committee

In 2004, a Trainee Committee was established. Terms of reference are attached as Appendix 5. The general purpose of the Committee is to represent Trainee interests and contribute to matters concerning education and training. The Trainee Committee meets by teleconference three times per year prior to the Education Committee meeting.

The Committee comprises a representative from each region of Australia and from New Zealand. If more than one Trainee is nominated from a region, an election is held among all Trainees within that region or New Zealand to decide upon a representative. Trainees are required to have registered for training for at least two years, or be an Advanced Trainee, before being eligible for nomination. Once elected, they are eligible to serve for up to three years, provided they remain a Trainee.

The Trainee Committee is chaired by the New Fellows Representative on the Board, who currently represents the interests of Trainees at Board Meetings, and also supports and encourages activities by the Trainees. The New Fellows representative is a full voting member of the Board. The Administrative Officer (Education) also provides assistance to the Committee as required. The Chair of the Trainee Committee, i.e. the New Fellows Representative, also sits on the Education Committee to represent the interests of Trainees and to ensure efficient communication to the Trainee Committee on specific educational issues.

Normally each representative on the Trainee Committee also takes the role of the Trainee representative on each Regional Committee and the New Zealand National Committee.

### Engagement of Trainees

Some ways in which Trainees have been and are engaged include:

- A survey of Trainees undertaken in 2004 which required Trainees to rate their satisfaction with aspects of training and suggest improvements.
• The establishment of an Annual Scientific Meeting in 2005 has increased the ability for Trainees to meet and share experiences.
• Seeking opinions of Trainees as part of the Hospital Accreditation review process. Trainees are assured of confidentiality and are encouraged to comment on all aspects of their training.
• Trainee forums at CICM and ANZICS ASMs, chaired by the New Fellows Representative.

The Board has recently decided to award a ‘President’s Medal’ to the Trainee judged to have made the best contribution to the College.

**Trainee Involvement as Part of the Strategic Plan**

Because of the diversity of Trainee origins and their changing terms, some difficulty has been experienced in engaging the Trainee Committee, although this has markedly improved since the new College was formed. One of the reasons for this is that intensive care Trainees often register late in the training program, and have a great deal to complete during their Advanced Training years. Hence they often have less time to focus on College affairs, than Trainees of other colleges. The College has endeavoured to encourage and facilitate interest by ongoing initiatives for involvement eg. blogs and regional networks.

In November 2010, the Board resolved to co-opt a Trainee to the Board as an invited Observer, as well as to the Hospital Accreditation and Education Committees, and hospital accreditation review teams.

The Training Agreement (Document T-2, Appendix 33) identifies the Trainee’s rights and responsibilities.

**7.3 Communication with trainees**

<table>
<thead>
<tr>
<th>AMC accreditation standards</th>
</tr>
</thead>
<tbody>
<tr>
<td>7.3.1 The training organisation has mechanisms to inform trainees about the activities of its decision-making committees, in addition to communication by the trainee organisation or trainee representatives.</td>
</tr>
<tr>
<td>7.3.2 The training organisation provides clear and easily accessible information about the training program, costs and requirements, and any proposed changes.</td>
</tr>
<tr>
<td>7.3.3 The training organisation provides timely and correct information to trainees about their training status to facilitate their progress through training requirements.</td>
</tr>
</tbody>
</table>

The New Fellows representative on the Board contacts all Trainees by email prior to the Board meeting to ask for any particular issues they would like to have raised or discussed by the Board. The results of the Board deliberations on the issue are fed back in an individual reply to the Trainee from the New Fellows Representative.
There is a dedicated area in the regular newsletter to Fellows and Trainees, which particularly addresses issues of special interest to Trainees. This and the College website are the primary channels for communication with Trainees. The Board has approved a proposal to increase opportunities for Trainees to discuss various topics (eg. College website, online forums). Feedback on the value of such communication is via the Trainee Committee. All Trainees have access to the Trainee representative in their region, who also sits on Regional Committees and the New Zealand National Committee.

Following each Board meeting a report is circulated to Supervisors and Trainees highlighting important changes in training, as well as general news regarding the College. Any significant changes that will affect Trainees and their programs are notified well in advance. Changes in the Regulations generally apply only to newly registering Trainees.

Feedback from Trainees can be:

- to the Censor via the Training Department, usually regarding individual training problems;
- to the Board and Education Committee, through the Trainee Committee;
- to the Regional Committees and New Zealand National Committee;
- at workshops / training courses held throughout the year;
- from Supervisors of Training;
- from Surveys conducted periodically;
- to the New Fellows Conference;
- through membership of the Board, Hospital Accreditation and Education Committees, and
- during site visits.

Decisions of the Censor regarding prospective or retrospective approval of training are communicated formally to Trainees by mail, and copied to the Supervisor if necessary. A new training database is under development and it is intended to enable Trainees to access their training records online.

The College has produced a careers booklet for prospective Trainees (Appendix 31) that is currently under revision. This and other resources are used at regional medical careers conferences which are held annually and representatives of the Regional Committees attend the booths and are available to explain aspects of training.

Trainee feedback has impacted on policy change in at least two areas. One is the introduction of rural rotations, and another is the amendment of the policy referring to the anaesthesia component of training so that training could be undertaken in non-accredited posts.
7.4 Resolution of training problems and disputes

AMC accreditation standards

7.4.1 The training organisation has processes to address confidentially problems with training supervision and requirements.

7.4.2 The training organisation has clear impartial pathways for timely resolution of training-related disputes between trainees and supervisors or trainees and the organisation.

7.4.3 The training organisation has reconsideration, review and appeals processes that allow trainees to seek impartial review of training-related decisions, and makes its appeals policies publicly available.

7.4.4 The training organisation has a process for evaluating de-identified appeals and complaints to determine if there is a systems problem.

The College developed a specific process for dealing with disputes and resolution of training issues in 2009. This is outlined in Documents T-13 ‘Guidelines for Assisting Trainees with Difficulties’ (Appendix 45) and T-14 ‘Trainee Performance Review’ (Appendix 46).

Document T-13 details the processes to be followed at a hospital level, including initial steps, remedial learning, advice and counselling, how unsatisfactory progress is handled and disciplinary action. Depending upon the issue, this may involve the College Censor.

Document T-14 details a process whereby the performance of a Trainee may require an independent review but can also be used for issues the Trainee may have with the training environment, or Supervisor, and is seen as an independent review of training.

The process may commence when local measures have failed to resolve the problems. A report prepared by the Supervisor or Trainee is considered by the Censor. An independent review team will be established, interviews conducted, with a report being considered by the Education Committee and ultimately by the Board. If the matter is not satisfactorily resolved a further avenue exists as outlined in Regulation 12 and 13 of the Regulations, pertaining to the Review, Reconsideration and Appeals Process.
8 Implementing the training program – delivery of educational resources

8.1 Supervisors, assessors, trainers and mentors

AMC accreditation standards

8.1.1 The training organisation has defined the responsibilities of hospital and community practitioners who contribute to the delivery of the training program and the responsibilities of the training organisation to these practitioners.

8.1.2 The training organisation has processes for selecting supervisors who have demonstrated appropriate capability for this role. It facilitates the training of supervisors and trainers.

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.

8.1.4 The training organisation has processes for selecting assessors in written, oral and performance-based assessments who have demonstrated relevant capabilities.

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 Role of the Hospital in Delivering the CICM Training Program

Intensive Care Medicine is a hospital-based specialty, and the College delivers its education and supervision through the Supervisor of Training (SOT) attached to each accredited Intensive Care Unit. There are 109 accredited units; Australia (83), New Zealand (12), Hong Kong (7) and other overseas countries (7). Eight of these units are in rural centres, 15 in private hospitals and 13 are accredited only for Basic Training. Each unit must have one or more dedicated SOTs.

The College is acutely aware that clinicians make significant contributions to medical education as examiners, mentors, teachers and role models for doctors in training. The College understands that the roles of supervisor, assessor, trainer and mentor are critical to the success of its training program, especially given the apprenticeship nature of ICU specialist training. The College believes that it is essential that there is adequate training and resources for these roles.

The College has defined the responsibilities of the intensive care specialists who contribute to the delivery of the training program in specific policy documents that are freely available and distributed in printed form to SOTs and their line managers. Conversely the training department and employer have responsibilities to these intensive care specialists, who provide many hours of supervision and mentoring. These obligations are communicated to employers at the time of routine accreditation visits, and evidence of support for SOTs is sought. ICUs are reviewed for appropriate office space, and teaching and mentoring facilities. Rosters and staff numbers are audited to ensure appropriate non-clinical time is available for the completion of SOT duties. These requirements are stated in the
Regulations.

An SOT, who has overall responsibility for training in a large ICU department, cannot normally be involved on a day-to-day basis with all Trainees in the work environment. The nature of ICU clinical work as a team-based specialty of many disciplines means that from day to day the Trainee is usually in contact with many and varied team members and supervised by one intensive care specialist, the trainer. Whilst a Trainee is likely to be involved with a number of specialists during a single term, the SOT usually designates the specialist who has frequent involvement with the Trainee during the week to have particular responsibility for appropriate hands-on supervision and training of an individual Trainee. Thus that specialist usually provides feedback to the SOT on the Trainee’s performance. In order to provide a balanced assessment it is recommended that a 360-degree assessment is performed by other members of the multidisciplinary team including other specialists, nurses, social workers, physiotherapists and administrative staff.

Guidelines for the SOT are set out in Document T-10 ‘The Role of Supervisors in Training of Intensive Care Medicine’ (Appendix 42). This document outlines:

- duties and responsibilities of the SOT;
- support to be provided for the SOT by the hospital;
- processes for appointment of the SOT;
- the relationships of the SOT with the Trainees and the College, and
- the continuing professional development of the SOT.

Information is also detailed in Document IC-2 ‘Intensive Care Specialist Practice in Hospitals Accredited for Training in Intensive Care Medicine’ (Appendix 16) and Document IC-4 ‘The Supervision of Vocational Trainees in Intensive Care Medicine’ (Appendix 18).

During the Anaesthesia and Internal Medicine terms the Trainees are supervised by specialists in those fields and the aims of those terms are set out in Documents T-7 ‘Aims of the Medical Term’ and T-8 ‘Aims of the Anaesthesia Term’ (Appendices 39 and 40). The In-Training Assessment forms are completed by the supervising specialist.

Appointment and Role of Supervisors of Training

The College has a defined process for selecting and appointing Fellows who have demonstrated appropriate capability for the SOT role, and it facilitates the training of these supervisors. The SOT selection and appointment process is set out in Document T-10 which lists the qualifications and experience required of the SOT and the steps that should be taken to ensure that the SOT is the appropriate person for the role.

The SOT is nominated by the Director of Intensive Care. The Director is then responsible for notifying the Board of the recommendation in a letter with the proposed SOT’s Curriculum Vitae and a description of their qualities and abilities relevant to the role. The Education Committee reviews the references and curriculum vitae of the individual and makes a recommendation to the Board. The SOT is then appointed by the Board and both the Director and Hospital Administration are advised of the appointment.

Large ICU Departments, which may have 35 to 50 ICU beds and many Trainees, have
recently been encouraged to appoint co-supervisors, such as the combination of a very senior specialist and more junior specialist, to provide the blend of experience and youth. This change has been supported by the Hospital Accreditation Committee, the Education Committee and the Board.

The SOT (or SOTs) receives a folder of guides and information (Supervisor of Training Support Kit, Appendix 43) and is required to attend an initial workshop and then regular workshops for professional development in the roles of mentor, supervisor and educator. A new format for SOT workshops will be introduced in 2011.

Evaluation of SOTs and Other Teaching Staff

The College routinely evaluates supervisor and teacher effectiveness by formally seeking feedback from Trainees during interviews at hospital accreditation reviews. All available Trainees at each ICU are interviewed specifically about the quality of the supervision, the quantity and quality of the internal teaching program and the content (refer ‘Guide for College Accreditation Team’, Appendix 65). The College expects SOTs to participate in the MOPS program and attend regular workshops on specific topics relevant to teachers, trainers and mentors. At the workshops the College offers guidance in the professional development of SOTs.

Accredited ICUs undergo an accreditation review routinely every seven years, or ad hoc reviews are performed if the hospital requests a change in accreditation status or if the hospital, ICU Director or SOT notifies the College of any problems or major changes to the training environment. At the visit the reviewers focus on receiving feedback from the SOT and the Trainees about all matters relating to the training, supervision and education of the Trainees. The Trainees may be interviewed individually at this time or as a group depending on the circumstances.

Appointment, Training and Duties of Examiners

The College has processes for selecting assessors in written, oral and performance-based assessments who have demonstrated relevant capabilities. These processes are set out in Document Ex-4 ‘Guidelines for Appointment, Training and Duties of Examiners’ (Appendix 53).

Any Fellow of the College may nominate or be nominated as an Examiner of the College and from time to time the Chairman of the Examinations Committee may approach outstanding professionals from other Colleges and ask them to nominate to fill a vacancy.

Examiners are appointed for three years and may be reappointed for a total of no more than 12 years. The number of Examiners on the Panel is limited, so that the examiners can maintain their skills by frequent attendance at the Examination.

Nominations are addressed to the Training and Examinations Co-ordinator, who refers them to the Examinations Committee. All nominations include a full curriculum vitae and letters of recommendation from two referees, one from the applicant’s hospital and the second from an inter-state referee or from an examiner of more than five years standing. The reference has to clearly indicate why the nominee will be a useful member of the Examiners Panel, based on the criteria set out in Document Ex-4 (Appendix 53). The
Chairman of the Examination Committee may seek two further written references from Fellows who have knowledge of the nominee.

The Examinations Committee will make a recommendation to the Board concerning appointment, based on specific criteria. An Examiner must:

- Be at least five years post-Fellowship of CICM and have evidence of current MOPS certification.
- Be actively involved in teaching and training postgraduate intensive care Trainees. This may include running or active participation in examination preparation courses, active involvement in departmental educational activity, or conduct of regular tutorials or bedside teaching.
- Be clinically involved in the practice of intensive care medicine for a significant proportion of the working week (0.5 FTE or more).
- Be clinically competent and of high professional standing.
- Possess a suitable personality to examine without bias.
- Be a fair interrogator and skilled evaluator who is able to create an environment in which the candidate has the opportunity to perform to potential. The examiners should be capable of allowing consideration of alternative viewpoints regarding patient care and management.
- Be willing to be actively involved in the examination process including marking, setting, examining and reviewing results.
- Be familiar with the curriculum.
- Have an understanding of and experience in research.

Evaluation of Assessors and Examiners

The College has established processes to evaluate the effectiveness of its assessors and examiners. These include:

- Detailed statistical analysis of examination results to evaluate consistency of assessment.
- Mock examinations assessment of examiners.
- Use of examiner assessors.
- Use of calibration videos for examiner panels.

Feedback from General Fellowship Examination candidates is sought via a questionnaire (refer Appendix 58). The Examiner Assessor, present at most examinations, critically evaluates examiner performance.

Before commencing, an Examiner is expected to:

- Observe all components of the oral examination.
- Submit 10 short answer questions for review.
- Attend a workshop on the examination explaining the format, objectives and style and for calibration procedures.

On commencement of examining, the Examiner is expected to:
• Mark a section of the written paper with the assistance of a senior examiner (defined as one who has completed five years of examining).
• Go through a process of shadow marking candidates for the clinical component of the examination and discuss the marking with the examiner supervisor.

8.2 Clinical and other educational resources

<table>
<thead>
<tr>
<th>AMC accreditation standards</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>8.2.1</strong> The training organisation has a process and criteria to select and recognise hospitals, sites and posts for training purposes. The accreditation standards of the training organisation are publicly available.</td>
</tr>
<tr>
<td><strong>8.2.2</strong> The training organisation specifies the clinical and/or other practical experience, infrastructure and educational support required of an accredited hospital/training position in terms of the outcomes for the training program. It implements clear processes to assess the quality and appropriateness of the experience and support offered to determine if these requirements are met.</td>
</tr>
<tr>
<td><strong>8.2.3</strong> The training organisation’s accreditation requirements cover: orientation, clinical and/or other experience, appropriate supervision, structured educational programs, educational and infrastructure supports such as access to the internet, library, journals and other learning facilities, continuing medical education sessions accessible to the trainee, dedicated time for teaching and training and opportunities for informal teaching and training in the work environment.</td>
</tr>
<tr>
<td><strong>8.2.4</strong> The training organisation works with the health services to ensure that the capacity of the health care system is effectively used for service-based training, and that trainees can experience the breadth of the discipline. It uses an appropriate variety of clinical settings, patients and clinical problems for training purposes, while respecting service functions.</td>
</tr>
</tbody>
</table>

Process and Criteria for Accreditation of Training Sites

The College accredits Intensive Care Units for training rather than training posts. The College has a well-defined process and criteria to select and recognise ICUs for training purposes. The accreditation standards are publicly available on the College website and widely distributed and promulgated in hard copy form from the College. The data sheets that must be completed by the applying ICU/hospital are freely available. The process of hospital accreditation is overseen by the Hospital Accreditation Committee. The roles of this Committee include:

• Accreditation and review of training sites.
• Appointment of teams for accreditation visits.
• Collation and analysis of data obtained from accredited and prospective training sites.
• Review of documentation relating to accreditation.

The criteria for accreditation are set out in a number of publicly available policy
statements:

- ‘Minimum Standards for Intensive Care Units’ Document IC-1 (Appendix 15)
- ‘Guidelines for Intensive Care Units seeking Accreditation for Training in Intensive Care Medicine’ Document IC-3 (Appendix 17)
- ‘Recommendations on Standards for High Dependency Units Seeking Accreditation for Training in Intensive Care Medicine’ Document IC-13 (Appendix 28)
- ‘The Supervision of Vocational Trainees in Intensive Care Medicine’ Document IC-4 (Appendix 18)

Supplementary documents provide guidance in particular situations:

- ‘Minimum Criteria for Accreditation of Units for Basic Training’ (Appendix 63)
- ‘Accreditation of Units Overseas for Core Training’ (Appendix 64)
- ‘Guide for Hospitals Seeking Accreditation of Training’ (Appendix 62)
- ‘Guide for College Accreditation Team’ (Appendix 65)

The College specifies the clinical workload, infrastructure and educational support required of an accredited hospital/training ICU in terms of the experience, supervision and teaching that is available to the Trainees. The College implements a clear and rigorous process to assess the quality and appropriateness of the experience and support offered with routine and ad hoc accreditation reviews. The accreditation review team is made up of three members including an experienced reviewer who is a member of the Board from a State or region outside that of the hospital to be reviewed and two other reviewers who are members of the relevant National or Regional Committee, but not working at that hospital to be reviewed. The Board has also approved the appointment of a Trainee representative to Accreditation Teams. The accreditation visit is structured to cover all relevant areas of the clinical and teaching environment and is marked according to a comprehensive proforma (refer Hospital Accreditation Report Form, Appendix 66).

Requirement for Accreditation

The College’s accreditation requirements cover orientation, clinical exposure and experience, appropriate supervision at all times of day, quarantined and structured educational programs, educational and infrastructure supports such as access to the internet, library, journals and other learning facilities, continuing medical education sessions accessible to the Trainee, dedicated time for teaching and training, and opportunities for informal teaching and training in the ICU department. Opportunities must also exist for Trainees to undertake a research project.

Before an accreditation visit/review, the ICU must complete and submit a detailed proforma listing the hospital size and caseload, the ICU caseload, casemix, physical environment, training and teaching timetables, rosters, patient outcomes, support services and support personnel. The Hospital Accreditation Committee reviews this information and if criteria for accreditation are met, an accreditation review team is appointed and a date for the visit is set. A half-day is allocated for the visit and interviews are held with representatives of hospital administration, the ICU Director, the SOT, the ICU Specialists and trainees. The team reports on an extensive proforma to the Hospital Accreditation Committee which makes recommendations to the Board regarding accreditation.
At the time of writing, a comprehensive review of Document IC-3 is being undertaken.

Use of the Clinical Setting for Training

The College works with the national and regional health services to ensure that the capacity of the health care system is effectively used for service-based training, and that Trainees can experience the breadth of the discipline of intensive care medicine. Accredited units include all clinical settings, and include tertiary metropolitan, private, regional and rural hospital ICUs and provide a broad case mix for training purposes.

The accreditation process determines whether it is appropriate for the Trainee to spend 6, 12 or 24 months of their training in the unit in question and the unit is then classified as C6, C12 or C24 accordingly. In determining this classification the accreditation team, HAC and Board take into account all aspects of the training available using criteria that are transparent and publicly available.

Intensive Care Medicine is essentially a hospital-based specialty centred on adult, paediatric and mixed ICUs. The College Regulations, ensure that the trainee gains a broad experience. The caseload, casemix and patient outcomes of each ICU are assessed at the accreditation visits, ensuring that Trainees are exposed to sufficient numbers and diversity of critically ill patients.

The College has clear pathways for assessing prior training and a program for facilitating combined training with RACP, ANZCA and ACEM. The aims have been to train multi-skilled specialists for ICUs in Australia and New Zealand and to train specialists who will be able to move between ICU and emergency department or operating theatre – a situation of great value to rural and regional hospitals. The training requirements, allowances to shorten training and the assessment of prior learning are detailed in the Regulations.

Training in clinical settings outside hospitals (eg. retrieval or disaster services) is encouraged by the approval of elective training in the program. Training in private hospitals is approved in accredited hospitals in NSW, VIC, QLD, WA and SA. Training in doctors' rooms is not regarded as appropriate.

The College’s Trainees are encouraged to gain experience in many ICUs each providing a varying range of clinical exposure and experiences. The College has accredited ICUs in private hospitals, paediatric hospitals, regional centres and in smaller rural cities. It is prepared to accredit rotations or networks of training sites rather than single hospitals or other facilities and has a process of accreditation visits to ensure that the education, training and assessment at all sites satisfy the standards of the College.

Accreditation criteria apply equally to all training settings and are applied fairly under the guidance of the accreditation teams and the HAC.

A list of the Units/Training Sites accredited for training and their classification is attached as Appendix 67.
Table 8.1: Accreditation of Training Sites, 2006 – 2010

<table>
<thead>
<tr>
<th></th>
<th>Number of new applications received</th>
<th>Number of ICUs inspected</th>
<th>New applications approved</th>
<th>Total number of Accredited Units</th>
</tr>
</thead>
<tbody>
<tr>
<td>2006</td>
<td>16</td>
<td>14</td>
<td>14</td>
<td>77</td>
</tr>
<tr>
<td>2007</td>
<td>19</td>
<td>15</td>
<td>12</td>
<td>89</td>
</tr>
<tr>
<td>2008</td>
<td>14</td>
<td>14</td>
<td>10</td>
<td>99</td>
</tr>
<tr>
<td>2009</td>
<td>8</td>
<td>18</td>
<td>5</td>
<td>104</td>
</tr>
<tr>
<td>2010</td>
<td>9</td>
<td>13</td>
<td>5</td>
<td>109</td>
</tr>
</tbody>
</table>

Unscheduled Reviews

The College routinely reviews accredited training sites every seven years. Issues of compliance are identified and correspondence and follow-up visits are arranged to ensure the standards are being met. Document IC-3 requires that accredited units must notify the College of any changes that will affect training.

In the case of unscheduled reviews, issues are usually identified by regional or national committees or by the Supervisor of Training and reported to the Chair of the Hospital Accreditation Committee. Circumstances may involve a change in staffing or the educational program, or a reduction in available resources.

Specific examples of Hospital Accreditation Reports are available upon request.
9  Continuing professional development

9.1  Continuing professional development programs

AMC accreditation standards

9.1.1 The training organisation’s professional development programs are based on self-directed learning. The programs assist participants to maintain and 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.

9.1.2 The training organisation determines the formal structure of the CPD program in consultation with stakeholders, taking account of the requirements of relevant authorities such as medical boards.

9.1.3 The process and criteria for assessing and recognising CPD providers and/or the individual CPD activities are based on educational quality, the use of appropriate educational methods and resources, and take into consideration feedback from participants.

9.1.4 The training organisation documents the recognised CPD activities of participants in a systematic and transparent way, and monitors participation.

9.1.5 The training organisation has mechanisms to allow doctors who are not its fellows to access relevant continuing professional development and other educational opportunities.

9.1.6 The training organisation has processes to counsel fellows who do not participate in ongoing professional development programs.

Overview

The current continuing professional development program has been developed from the Maintenance of Professional Standards (MOPS) Program that was introduced by the Faculty of Intensive Care, ANZCA in 1996. It underwent a major revision in 2000 and has had a number of minor revisions since then, such as development of an on-line diary and on-line certificate and provision of a list of approved activities on the College website. A new CPD program is currently in development.

The principal objective of the MOPS program is to foster continuing scholarship and quality improvement in order to maintain a high standard of clinical practice. Thus the principal role is educational and the program validates continuous medical education (CME), quality assurance (QA), and other self-improvement educational activities.

The MOPS program credits points according to the educational activities that are undertaken. Activities are varied and the program offers flexibility and diversity in crediting educational activities to meet the varied needs of individual participants, especially those in rural and private practice. Participants must obtain at least 50 points for CME/TTR (Continuing Medical Education/Training, Teaching and Research) activities and
25 points for QA (Quality Assurance) activities every year. Apart from this requirement, the program is not points driven and is based on self-directed learning.

Activities are recorded in a diary or log book and areas that are deficient can be self-targeted for improvement. Participants are required to submit an annual return of their activities from 1 January to 31 December of each year. Returns can be submitted by paper forms or via the web. Upon receipt of their Annual Return, Participants are issued with a Statement of Participation for the past year.

The College encourages all Fellows to participate. Non-Fellows may do so at a fee determined by the Board. There are no differences in policy or procedures for Fellows and non-Fellows. Because of the new National Registration system, from 2011 it will be compulsory for all specialists to take part in the appropriate College MOPS program to renew medical registration.

Developments in the Program in Response to External Changes in Service Delivery or Models of Care

Delivery of specialist intensive care medicine services and models of care for critically ill patients in Australia and New Zealand have been relatively constant over the past ten years or so. There have, however, been some subtle changes.

Intensive Care Units have become larger and staff are now more involved in activities outside the ICU than in the past. There has consequently been a requirement for expanding the numbers of intensive care specialists in individual hospitals and having multiple medical teams working concurrently. Intensive care specialists are increasingly becoming involved in resuscitations in the general wards of the hospital. The MOPS program has addressed these issues by accrediting courses in communication and team work, and also in resuscitation skills such as the Advanced Life Support Course (run in conjunction with the Australian Resuscitation Council) in a number of teaching Hospitals.

Some relatively new practical and procedural skills have become integrated into intensive care practice in recent times. These include use of the fibre optic bronchoscope and laryngoscope, 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 MOPS program. Further, emergence of new diseases such as Severe Acute Respiratory Syndrome (SARS) and swine flu (H1N1) requires advanced mechanical ventilation as well as the aforementioned skills. These also are addressed in the program, for example an advanced mechanical ventilation course is run by Fellows of the College at the Alfred Hospital Melbourne and accredited prospectively by the College for its MOPS program.

The major Continuing Medical Education activity run by the College is 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.
Evaluation of the MOPS Program Including Cycle for Review, the Criteria and Process

Previous evaluation and the resultant changes are summarized as follows:

- Following audits undertaken in 2004 and 2005, the participation of Supervisors of Training, Examiners and Board members in the Program became mandatory.
- In 2006, a further audit was undertaken, revealing that Fellows easily achieved the minimum requirements but were not documenting activities sufficiently in their returns. Articles were subsequently published via the Bulletin and electronic newsletters, in order to encourage proper participation.
- A survey was conducted in the same year, revealing:
  - 383 (73.5%) of the 521 Fellows participating in 2005 were members of the MOPS Program with 150 (39.1%) submitting returns that year.
  - 390 (72%) of the 540 Fellows in 2006 were members of the MOPS Program with 140 (36%) submitting returns that year.
- In 2008, an updated list of pre-approved meetings and activities was distributed. A system for streamlining accumulation of points was proposed and the first steps towards developing a revised CPD Program were supported by the Board. JFICM representatives participated in the ANZCA CPD Review and information was sought from the RACP.
- The College is now investigating a new IT platform on which to run the new CICM CPD program.

Resources

The College has established the Fellowship Affairs Committee that oversees general aspects of the MOPS program, such as its development and evaluation, and matters relevant to Fellows such as welfare, safe hours, credentialing and certification. The program is managed by a designated member of the College staff. Specific questions are directed to the MOPS Officer, a Board member who is responsible for maintaining a register of approved courses and activities.

The major College CME event, the ASM, is resourced from registration fees paid by participants and by industry sponsorship.

A number of courses are organised by Fellows using local resources. A first “Transition to Specialist Practice” course has been run by Fellows for new Fellows and may become a useful resource for senior Trainees preparing to apply for specialist positions.

The Impact of the Medical Board of Australia and Compulsory CPD

From July 1st 2010 the Health Practitioner Regulation National Law took effect requiring medical practitioners who are involved in any form of medical practice to participate regularly in CPD that is relevant to their scope of practice. This is required to develop, update and enhance the specialist’s knowledge, skills and performance to ensure that care is delivered appropriately and safely.

The Medical Board of Australia (MBA) requires CPD programs to include a range of activities to meet individual learning needs including practice based reflective elements,
such as clinical audit, peer review or performance appraisal, as well as participation in activities to enhance knowledge such as courses, conferences and on-line learning.

The College substantially follows the structures and requirements set out in Medical Board of Australia: Continuing Professional Development Registration Standard (1st July, 2010). CPD programs accredited by the AMC meet requirements of the MBA. An open letter to Fellows has been posted on the College website explaining that major changes are coming in 2011 due to the formation of the MBA and compulsory CPD; that there will be a transition from MOPS to CPD and that they will be consulted.

The College will continue to provide the program to non-Fellows who work in intensive care medicine.

Process and Criteria for Assessing and Recognising CPD Providers and/or Individual CPD Activities

Some educational activities are automatically recognised for the MOPS program and no approval from the MOPS Officer is required, providing the appropriate documentation is submitted. The MOPS Officer is a Member of the CICM Board who has been elected/appointed to the MOPS portfolio and who oversees all MOPS activities. Records are expected to be kept and random audits are undertaken.

Appropriate activities include:

1. Annual Scientific Meetings of internationally recognised Intensive Care Medicine Organisations. Examples include the College ASM, ANZICS ASM, Regional College and ANZICS meetings, European Society of Intensive Care Medicine meetings, Society of Critical Care Medicine Annual Meetings.

2. Annual Scientific Meetings of other Colleges relevant to intensive care medicine. Examples include ANZCA, RACP.

3. Local Continuing Medical Education Meetings. Examples include Hospital Grand Rounds, Department Educational Meetings and Seminars. (These are only recognised if there are attendance records, minutes or certificates that document the presence of the Fellow.)

4. Self-Directed Learning. Examples include self assessment programs, reading journals and books, listening and watching relevant audio and videotapes.

5. Continuing Medical Education Committee Work. Examples include planning CME activities as part of a formal committee of a hospital or professional organization.

6. Preapproved Courses. Examples include EMST, ATLS, APLS, ADAPT, CcRISP.

7. Remote Group Learning Activities organised by the College or ANZICS.

8. All Quality Assurance Activities.

A full summary of the current program framework is detailed at Appendix 68.

All other activities are evaluated by the MOPS Officer for relevance to the enhancement of the participant’s intensive care practice using the following principles and criteria:

- Relevance of learning objectives of the activity to the clinical, administrative or managerial practice of intensive care medicine.
- 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.
- Time spent completing the activity.

Based on the degree of compliance with each of these criteria, activities are rated and credited appropriately. For example, learning projects are rated as Category 1-4 activities, with the highest category accruing the highest number of credits. Educational activities that have components of situated and experiential learning, or robust reflective and assessment components are credited advantageously.

Specific learning projects are encouraged and participants may pursue projects in areas of interest in a structured and systematic manner. The projects should be learner-initiated and planned and must have educational objectives.

The College is constantly assessing new courses and relevant material for accreditation of MOPS points.

**Participation Rates**

**Table 9.1: Participation rates of Fellows, 2005 – 2010**

<table>
<thead>
<tr>
<th></th>
<th>Total Number of Fellows</th>
<th>Number of Fellows submitting returns in that year</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>2005</td>
<td>521</td>
<td>150</td>
<td>28</td>
</tr>
<tr>
<td>2006</td>
<td>540</td>
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<td>2007</td>
<td>613</td>
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<td>2008</td>
<td>630</td>
<td>126</td>
<td>20</td>
</tr>
<tr>
<td>2009</td>
<td>688</td>
<td>152</td>
<td>22</td>
</tr>
</tbody>
</table>
Table 9.2: Participation rates of Non-Fellows, 2005 – 2010

<table>
<thead>
<tr>
<th>Year</th>
<th>Number of non-Fellows</th>
</tr>
</thead>
<tbody>
<tr>
<td>2005</td>
<td>5</td>
</tr>
<tr>
<td>2006</td>
<td>4</td>
</tr>
<tr>
<td>2007</td>
<td>4</td>
</tr>
<tr>
<td>2008</td>
<td>5</td>
</tr>
<tr>
<td>2009</td>
<td>4</td>
</tr>
</tbody>
</table>

*Note data for 2010 unavailable at time of printing

Policy on Auditing Participants MOPS Records and Returns

Each year, random reviews are undertaken on up to 5% of participants to verify the accuracy of returns and the relevance of activities claimed in individual programs. Participants are advised that documentation related to MOPS activities - such as meeting programs, agendas, timetables, reports, invitations and publications - for the current and previous year’s activities should be kept on file with the MOPS Diary. A participant who has successfully completed a random review will not be liable for another review for the subsequent five years.

Requirements for more Formal Assessment of Ongoing Competence and Performance of Fellows

Where a Fellow finds it impossible to participate in the MOPS program (eg. 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-day review of a participant’s practice, on-site in the intensive care unit, by a peer nominated by the Regional/National Committee and endorsed by the MOPS Officer. For participants who work at the same institution, up to two participants can be reviewed by the peer on that day. When the visit has been completed and PPR is approved, the participant will be awarded 25 points for CME and 50 points for QA.

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 who will be entitled to claim 30 QA points.

Despite the availability of this form of assessment, the College has received only one enquiry to date and no Fellow has requested a PPR. Consequently the College has no data to support its validity or reliability.
Strengths and Challenges Facing the College

Strengths of the current program include flexibility, simplicity and the ability to target specific areas of interest. The introduction of a new CPD program is a major challenge for the College. Developing appropriate IT solutions and a system for accreditation of providers are important initiatives.

The New Continuing Professional Development Program

The College is developing a new CPD Program to be implemented in January 2012. This new program will bring the College into line with other Colleges and the LEAP Framework that is recommended by the CPMC.

The philosophy behind the new program is similar to the current MOPS program, the aim being to foster ongoing learning of all intensive care specialists, both Fellows and Non-Fellows, in order to improve their clinical practice. The new CPD program will be compulsory for all Fellows.

A taskforce involving Fellows and College staff is working under the supervision of the Fellowship Affairs Committee to develop the new program. Advice and information has been sought from a variety of sources including other medical colleges. The new CPD program will have a different framework, with improved educational features. Continued technical improvements will be designed to enhance the working interface for Fellows. Several initiatives to improve the access to educational material are in the development stage, with some having been introduced on a trial basis.

Features of the New Program

- The cycle will move from one to two years, with the first cycle beginning January 2012 and ending in December 2013.
- Reflective and evaluative processes have been incorporated as compulsory activities.
- Opportunities for the inclusion of activities relating to QA, medical professionalism (including cultural awareness), and patient safety as well as appropriate Personal Advancement are specifically enhanced and as a group form a compulsory activity.
- The process for assessing and recognizing CPD providers will not change. However, accreditation of providers will be for a fixed term, followed by re-application, to ensure a high standard is maintained.
- A simpler and more user-friendly online diary is being developed. An online certificate will be available, along with a list of all accredited courses and events with automatic diary accreditation. A paper diary will also be available on the College website and in hard copy.
- Processes to enable automatic credits for College run activities and hospital meetings will be available.
- The CPD Webpage and e-news bulletins will feature a list of all accredited courses and promote current courses to participants.
- The existing system of random reviews (of up to 5% of participants) will be retained, however, those participants who complete a random review will not be exempt from any future reviews.
• Non Fellow participants will have full access to the online diary and statements of participation provided yearly for an annual fee.
• The program will be the same for both Fellows and Non-Fellows, requirements and minimum standards will be equivalent.
• As the program will be compulsory, there will be steps made to ensure Fellows are participating. Those who have not entered any activities in the online diary mid way through the cycle will be sent reminders. Those who have not entered any activities for a full cycle will be contacted, initially by the College staff, and then the CPD Officer to discuss reasons for non-participation.

The key components and framework of the College’s new CPD program is attached as Appendix 69.

9.2 Retraining

AMC accreditation standard

9.2.1 The training organisation has processes to respond to requests for retraining of its fellows who have been absent from practice for a period of time.

Document IC-15 ‘Recommendations on Practice Re-entry for an Intensive Care Specialist’ (refer Appendix 30) outlines the process whereby the College responds to requests for retraining of its Fellows who have been absent from practice for a period of time.

In brief, the program requires supervised experience in an Intensive Care Unit for a period appropriate for the participant’s circumstances. In general this is at least four weeks for every year of absence from intensive care clinical practice. The specialist submits an individual program that must be approved prospectively by the Censor. The program submitted must include the department, details of the clinical experience and endorsement of the program by the ICU Director. A Supervisor should be appointed who is authorised to provide progress reports to the College.

On completion of the program, the Supervisor confirms in writing that the participant has satisfactorily completed the program.

This process is distinct from the Professional Practice review component of the Maintenance of Professional Standards program, and is also distinct from any process involving assessment of a specialist’s practice at the request of a medical Board, Council or Health Authority.
9.3 Remediation

AMC accreditation standard

9.3.1 The training organisation has processes to respond to requests for remediation of its fellows who have been identified as underperforming in a particular area.

At present the College does not have a remediation process, but acknowledges that the development of a clear and manageable process for remediation will be required as recertification through national registration develops. Resourcing and developing a remediation process will form part of the College’s strategic plan into the future.