The Australian and New Zealand College of Anaesthetists Specialist Training Program (STP) Evaluation Report

Dr Jo Burnand
Executive summary

The Specialist Training Program (STP) has led to the development and expansion of anaesthetic training in Australia beyond the traditional metropolitan tertiary hospital to include a range of settings in metropolitan and regional private hospitals, (some with a public/private mix), in addition to regional (RA2-5)\(^1\) public hospitals.

The Australian and New Zealand College of Anaesthetists (ANZCA) commissioned this review to explore the question of whether setting impacts on the quality of training in addition to identifying any issues with regards to the STP posts.

A consistent finding of this evaluation is the high level of support for STP posts and training in expanded settings in making a valuable contribution to current anaesthetic training. Both trainees and consultants expressed the view that training in expanded settings provides a valuable adjunct to traditional tertiary teaching hospital experience.

There were differences in trainee and consultants’ perceptions of training in regional public and regional and metropolitan private hospitals. Table 1 provides a summary of characteristics, identified through the consultation process, that appear to contribute to a successful STP post.

Trainees in public regional settings highly valued the ‘bread and butter’\(^2\) experience gained in regional public hospitals and the opportunity to learn and consolidate basic anaesthetic skills in the context of a supportive and well-supervised training environment.

Supervisors of Training (SOT) and Heads of Department (HOD) value having trainees attached to their regional hospital departments and highlighted the benefits of supervisors retaining currency of training requirements, particularly in basic sciences as they support and supervise trainees preparing for the primary exam. Supervisors noted however that shorter rotations resulted in a churn of junior trainees requiring Level 1 or 2 supervision and this created an additional burden on regional departments with smaller numbers of consultants.

Experiences in the private sector were far less homogenous with different views expressed by both consultants and trainees in relation to: the structure and nature of the post; attitudes of consultants; level of supervision and clinical autonomy; exposure to private anaesthetic practice; and opportunities to perform procedures.

Whilst the majority of trainees and consultants reported that the private sector provides valuable training opportunities, it is clear that further structure and support of private STP posts is required in order to optimise their training capacity.

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2. Core competencies
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<tr>
<td>All settings</td>
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<td>Clinical champion</td>
<td>Either a Supervisor of Training or Head of Department who promotes ANZCA training within the facility – this is particularly critical for the private hospital setting</td>
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<td>Length of rotation 6/12 or longer</td>
<td>Whilst rotations of 3/12 or less were sometimes seen as useful from both the perspective of the trainee and consultants, rotations of longer duration were preferred in allowing for skills consolidation, and at the same time reducing the churn of trainees (particularly junior trainees who require Level 1 supervision) on senior staff</td>
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<td>Prior experience with medical training/trainees</td>
<td>The facility (or consultants through concurrent or previous appointments) has prior experience with vocational training programs or medical students</td>
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<td>Private hospital setting</td>
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<tr>
<td>Co-location with public hospital</td>
<td>Rotations co-located with the public hospital tended to have integrated terms, where small cohorts of (usually) senior trainees each spend one or two days per week working in the private setting, usually with consultants who have appointments across both facilities (and were therefore known to the trainees). This model also enables trainees to attend teaching in the public hospital setting in addition to continuing involvement with the whole trainee cohort (including participation in study groups and so forth)</td>
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<td>Casemix</td>
<td>Enabling Volume of Practice (VOP) requirements to be met, and in some cases, providing trainees with exposure to subspecialty areas that may not be available through other rotations within the training network (for example in cardiothoracic and neurosurgery)</td>
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<td>Regional/rural public hospital setting</td>
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<td>Planned timing of rotation</td>
<td>Either during basic training (to optimise procedural skills acquisition) or late in advanced training (consolidation of skills in managing cases/lists with minimal supervision)</td>
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<td>Adequate training infrastructure</td>
<td>Particularly with respect to IT infrastructure to enable the trainee to access web-based training and continue to participate in study groups or teaching sessions whilst on rotation</td>
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Recommendations

1. Support for STP posts in making a significant and valuable contribution to anaesthetic training in Australia should continue.

2. The College gives consideration to the development of additional resources (including online resources) to support consultants in supervising trainees working in rural and regional facilities.

3. The College works with key stakeholders through advocacy and accreditation mechanisms to improve infrastructure (including IT resources) for training in regional sites (in both private and public hospitals) with the aim of facilitating continuity of participation by trainees in study groups and formal education programs.

4. The College supports rural STP sites giving consideration to the stage in training (both basic and advanced) for trainees in terms of experience of casemix and acuity across settings.

5. Information regarding Rural Support Loading funding is clearly communicated to all key stakeholders, including SOTs at eligible regional/rural locations.

6. Consideration be given to the structure of STP posts in private hospitals to ensure that there are explicit arrangements made for the allocation of basic and advanced trainees to lists.

7. Further strategies are explored with the aim of optimising the engagement of consultant staff within private facilities in the training of anaesthetic trainees.
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Introduction

Background

The Australian and New Zealand College of Anaesthetists (ANZCA) is the professional organisation for approximately 5000 specialist anaesthetists (Fellows) and 2000 anaesthetists in training. ANZCA is responsible for the training, examination and specialist accreditation of anaesthetist and pain medicine specialists and for setting the standards of clinical practice in anaesthesia within Australia and New Zealand.

Anaesthetic training must be undertaken in hospitals and other facilities accredited by ANZCA for anaesthetic training. To this end, ANZCA accredits training sites using the accreditation standards which articulate the requirements of training provided across the following seven domains: quality patient care; clinical experience; supervision; supervisory roles and assessment; education and teaching; facilities; and clinical governance.

Whilst traditionally, specialist training in anaesthesia, like other postgraduate medical training programs has been delivered primarily within the public teaching hospital system, the emergence of a number of key factors has impacted on the sustainability of historical models. These include meeting the challenges of accommodating increased numbers of medical graduates in the context of increased demand on both health services and the senior medical staff who provide the training and supervision of trainees.

The response to these challenges called for an exploration of non-traditional training settings particularly within the private sector and regional/rural public facilities, which until recently were largely underutilised in terms of provision of postgraduate medical training. The expansion of medical training settings has been strongly encouraged through a federal government initiative, the Specialist Training Program (STP).

In January 2010, the STP became the single platform for Commonwealth grants support for specialist training initiatives. The two main aims of the programme are to:

i. Enhance workforce distribution by providing specialist registrars with training opportunities in rural areas and areas of workforce shortage; and
ii. Increase specialist training capacity and quality by providing educational opportunities in settings where registrars will work once they obtain Fellowship, such as private hospitals, specialists’ rooms and community health settings.\(^1\)

The STP funding provides a salary contribution of $100,000 for training positions per FTE per year. Posts in rural locations may also be provided with Rural Support Loading, of up to $20,000 per FTE per year. In addition to establishing specialist training posts, the STP also provides funds for a range of education support activities and infrastructure.

ANZCA became a signatory to the current program in November 2011 and has since expanded its STP FTE positions from 25 to 58 (as at September 2014). This includes oversight of STP training positions across the three disciplines of anaesthetics; pain medicine and intensive care medicine (the latter on behalf of the College of Intensive Care Medicine).

In 2012, ANZCA engaged a consultant to develop the framework for the evaluation of the STP, including support enhancement projects. The evaluation was intended to address key operational aspects of the program. The findings of the evaluation were summarised in the Evaluation of the Australian and New Zealand College of Anaesthetists Specialist Training Program Evaluation Report 2012–2013. The report concluded that the STP has successfully expanded the number of accredited training sites and provided opportunities to increase the number of doctors progressing to Fellowship, as well as adding value by increasing the quality of the learning through the support activities, such as teacher training and e-learning.

Primary Areas of Focus

Does setting impact on the quality of training? Identify issues of training in expanded settings.

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In late 2014, ANZCA commissioned IECO Consulting to work with the College in undertaking a research evaluation project on the qualitative implications of the STP program, in particular to explore the following:

- Does setting impact on the quality of training?
- Identify issues of training in expanded settings for anaesthetists.

This report provides the key findings and recommendations arising from the evaluation project.

### Anaesthetic training in expanded settings

With support through the STP, anaesthetic training in Australia has expanded beyond the traditional metropolitan tertiary hospitals to include a range of settings in metropolitan and regional private hospitals, in addition to regional (RA2-5) public hospitals.

Whilst all anaesthetic training posts are required to meet the seven ANZCA accreditation standards, the Specialist Training Program has facilitated the development of a number of different models, in relation to term structure and location. In some cases, the STP has led to the development of innovative training opportunities (usually undertaken in the provisional fellowship year) in novel training posts, such as simulation or a combination of clinical and teaching responsibilities in partnership with an undergraduate medical program.

A number of private hospitals are accredited for anaesthetic training through the STP including stand-alone facilities in both metropolitan and regional locations and co-located private hospitals with metropolitan tertiary facilities. The duration of time that an individual trainee may be rotated also varies with the majority of private terms being accredited for between 3 to 6 months duration. A few private hospital posts are accredited for 12 months, usually for the Provisional Fellowship (PF) year of training.

Some private hospital posts have an entirely different structure with the post being blended with a public hospital training post, and trainees rotating to the private hospital either one or two days a week or in some cases a whole cohort of trainees (of varying seniority) being rotated through the private hospital post in a given year so that each trainee spends two or three weeks in the private hospital at a time.

STP posts within public regional facilities have a more traditional structure although some posts have a single ANZCA trainee working alongside trainees from other specialties or disciplines. (for example ACEM trainees undertaking a mandatory anaesthetic rotation or RACGP/ACRRM trainees completing advanced skills training in anaesthetics). In other public regional facilities, the STP funded post might be one of a number of ANZCA trainees.

**Figure 1: ANZCA managed STP posts by state/territory by private or public or private/public mix**

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Methodology

The purpose of this evaluation project was to examine whether or not setting impacts on the quality of training in anaesthesiology and to identify issues of training in expanded settings. The evaluation project was commenced in mid-December 2014 and finalised in June 2015. A report was submitted to the College in August 2015.

During the study period, the following activities were undertaken:

- Literature review – 33 articles were identified in the peer-review journals as being relevant to this evaluation project. A more detailed description of the methodology of the literature review is provided in the following section and the annotated bibliography with all included papers is provided at Appendix A.
- Review of College documents relevant to the evaluation project. A list of source documents is provided at Appendix B.
- Focus groups and semi-structured interviews with trainees who had completed or were currently undertaking an STP post.
- Focus groups and semi-structured interviews with SOTs and HODs involved in the STP posts. More detailed information about the methodology of the focus groups and semi-structured interviews is provided in the relevant section of the report.
- Review of TPS data for the period 1 May 2014 – 1 January 2015.

The purpose of this report is to provide the results of the key findings arising from the literature review and analysis of the information obtained through the focus groups and semi-structured interviews, in addition to Training Portfolio System (TPS) and exit survey data, and to make recommendations addressing identified issues.

Evaluation project advisory group

A project advisory group was convened by the College to provide oversight and governance of the evaluation project. Membership included Fellows, trainees and College staff. A list of members of the Evaluation Project Advisory Group is provided at Appendix C.

Figure 2: Summary of evaluation project methodology

- Literature search
- Review of relevant ANZCA documents
- Development of questions for focus groups/semi-structured interviews
- Focus groups and semi-structured interviews with trainees
- Focus group and semi-structured interviews with SOTs and HODs
- Thematic analysis of transcripts of focus groups and interviews
- Comparison with themes arising from exit surveys
- Development of key findings and draft report
Literature search

Search methodology

The purpose of the literature review was to inform the development and refinement of the questions with respect to exploring whether setting impacts on the quality of training, in addition to identifying any issues related to training in expanded settings.

The literature review was undertaken in early 2015. Electronic databases using MEDLINE and Embase were searched for articles written since 2004, using combinations of the following terms: ‘anaesthesiology’, ‘private sector’, ‘rural health service’, ‘hospitals, private’, ‘internship and residency’, ‘education, medical, graduate’, ‘postgraduate education’, and ‘anaesthesia training in private healthcare facility’.

A total of 793 articles were retrieved during the initial search and the titles (and in some cases, abstracts) were reviewed for relevancy to the evaluation project. 43 articles were selected for a more detailed review. A manual search of the references of these selected articles was also conducted and relevant articles (including some pre 2004) were added.

A total of 33 articles were included in the final review. Selected pieces included studies, theme and opinion pieces, editorials and letters. A summary of these articles is tabulated in the annotated bibliography at Appendix B.

Key themes arising from the literature

Whilst limited, there is some discussion in the literature exploring expanding specialty medical training into non-traditional training settings. The expansion of training settings appears to be primarily driven by the recognition of the requirement to increase training capacity in response to the growth in the number of medical graduates, but it also recognises that many doctors will ultimately work in rural/regional locations or the private sector on achieving Fellowship.

Perhaps reflecting the relatively recent introduction of expanded settings, there are few formal studies exploring the role of expanded settings in specialist medical training within Australia or elsewhere, with the majority of papers being opinion pieces or letters to the editor.

There is a consistently expressed view that there is a significant untapped resource for training in both private hospitals and rural/regional sites, (Hislop, 2013; Gelbart and Creati 2013; Sutherland 2010; Watters et al, 2009; Crotty, 2005).

On balance, the opportunities offered within expanded settings are seen as potentially making a valuable contribution to specialist medical training and most authors writing about STP express support for its further development (Gough et al, 2010;) but argue that training in expanded settings should be regarded as an adjunct to and not a replacement for training within traditional settings.

The importance of local consultant champions in establishing training in expanded settings is highlighted by some authors (Hislop, 2013) and the quality of supervision is an important consideration in STP posts (Schweizer et al, 2009)

There is recognition that the clinical training in expanded settings, in terms of casemix and acuity is different in rural/regional versus metropolitan, and in private versus public settings.
Private hospitals have a lower acuity and complexity of patients (Hislop, 2013; Watters et al, 2009), as do rural hospitals (Wadman et al, 2010). Far from adversely impacting on the quality of training, some authors argue that private hospital rotations can supplement or add valuable opportunities to the training experiences gained in tertiary centres (O’Connor and Spratt, 2010, Schweizer et al, 2009).

Some studies have attempted to quantify the differences in training experience between the private hospital and traditional teaching hospital. Watters et al, (2009) attempted to quantify the differences in training experiences for surgical trainees presenting two models of surgical training in the private sector and including logbook data of the trainees.

There are a number of perceived challenges to delivery of training in expanded settings and these are also different depending on the setting. A number of papers addressing training in private hospital settings raise the issues of consultant attitudes to having trainees (O’Connor and Spratt, 2010a; Watters et al, 2009) and others deal with perceptions of private patients (Schweizer et al, 2009; Schenker et al, 2006).

In one Australian study of private urology patients, the authors conclude that the acceptance of registrars in private hospitals will increase if consultant involvement is emphasised to patients and that patients generally accept trainee involvement in surgical assistance and performance of minor parts of surgery (Huyhn et al, 2010).

The actual level of involvement of trainees in patient care in the private sector has also been identified as an issue with questions raised regarding the value of training where the trainee has little or no direct involvement in the clinical care of the patient (O’Connor and Spratt, 2010b; Watters et al, 2009).

A number of authors raise the issues of costs, including opportunity costs, of training within the private sector. Aitkin, (2012) used a literature search to identify studies that compared operation time required by a supervised trainee with that of a consultant and then applied a business model to cost the time, calculating the costs of training surgical trainees in the private hospital setting for the surgeons, anaesthetists and private hospital (Aitkin, 2012).

Some authors have highlighted the potential benefits of training in expanded settings to the facility in which training is undertaken. Hislop commenting on intensive care training in private hospitals argues that the presence of trainees may lead to improvements in ward cover (Hislop, 2013). Watters et al (2009) argue that private facilities taking on a training hospital ethos will lead to quality improvements.

Whilst broadly supportive of expanded settings in rural and regional settings, several authors highlight a number of issues to be considered including: relocation issues for trainees and their families; capacity for rural supervisors to train given clinical service load; costs; access to education and training resources; and professional and personal isolation of trainees (Berston et al, 2005; Dugdale, 2010).

Whilst the majority of articles commenting on the relationship between undergraduate or early career exposure in rural settings and subsequent choice of location of practice were excluded from the literature review, one paper by Dooney and Osborne (2010) which explored attitudes of specialist anaesthetists toward anaesthetic training at rural and regional hospitals and choice of practice setting was included given the relevance to the proposed study.

Dooney and Osborne found that specialist anaesthetists with experience of rural/regional training were more likely to choose rural practice after finishing their training but also noted that rural upbringing is also influential. attitudes toward rural training appear to be favourable and well regarded by those responding specialists who had experienced it. This is relevant given one of the primary objectives of the STP is to address rural and regional specialty workforce issues.

A number of other articles with themes or issues considered to be relevant to the context of this review have been included in the annotated bibliography at Appendix A.
Trainee perceptions of STP posts in expanded settings

Methodology

Following a preliminary review of the literature and relevant College documents, questions for the trainee focus groups and semi-structured interviews were developed around the following themes:

- Demographic information on rotation
- Clinical exposure and experience
- Roles and responsibilities
- Supervision
- Attitudes of consultants, other staff and patients (for private posts)
- Access to education and training program and resources
- Employment arrangements during STP post.

The questions asked during the focus groups and semi-structured interviews are detailed in the text box to the right.

College staff sent an email to a sample of trainees who had undertaken an STP post during the last two years inviting them to participate in the evaluation project. Trainees indicating their willingness to participate were subsequently assigned to a focus group in their home state. Additional trainees were invited to participate in a semi-structured interview, conducted via telephone.

Questions for focus groups and semi-structured interviews with trainees

1. Demographic information about participants, location of training, stage of training and previous rotations.
2. Describe the STP post? (Roles and responsibilities of the trainee, clinical experience, casemix, volume, elective versus emergency, procedures, on call and outreach requirements, workload versus training balance).
3. How do you regard the STP post? (Would you recommend it to colleagues?)
4. Describe the supervision of the STP post? (Access, level, engagement)
5. Describe the education program and resources available to you on the STP post? (Access to formal teaching, department and facility meetings, simulation training, online resources)
6. Any issues with the STP post?
7. For those completing rotations within the private hospital setting – how did you find the attitude of: (i) consultants; (ii) patients; (iii) other staff with whom you interact?
8. Describe the practical, employment related aspects of the STP post? (Contract, continuity of entitlements, accommodation, access to leave)
9. Any other aspects related to the STP post that you would like to raise?
A pilot focus group involving 6 trainees was held in Sydney during mid-December 2014. A further three focus groups were conducted with trainees during May and June 2015 in Perth (7), Melbourne (5) and Brisbane (4). [The bracketed number denotes the number of trainees involved in each focus group]. Each focus group lasted between one and a half to two hours.

The focus groups were supplemented with semi-structured interviews, using the same questions and were conducted during May and June 2015. A total of 14 trainees participated in the semi-structured interviews. The duration of the semi-structured interviews lasted between thirty and sixty minutes.

With the permission of participants, all focus groups and semi-structured interviews were audio taped. A full transcript of each audiotape was undertaken and a thematic analysis conducted on each of the transcripts.

**Results**

A total of 36 trainees, at various stages of training participated in either a focus group or semi-structured interview. Table 2 shows participating trainees by gender and stage of training at the time of undertaking the STP post.

Participating trainees had completed STP posts across a range of settings (metropolitan and regional private hospital and regional public hospitals) in all states within Australia (with the exception of Tasmania). Table 3 shows participating trainees by type and location of STP post.

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3 In addition to 4 trainees, 3 IMG doctors who had participated in the IMG upskilling program joined the Brisbane focus group. The IMG upskilling program is considered in Section 6 of this report and not included in this section.
Key findings

The following section provides the results of the thematic analysis of the focus groups and semi-structured interviews with trainees. There were clear differences in trainee perceptions and reported experiences between public and private hospital settings and the findings are therefore reported separately under the relevant section.

Regional public hospital STP posts

Overall levels of satisfaction

Participating trainees reported high levels of satisfaction with their anaesthetic training in regional STP posts. This was consistent throughout all interviews and focus groups. The following quotes from trainees were typical of comments made:

“It was an extremely enjoyable rotation… I think that the clinical learning opportunities were fantastic.”

“It’s just a small, small department, but highly, highly educational.”

“I highly recommend the post to anyone… I really enjoyed my time there and I think that it has done a lot of good for my training.”

Clinical exposure and casemix

Trainees reported exposure through the regional public hospital STP rotations to a wide range of cases including general surgery, ENT, orthopaedics, vascular, obstetrics and gynaecology, urology and paediatrics.

Many regional hospitals with STP posts have busy emergency departments with trainees also reporting a good balance between emergency and elective work. Those with obstetric units provided trainees with additional emergency work as well as exposure to epidurals.

Whilst many trainees acknowledged the lower acuity of patients within the regional public hospital setting (when compared with the casemix of the metropolitan tertiary hospital), they highlighted that the high volumes of patients provided valuable opportunities for learning and consolidating ‘bread and butter’ skills.

Some centres have a reputation for particular skill development and are highly valued by trainees. For example, one regional hospital is renowned for regional anaesthesia techniques and is a sought after rotation by trainees.

Trainees also recognised the value in other learning opportunities given the regional context of the rotation as expressed by the following:

“We’re really dealing with resource limitations and issues, such as, do we transfer this patient? Do we treat this patient here? A lot of treatment decisions come down to the fact that you are isolated and to transfer a patient is risky in and of itself as well. I think it really makes you think about it a lot more. I would absolutely recommend it to other trainees.”

Timing of regional public hospital rotation

The timing of undertaking a regional post was seen by trainees as very important, with many commenting that completing a regional hospital post as an introductory or basic training year one provided valuable opportunities to learn basic anaesthetic skills and procedures, as characterised by the following:

“I’ve been pleasantly surprised with the large quantity and variety of cases that I get on a daily basis… I think we get really good general experience… relative to say a first year trainee in a big tertiary where you are going to be in a huge line [of other trainees] to do a lot of things… I think this is confirmed with evidence when you look at your TPS and you see what you’ve entered… I’m like… wow. I’ve done a lot of things.”

“They’ve got a really, really great casemix. I’m getting to do a lot of paediatrics and obstetrics which I am guessing in a tertiary centre… I am not really going to get any exposure to that until I’m more senior in my training.”
Trainees also highlighted that this experience better prepared them for their next rotation:

“Compared to my colleagues, I’m getting access to a wider variety of cases… I feel like I’m more equipped to handle the basics… it was quite a challenge… having to uproot and come up to another [regional] city but honestly, they have made me feel very welcome here, very supported and I feel like if anything, I’ll be more confident when I actually get back to [the tertiary teaching hospital].”

When talking about the value of timing of the regional post, a number of trainees also commented that, in addition to early on in their training, completing a regional rotation at the end of training was also valuable because it afforded opportunities to consolidate general skills in the context of transitioning to the role of consultant:

“I’d say as far as casemix goes, there’s two really good times to go to regional places. That’s at the beginning of your training, where there’s lots of bread and butter stuff, and at the end of your training, when you haven’t done the bread and butter stuff because you spent the last three years doing cardiac, neuro and so on.”

Supervision

When questioned about supervision within regional public hospitals, trainees consistently expressed positive views about the quality of supervision and level of engagement of supervising consultants. Some noted that many regional centres have employed young (newly graduated) Fellows who have relatively recent tertiary experience and are familiar with College training requirements:

“I had a great experience out there. I think it’s a pretty young and new and energetic department. The SOT’s very keen to make a really good training post… the head of department is pretty new and very diligent… and would always encourage me to know what cases I needed… had stickies on the wall of particular cases that different people needed… sure enough, the next week, you’d land on exactly the right list to get what you wanted.”

The majority of trainees working at regional public hospitals participate on an out of hours duty roster. Supervision out of hours was also reported as being very good and there were no reports by participating trainees of gaps in supervision or feeling unsupported.

“They were always very good at supporting and coming in. They’re more likely to come in than not, and certainly if I was uncomfortable with anything during the night, and I said ‘it might be a good idea to come in’, they were there straight away, without exception.”

“It [supervision] was excellent. Excellent. From the day to day cases, list by list, the supervision and teaching that went on during the lists to the out of hours.”

“You get called in for all the cases but you always have a consultant there with you so you are in a very supportive environment, but you’re still getting exposure to those emergency situations.”

There is of course a flip side to the above. Introductory and basic trainees requiring Level 1 or Level 2 supervision for even basic anaesthetic procedures can increase the workload of the supervising consultant. Short rotations of three months may exacerbate this by increasing the number of trainees rotating to a regional hospital and resulting in a constant churn of trainees who just as they acquire basic skills and are ready to move to more independent practice, complete their rotation and move on. Over time, there is a risk that this may erode the goodwill of consultants involved in regional training. This issue is dealt with in more detail in the following section on consultant perceptions of STP posts.

When describing their relationships with supervising consultants within regional public hospitals, trainees spoke very favourably. A few trainees pointed out that some of the regional departments have a small number of consultants that resulted in consultants getting to know the trainee better, particularly with respect to their skills and experience and that this in turn optimised graded clinical supervision. One trainee expressed it this way:
“The registrars get the opportunity to work within a very core, small group of consultants who get to know them... within a couple of weeks those bosses will know that trainee better than any of the bosses at their home hospitals... what that allows them to do is to know what they are capable of and not capable of, so that their level of solo practice goes up quite considerably... I think that is often read as, the regional places just let people do whatever, but I think that it’s the consultants actually being able to know the trainee better and that allows them to give people more [clinical autonomy].”

One of the issues identified by a few trainees with respect to regional hospitals with relatively small anaesthetic departments was the availability of consultants to undertake the work-based assessments. Some trainees reported difficulty in getting work-based assessments signed off:

“There just weren’t enough consultant anaesthetists available to actually do them.”

Access to education and teaching

An issue identified in the literature with respect to training in expanded settings is access by the trainee to the formal education program and other educational activities that are typically based within the tertiary teaching hospital or run out of the regional college office.

Whilst many trainees in this study reported issues with access to formal teaching activities they were also quick to recognise the challenges facing consultants within (relatively) small regional anaesthetic departments in terms of providing formal teaching. The larger regional departments were able to do this and there were also reports by trainees of well-regarded teaching programs in these sites.

Features which appear to impact on the capacity of a regional public hospital to provide a regular formal education program included size of department; number of consultants in a given department; number of staff versus private VMOs (however named); range of seniority of trainees (many trainees recognised that it is not practical to split a teaching program to primary or fellowship focus if variable seniority and small number of trainees).

The availability of IT infrastructure has a significant impact (not only at the regional hospital, but also at the other end) on a trainee’s capacity to attend education sessions. There were multiple reports by trainees regarding lack of teleconferencing of education sessions and meetings held in the tertiary hospitals. As one trainee put it:

“Access to ongoing weekly education sessions, in terms of the primary, was essentially cut off... anybody that’s in [capital city] has an afternoon off and goes and attends... that was specifically not possible and that, unfortunately, is not telecast in any way, so I could not participate.”

Even when teleconferencing facilities are available, Internet access can be problematic and this also impacts on trainees’ capacity to be included in regular teaching activities or study groups whilst in regional settings:

“You can’t do several teaching things without good quality, fast internet access.”

“I’m fortunate enough that part of my study group is happy to give me a phone call and can do it over the phone, but having access to Wi-Fi would make a huge difference to the ability to do private study in a group of others.”

However, this issue was not universal and some trainees who participated in regular tertiary hospital department meetings through videoconferencing, whilst on the regional hospital rotation, highlighted the benefits in comments characterised by the following:

“The large departmental meeting was held every week and that was actually telecast to my hospital. That was very helpful and you felt a bit more in the loop with what’s happening in the anaesthetic world back in [capital city].”

Administrative and employment issues

There have been a number of reports in the literature of administrative and employment issues relating to training in expanded settings.
These include: continuity of employment entitlements; access to leave; relocation and accommodation; medical indemnity and so on.

Although there were specific exceptions to this, the majority of trainees interviewed in this study reported no concerns with regards to employment and administrative issues. The exceptions were generally where a trainee reported being the first trainee to go to a newly established STP post.

As the STP post becomes more established, it appears that administrative processes are developed and refined and issues resolved for those trainees who follow. Many trainees identified specific staff within the STP post, often the SOT or department secretary (however named), who held the corporate knowledge and was able to successfully mitigate or navigate administrative or employment issues on behalf of the trainee when they arose.

Access to Rural Support Loading

The Rural Support Loading provides an additional amount of STP funding to be used by the regional facility for education and training purposes. This can be used to improve education and training infrastructure or provide assistance to individual trainees to attend courses.

Whilst there was variable awareness by trainees of the existence of the funding, those who were aware confirmed the positive impact of the funding on education and training within their STP post:

“I used some of the funding and went to three or four courses over the second half of the year so it was very useful.”

“The library was next to nothing. I think the department was intentionally quite proactive in trying to address those issues and secure new computers and more space and more books.”

Private hospital STP posts

Perceptions by trainees of the STP posts in private hospitals were far more variable compared to those who had undertaken regional public hospital STP posts. This is perhaps a reflection of the heterogeneous nature of the private hospital STP posts, particularly with respect to their location, structure and organisation.

Private hospital STP posts are located in a variety of settings including: private regional hospitals; stand-alone private hospitals located in metropolitan areas; and private facilities co-located with tertiary public hospitals.

The organisation of terms also had significant variation with some rotations being between 3 months and 6 months in length rotating an individual trainee. In other models, a small cohort of trainees share a roster which incorporates private hospital lists so that a trainee may spend one or two days per week in the private hospital and the remainder of their time, contributing to the nearby or co-located public hospital, including on-call requirements. Still other models had the entire cohort of trainees within a tertiary anaesthetic department, at all levels of seniority, rotating for two to three weeks to the private hospital.

Benefits of private hospital STP posts

Trainees reported a number of benefits with respect to the private hospital posts, particularly in giving them exposure to the private hospital environment; access to casemix to enable them to meet volume of practice and special study units requirements; exposure to casemix not available within the public hospital system; and (with respect to the blended public/private posts), allowing for an additional registrar to be added to the (public) on-call roster.

Exposure to private hospital environment

Despite the difference in structure and organisation of the model of the private hospital STP posts, the majority of trainees interviewed during this study, reported the value in having some exposure to the private hospital environment. Not only did many trainees recognise that a component of their consultant practice in the future might be within a private hospital context, they also saw advantages in observing differences in the organisation of theatres, particularly with respect to efficiency and patient flow. Comments such as the following were typical:
“It was an eye opening experience in terms of the turnover they do in private hospitals… their time efficiency at least in terms of getting the patients in and out and ready to go, which is sometimes lacking a bit in the public system by comparison.”

“I think that is one strength… private practice is something you want to be involved in at some point in your life and you have no exposure to that as a trainee… there’s a lot of nuance, the difference in practice which you couldn’t quite understand unless you have done it.”

Meeting volume of practice requirements

Many trainees who had undertaken an STP post in a private hospital reported that the rotation provided opportunities to meet the volume of practice requirements, particularly with respect to some of the special study units. It is clear that in some cases, STP private hospital rotations are giving trainees access to casemix that would not otherwise be available to them within their tertiary hospital or training network, particularly with respect to cardiothoracic and neurosurgery. In other cases, trainees highlighted that they had exposure to casemix that is not generally provided within the public hospital system, for example, plastic and bariatric surgery.

A number of trainees emphasised the high turnover of cases within the private hospital system and recognised the value this afforded in terms of meeting College requirements.

Comments such as the following were typical:

“The main strength is that all the lists are at my beck and call every day. So I really got to tailor my volume of practice… I got in that three months as much as I did for six months or a year, [compared with a term in the public hospital].”

“It’s very different from the public system. There’s a very high turnover. I found it very helpful for training… we do quite a bit in a day compared to what we would normally do in the public.”

“I think the best resources were the fact that you’re working in a nice environment, being exposed to high level cases that prepare you incredibly well for the exam.”

Additional registrar for public hospital on-call roster

A number of trainees who were working in blended public private terms where they were assigned to the private lists one or two days per week but otherwise working at the public hospital reported the value of the private STP post in increasing the medical workforce FTE for the public hospital, thereby allowing for an additional registrar to contribute to the after hours roster.

“It was a great addition… taking into account that it provides the department with an extra registrar for the term and by doing that it means that the on-call roster was so much more bearable… before the private was included, the on-call roster was horrendous… so the extra registrar really made the roster a lot more bearable.”

Flexibility of working arrangements

Given the way in which many private posts were organised, coupled with the supernumerary nature (see comments in following section), many trainees reported that the private hospital post provided quite a lot of flexibility with respect to working arrangements. This was seen as particularly advantageous to those trainees approaching exams or those wanting to attend training courses:

“Whenever you want to be there, daytime, nighttime or weekends or whatever is up to you completely. So, that’s one of the positives that in it’s incredibly flexible and allows the time for conferences and other training events without too much organisational disruption to your training.”
Access to consultant teaching (and vice versa)

The supernumerary nature of many of the rotations within the private setting had a flip side in that trainees, with very few exceptions, had one on one access to consultants for the duration of the lists. Where trainees identified consultants as being willing to teach, and provided teaching activities that did not delay the list, trainees reported positive experiences and interactions with consultants.

“There was quite a lot of in theatre on the job teaching, and very well supported by consulting senior staff. They were inevitably there pretty much 24/7 because they also had a private role as well.”

Trainees also highlighted that anaesthetists working solely in the private sector sometimes welcomed their presence:

“Some of the anaesthetists were really happy for you to be there regardless of whether you’re doing anything or not. You were bringing that information from the public system into their practice.”

“Some of them really enjoyed it and quizzed you to death on everything because they want quick information.”

Identified issues with private hospital STP posts

Whilst the majority of trainees recognised the value of STP posts in private hospital, they also raised a number of issues. These included the supernumerary role of the trainee and organisation and allocation of trainees to lists.

Supernumerary nature of many roles

A consistent finding in trainee’s reflections of their experience in private hospital STP was their view that in many cases their role was essentially supernumerary, given the private hospital context, with even the most senior trainees supervised at Level 1 and occasionally, Level 2.

Whilst trainees were cognisant of the drivers for this and highlighted that it was consultant dependent, many reported a frustration with the limited involvement in either practical procedures (in the case of junior trainees) or clinical decision-making (in the case of senior trainees)

“It’s a difficult conundrum because at the junior level where you don’t really want to be making decisions, at that stage, you’re learning a lot of the procedures. So in the public setting where you’re happy for the consultant to make the decision, you want to do the procedures yourself. If you slip that over to the private sector, the consultants aren’t really happy and patients probably wouldn’t be if they were fully informed. You don’t want to be learning procedures on patients who are spending a lot of money for a consultant to provide a service.”

“On my first day, I left feeling really depressed and thinking that I was going to be like a medical student, because one of the first comments, I think with the intention of reassuring me, was that ‘we don’t need you to be here’… I actually have a role in trying not to get in the way.”

“In the private sector, the decision making is all essentially independent of you as a registrar. For those cases that I’ve logged there… I’m sure it was not like I didn’t know what was going on, but I just did not feel like I was taking ownership of that case.”

“But when you are procedure competent as an advanced trainee, the consultants are probably happy for you to do the procedure… but at that stage, you’ve learned that skill, the skills you need to learn are managing the case independently yourself.”

“I found it quite demotivating because I like working hard and seeing things and just that feeling of am I being a burden to this person feels quite draining. I think I enjoy getting my hands dirty and it was a time in the training program where I wanted to be independently managing cases and being in the thick of it and thrown in the deep end… having all my skills tested and it just wasn’t that type of rotation at all.”

“I think that as an advanced trainee with your provisional fellowship… I think the majority of that year you should be forced to work independently under supervision and be allowed to have the autonomy to make those decisions, which isn’t feasible in the private setting.”
Organisation of lists

A number of trainees reported that some private posts are set up with the expectation that the trainee directly contacts the consultant and asks permission to join the list. Many trainees made statements about the ‘uncomfortable’ dynamic that this sets up between the trainee and in most cases, unfamiliar, consultant.

Not surprisingly, some private consultants elected not to have trainees join their lists. One of the factors that appears to influence the willingness of consultants, (at least in the perception of the trainees), to their inclusion on private lists, is whether the consultant has a public appointment and is used to having registrars.

In fact many trainees reported that over the duration of the private rotation, they increasingly self-selected lists with those consultants whom they were familiar with from the public side or whom they knew had experience working with registrars:

“I also think being a [x hospital] trainee, I think that it helps I know a lot of the consultants before I started doing cardiac, so some of them work on the general side as well and even the ones that don’t, I saw them all the time in the change room and so on. You know, I had a rapport with them so it made life a bit easier I think.”

However, many trainees were also acutely aware that this strategy ultimately concentrated the burden of training within the private hospital setting on a small number of consultants:

“That wasn’t an easy solution because I know a lot of these guys have registrars all week, and I’d say one day a week [whilst working in the private hospital] they would get a break from registrars.”

Other strategies used in allocating trainees to private lists involved the department administrative staff or secretary, who have a list of those private consultants who elected not to be involved with trainees and those who were willing. In other cases, trainees would be allocated to a regular list with the same anaesthetist and (presumably willing) surgeon.

Those trainees who were required to ring consultants the night before to negotiate being involved in the list highlighted some of the difficulties with this approach. These difficulties were exacerbated if the trainee was previously unknown to the consultant:

“Generally they’re a lot more conservative if they haven’t met us before, it’s the first time they’ve worked with us… they don’t know what your skillset is… if they’re not comfortable for any reason, they will very clearly and bluntly say, ‘I will do this… I will go ahead and do this, can you do something else?’ Fairly bluntly.”

In this regard, trainees reported a sense of constantly having to prove themselves over the course of the term to new (unfamiliar) consultants and over the time, this was ‘exhausting’. Some trainees pointed out that in the public hospital anaesthetic department context, they get to know the consultants and the consultants make assessments as to their clinical capacity in the early weeks of the term, sometimes also informed through discussion with consultant colleagues. In the private hospital setting, many private anaesthstists will have limited communication with other anaesthetists (certainly about individual trainees).

Not all trainees reported difficulties in accessing and contributing to private lists. More senior trainees, including those in provisional fellow positions, highlighted appropriate communication with consultants as important in this context:

“It really depends on your diplomatic skills…on the extent you can approach an individual consultant. It really depends on their view of you, with what esteem they hold you to whether they allow you to do work in the private or not.”

More senior trainees also reported more involvement in lists and when they were working on regular lists with the same consultants, they saw themselves as providing some service capacity and making a positive contribution to the running of the list:
“Certainly the days when I worked with the regular lists and also with the surgeons, they expected me to be there and in anticipation of me being there, they often booked more work or more complex work knowing that we’d have the capacity to get through the work with the anaesthetic trainee as well as the consultant.”

“Once you got to know the consultant anaesthetist and they knew where your skills could be used, they would take advantage of them in the care of their private patients.”

Other key findings related to private hospital STP posts

Attitudes of other healthcare staff and private patients have also been identified in the literature as an important consideration in training within expanded settings.

Attitudes of other healthcare staff

Most trainees in this study reported no issues with respect to attitudes of other healthcare professionals, including surgeons, in the private hospital setting. A few highlighted that those hospitals that had established STP posts or that had other trainees (surgical registrars and in some cases, medical students) were familiar with trainees and this was seen as positive.

“If you look at it from the perspective of the surgeon… the surgeon also had trainees who were either fellows or registrars who also participated in enabling the work to be done.”

“They are probably used to having a trainee there, so I haven’t found any difficulty whatsoever, because they would have had a trainee there for the last two years. The nursing staff, the technicians, the recovery nurses are all used to having a fellow there. I haven’t met with any difficulty at all.”

“I didn’t feel in the tea room or getting a cup of coffee that there was any questioning of my appropriateness of being there. To be honest it was quite a positive experience. The staff were very friendly and showed me around and helped orientate me.”

Attitudes of patients

The majority of trainees reported that the patients that they came into contact with were accepting of their involvement but also recognised that the patients were probably a self-selected group and that they (the trainee) only worked with patients where the consultants were happy for the registrar to be involved in their care.

Whilst many trainees reported being involved in procedures (particularly once the patient was asleep and generally with Level 1 supervision), responsibility for clinical decision-making and management of the case remained with the consultant.

“With very few exceptions, I think they were more than happy to have a trainee doctor involved in their care. It was made clear to them that the consultant was the person who was in charge and who would be making the decisions.”

“At the time where we consent for the anaesthetic, we are introduced as a trainee. We tell them that the trainee will be doing the procedure… that we are senior trainees. I’ve had no patients refuse really. They’ve all been really cooperative.”
Consultant perceptions of STP posts in expanded settings

Methodology

Following the literature review and review of relevant College documents, questions for the consultant focus group and semi-structured interviews were developed around the following themes:

• Description of the STP post (casemix, trainee roles and responsibilities)
• Perceptions of consultant regarding the STP post
• Supervision arrangements
• Education program and resources
• Issues or barriers in implementation.

The questions asked during the focus group and semi-structured interviews are detailed in the textbox to the right.

College staff sent an email to all Heads of Departments and Supervisors of Training with STP posts at their facilities that were registered to attend the College Annual Scientific Meeting (ASM) in Adelaide, inviting them to participate in a focus group on the STP posts. Subsequent emails were sent to Fellows inviting them to participate in a semi-structured interview by telephone.

The focus group was held at the ASM in early May 2015. The focus group had 7 participants and was of 80 minutes duration. The focus group was supplemented with semi-structured interviews, using the same questions and these were conducted during May and June 2015. A total of 9 consultants participated in the semi-structured interviews. The duration of the interviews were between 25 and 60 minutes.

With the permission of participants, the focus group and interviews were audiotaped. A full transcript of each audiotape was undertaken and a thematic analysis conducted on each of the transcripts.

Questions for focus groups and semi-structured interviews with consultants

1. Demographic information about participant (location and nature of practice, anaesthetic workforce, length of time as SOT, (if applicable)
2. Describe the STP post. (Roles and responsibilities of the trainee, clinical experience, casemix, volume, elective versus emergency, procedures, on call and outreach requirements, workload versus training balance).
3. How do you regard the STP post? (How is it working in your facility?)
4. Describe the supervision. (Who provides the supervision, access of trainee to supervisor, support/training provided for supervisors)
5. Describe the education program and resources available to the trainee during the term. (Formal department teaching, simulation training, on line resources)
6. Any issues or barriers with regards to the STP post in your facility?
7. Any other aspects related to the STP post that you would like to raise?
Results

A total of 16 consultants, who hold positions as either a Director of Anaesthetic Department or Supervisor of Training, participated in a focus group or semi-structured interview. Table 4 shows participating consultants by position, location and type of STP post.

<table>
<thead>
<tr>
<th>Type of Post</th>
<th>NSW</th>
<th>QLD</th>
<th>SA</th>
<th>TAS</th>
<th>WA</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Private STP post</td>
<td>3</td>
<td>1</td>
<td>2</td>
<td>6</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Public STP post</td>
<td>3</td>
<td>3</td>
<td>1</td>
<td>2</td>
<td>10</td>
<td></td>
</tr>
<tr>
<td>TOTAL</td>
<td>6</td>
<td>4</td>
<td>1</td>
<td>1</td>
<td>4</td>
<td>16</td>
</tr>
</tbody>
</table>

Key findings

The following section provides the results of the thematic analysis of the focus group and semi-structured interviews with consultant anaesthetists. Given the smaller number of consultants who participated in this study, relative to the numbers of trainees, the findings for both regional and private hospitals are presented together.

STP well regarded by consultants

Participating consultant anaesthetists expressed a high level of regard for the STP program and provided numerous examples of benefits to their facility or department in having STP funded posts. This finding was consistent across the range of STP posts in both public and private settings.

Benefits of STP posts

Benefits to trainees

A number of consultants made statements regarding the benefits of the STP posts to trainees particularly with regards to opportunities to work in a private hospital: seeing how the private health system operates; exposure to casemix not offered in the public system; and increased volumes of cases compared to the public system.

“There’s a couple of big advantages for trainees [working in private hospitals]… (1) they get exposure to anaesthetists working in the private system… who they wouldn’t have otherwise met… they need to see how the private world works and (2) they get exposure to casemix that isn’t found in the public system… for example… bariatric surgery and cosmetic surgery.”

There were several comments by consultants, echoing similar comments made by trainees, in relation to volumes of cases and capacity to undertake multiple procedures and meet volume of practice requirements.

“From the trainee’s perspective, I think getting to come out to a rural hospital, where you’re not fighting for procedures with other trainees, is fantastic… also they get to pick and choose a bit… so if a trainee wants more of something, then they just tell me and I kind of factor that into the roster… if you are working in a [tertiary] hospital where there are another twenty trainees to consider, it’s sometimes not particularly easy to get procedures.”
Benefits to the department

Some consultants also emphasised the benefits to the department in which the STP post was established. In some cases, this provided additional registrars to service the public on call roster (as also identified by trainees and discussed in the previous section) and in other cases, the establishment of STP posts provided opportunities to expand the FTE of the medical workforce in line with expanding service demands on the department.

One consultant in describing the way in which he had used STP funding to build the FTE of registrars within a private hospital said:

“There’s no question about it. It costs our hospital money, lots of it, to teach and train. There’s no question that the carrot in STP funding has been enormously beneficial to get things over the line.”

In the private hospital setting, the presence of a senior trainee was sometimes seen as a benefit to the efficient running of the list. One consultant expressed it this way:

“Even though I might be in the theatre most, if not all of the time with a private patient, that doesn’t mean I will take over every single thing that’s done. I pitch to the registrar. If the registrar is competent to do things, I’m happy to let them do things. It often speeds things up for me.”

Another consultant highlighted that trainees can add value to the list:

“The trainee becomes unbelievably useful. In a super efficient place you can make use of them… If I’ve got one of my busy lists, I’d put them with me, I want them to help me, I make them work.”

Not all consultants agreed with the above sentiments, with some emphasising the supernumerary nature of the trainee in the private sector. These comments were similar to those made by trainees as discussed in an earlier section of this report.

Some participants raised the value of having trainees in terms of facilitating the consultant’s currency of knowledge. One consultant in a regional public hospital expressed it this way:

“I think it’s been great, because otherwise we might not have had a trainee. From a department point of view, I think it’s actually really important to know that you’re imparting knowledge to someone else… because it keeps you on your toes as well. It reminds you of all the basic physiology and pharmacology that you did… so it refreshes your own knowledge.”

Factors that support the success of an STP post

Clinical champion

Participants emphasised the importance of having a consultant who was willing to work towards setting up the STP post. Whilst this was true for all settings in which STP posts exist, it was particularly relevant for the private hospital setting, particularly where the hospital may not have had any experience with training.

Length and structure of rotation

A number of participants commented on the length of rotation being an important consideration in optimising the value of the post, both for the trainee as well as the department. This appears particularly true for small regional departments where an experienced trainee may be able to buffer some of the work for the senior medical staff.

“When we only had them for three months, it felt like we were putting in all this effort, and then probably in the last two to four weeks, we were actually getting something back from them, which was a small amount of service provision.”

In the private hospital setting, some consultants reported that implementing the optimal model in terms of structure and organisation of a rotation has been challenging. As one anaesthetist commenting on the establishment of an STP post within a private hospital setting stated:

“We’ve wrestled with will they go for a week at a time or will they go for the same day each week? And we’ve been through the mill on that. They do go into the private… they do have some experience…thankfully it’s complemented by their public experience, but it’s a little tricky to define exactly how you move them into the private sector.”
Barriers to STP posts

The facility’s lack of experience with training

One barrier that was identified with respect to establishing an STP post was the facility’s lack of experience with training. This was particularly relevant to the private sector where there may not have been medical trainees working within the facility, and the consultants may not normally have any contact with registrars.

“I think you have to start with a willingness to train... with or without the money behind it. Then you can use the money to expand training much more successfully. Because I don't think you can just throw a lot of money into it and say now go train people... because you’re not going to have everything you need in a hospital... you are not going to have SOTs, you’re not going to have educational programs... a hundred thousand isn't going to buy you that.”

“I think it’s very hard to start with a hundred thousand dollars and create a training position. I think you have to start with a hospital that does training and then try to expand it... I notice in the application forms, that it is very much centred around the concept that it’s a completely new position, in a hospital that’s never been involved with training. But I actually think that’s probably the hardest way to start up training.”

With the recent increases to medical student places, medical schools have established clinical placements, in private hospitals (as have prevocational training programs for interns) and many consultants commented that in those institutions, the establishment of the STP posts had been easier.

“We’ve had students for about the same length of time and now for the very first time we’ve got interns... I think that culture will really help them change and drive the change.”

Attitudes of consultants

A number of consultants working within the private hospital setting raised the issue of attitudes of their colleagues with respect to establishing STP posts, particularly in the initial phase of setting up the post. The following are typical of the comments made:

“There was initially a lot of resistance... from the VMOs... many of them said 'can they (the trainee) give an anaesthetic?'”

“There are a number of consultants who would flat out say, ‘I don’t want trainees’”

Whilst it was reported that this resistance becomes less marked with time (and often in response to significant efforts by the SOT or HOD), it is clear that there remains a cohort of consultants working in the private sector who elect not to be involved with trainees.

“I'd always ring the consultant I was putting them with, and I had a pretty good idea of which consultants... I would put them with consultants who also worked in public teaching hospitals so they would be used to having trainees... even so... making the phone call was really important. I did it because some would say no... now four years in, I have a really good idea of who I can and can't put them with. ”

“The bigger problem initially was the small cohort of consultants who were anti (having a trainee) but that's diminished. We now have a teaching award... it encourages them... gives them feedback...”

One of the limitations of this review was the fact that participants were self-selected and the reviewer did not get an opportunity to canvass the views of those private consultants who do not want to have trainees attached to them.

One consultant whilst being interviewed in relation to an STP post in a public regional hospital who also had an appointment with a private hospital had this to say:
"In questionnaires and surveys where I've been asked should trainees be trained in the private hospital, I have said no. I often have very busy lists and I want to just get it done, and I can foresee very significant time impositions on teaching properly in the private sector."

Attitudes of patients

Consultants generally did not perceive an issue with respect to attitudes of private patients to trainee presence.

"I haven't seen any major problems with that [attitudes of private patients to trainees], by and large because we have a high consultant presence."

"I think as long as they (the private patient) are reassured that the consultant's there and the registrar isn't doing [the case alone]... I don't think it's a problem."

"I think it is an overrated thing... (perception that private patients would not accept trainees.)"

Some went so far to say that having trainees in the private sector was seen as adding kudos to consultants, from the perspective of patients:

"It's actually seen as a marker of how good our consultants are... that they have trainees that come to learn from them."

"Patients saw that we were a training practice so hopefully you must be good."

Seniority of trainee

The seniority of the trainee being rotated to a STP post was considered an important factor in ensuring the sustainability of the post, at least in the private hospital setting. Some consultants responsible for allocating trainees to rotations ensured that only senior trainees were rotated to the private hospital.

In regional public hospitals, many of the trainees on rotation are junior and this has an impact on the senior medical staff. Where introductory trainees are rotated to the regional hospital setting, there is very limited capacity to buffer the work of the senior medical staff

"Because they are introductory trainees, they need Level 1 supervision, so effectively they're not on after hours, because you'd have to come in anyway... once they become basic trainees and they've had their initial assessment, they could come in for on-calls but... to be honest unless it was a straightforward case, which it tends not to be out of hours, we wouldn't feel comfortable with just leaving a basic trainee."

Funding

There were a number of issues raised with respect to funding of STP posts particularly in relation to the salary contribution which many emphasised did not cover salary costs and in a fiscally constrained environment, was an issue. Aligned to this, there were a number of statements made in relation to the inability of trainees working within the private sector to access Medicare billing.

There were also a number of comments made in relation to the uncertainty of the STP, in terms of ongoing commitment to funding by the Federal government.

Many pointed out that whilst it takes a great deal of work to establish a post, once established, the trainee becomes part of the medical workforce and training network. Concern was expressed that discontinuing a post may lead to significant issues for either clinical service delivery (in the regional public hospital posts) or on the other hand, a network’s capacity to meet the training requirements for individual trainees, (in relation to the private hospital posts).

On a positive note, many consultants argued that the additional STP funding for training support has enabled the purchase of equipment and infrastructure.

"Courtesy of the STP funding… we have been able to purchase a lot of simulation equipment, which has been fantastic and has probably put us ahead of the pack… it's enabled us to do a whole lot of things."

When the Rural Support Loading is used in this way, it is clear that the benefit is extended to other health professionals working in that facility.
Supplementary information

Trainee rotation exit surveys

At the conclusion of each STP rotation, trainees are given the opportunity to provide feedback via a web-based survey. The survey collects information regarding the rotation and asks a series of questions about the supervision, clinical experience, teaching and training resources. The return rate for the exit survey for the period 31 July 2014 – 10 April 2015 was 55%. ⁴

ANZCA STP project staff undertook an analysis of the exit surveys and these results were compared with the thematic analysis of the focus groups and semi-structured interviews with trainees.

Themes arising through the exit surveys were very consistent to those described in the earlier section on trainees’ perceptions of the STP posts.

Strengths of the private STP posts included the casemix and opportunity to meet volume of practice requirements as well as the opportunity for exposure to private anaesthetic practice.

Issues raised in relation to the private hospital posts were again very similar to those raised in the semi-structured interviews and focus groups and included the attitude of some consultants towards trainees; having to contact consultants directly to seek permission to attend lists; and the supernumerary nature of the role in some hospitals with limited opportunities to perform procedures.

Strengths highlighted by trainees in relation to public regional STP positions included the case mix and exposure to a range of clinical material. A number of trainees highlighted clinical autonomy as one of the most beneficial aspects of the public regional rotations.

Trainees completing public regional posts raised issues in relation to access to formal teaching although this was balanced with a number of positive comments regarding the quality of informal teaching and the supportive nature of the training environment.

⁴ Source: Ellen Pascoe, Project Officer, STP, ANZCA. Personal communication by email dated 20 August 2015...

IMG upskilling program

The International Medical Graduate (IMG) upskilling program provides opportunities for international medical graduate specialists seeking fellowship with the College to access appropriate training and support. Historically this program was funded separately to the now named STP but from 1 July 2011 was consolidated into the STP.

Although the IMG upskilling program was not a specific focus of this evaluation, a number of participants had particular experience with this program and whilst out of scope of this evaluation, warrants some brief comments.

The IMG upskilling program continues to operate in Queensland as a distinct entity (with a contribution of funding from Queensland Health) although in other states, the program has now been consolidated as part of the STP.

In Queensland the IMG upskilling program provides international medical graduate specialists with the opportunity to rotate through 12 months in a peripheral (regional) hospital in addition to 12 months in a metropolitan centre.

Participants have access to additional education activities and support whilst completing the rotations. Additional support is provided through the Overseas Trained Specialist Anaesthetists’ Network (OTSAN).

The three IMG participants in the Brisbane focus group who had participated in this program made very positive comments regarding the program, particularly with respect to providing exposure to a metropolitan facility and the level of support and training in preparing for the Fellowship exams.

Both the IMG doctors and those consultants with experience of this program noted the benefit for the peripheral hospitals in having an IMG specialist contributing to the anaesthetic workforce. Whilst service commitments in the peripheral hospitals can have an impact on training opportunities, on balance IMG doctors were positive about the program.
Recommendations

1. Support for STP posts in making a significant and valuable contribution to anaesthetic training in Australia should continue.

2. The College gives consideration to the development of additional resources (including online resources) to support consultants in supervising trainees working in rural and regional facilities.

3. The College works with key stakeholders through advocacy and accreditation mechanisms to improve infrastructure (including IT resources) for training in regional sites (in both private and public hospitals) with the aim of facilitating continuity of participation by trainees in study groups and formal education programs.

4. The College supports rural STP sites giving consideration to the stage in training (both basic and advanced) for trainees in terms of experience of casemix and acuity across settings.

5. Information regarding Rural Support Loading funding is clearly communicated to all key stakeholders, including SOTs at eligible regional/rural locations.

6. Consideration be given to the structure of STP posts in private hospitals to ensure that there are explicit arrangements made for the allocation of basic and advanced trainees to lists.

7. Further strategies are explored with the aim of optimising the engagement of consultant staff within private facilities in the training of anaesthetic trainees.
## Appendix A Annotated bibliography

<table>
<thead>
<tr>
<th>Authors</th>
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<tbody>
<tr>
<td>Sinclair M.</td>
<td>Postgraduate specialty training in private institutions and anaesthesia training in a private healthcare facility</td>
<td>Anaesthesia and Intensive Care, 2013; 41(5): 678–679</td>
<td>Letter to the editor in which the author addresses potential barriers to anaesthetic training in the private sector, including potential to slow theatre turnover and economic issues.</td>
</tr>
<tr>
<td>Hislop R.</td>
<td>Postgraduate specialty training in private institutions</td>
<td>Anaesthesia and Intensive Care, 2013; 41(3): 289–290</td>
<td>Editorial accompanying the Gelbart and Creati letter (3) in which the author provides an overview of the STP program and outlines a number of challenges to the successful implementation in anaesthesia training.</td>
</tr>
<tr>
<td>Gelbart B. and Creati B.</td>
<td>Anaesthesia training in a private healthcare facility</td>
<td>Anaesthesia and Intensive Care, 2013; 41(3): 429–431</td>
<td>Letter to the editor in which the authors present the experience of an individual intensive care trainee completing a six month rotation in anaesthesia in a private institution, using log book data. They conclude that whilst trainees can experience a volume and range of anaesthesia training within private institutions, acuity and exposure to emergency cases was low. They argue that private institutions are a suitable adjunct to the training landscape.</td>
</tr>
<tr>
<td>Cooper C. and Cooper A.</td>
<td>Anaesthetic training: not better, not worse, just different</td>
<td>Anaesthesia, 2012; 67(9): 937–941</td>
<td>An editorial in which the authors examine the impact of the European Working Time Directive on anaesthetic training in the context of increasing trainee numbers, changes to medical education and health services; and argue for broader measures of learning outcomes which extend to improved patient outcomes.</td>
</tr>
<tr>
<td>Aitken R J.</td>
<td>Lost opportunity cost of surgical training in the Australian private sector</td>
<td>ANZ Journal of Surgery, 2012; 82(3): 145–150</td>
<td>The aim of the study was to estimate the time and lost opportunity cost of surgical training in the private sector. The author conducted a literature search to identify studies that compared the operation time required by a supervised trainee with a consultant. In 22 studies the median operation duration of a trainee was 34% longer than the consultant. Using a business model, the author calculated that the total lost opportunity cost of surgical training in the private sector would be approximately $467M</td>
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<tr>
<td>Huynh C. Brooks A. Nicol D. and Woo H.</td>
<td>Patients’ perceptions of surgical registrars’ training in the private hospital setting</td>
<td>BJU International, 2011; 108 Suppl 2: 58–61</td>
<td>In this Australian study, the authors surveyed private patients to determine their level of acceptance of surgical trainees within a private hospital setting. The study highlighted patient’s poor understanding of the term ‘registrar’. The authors concluded that acceptance of registrars is increased if consultant involvement is emphasised and trainees providing surgical assistance and performance of minor parts of surgery is well accepted by private patients.</td>
</tr>
<tr>
<td>Smith A, Galvin R, and Greaves J.</td>
<td>Defining excellence in anaesthesia: the role of personal qualities and practice environment</td>
<td>British Journal of Anaesthesia, 2011; 106: 38–43</td>
<td>In this study, the authors used a modified Delphi-type survey with specialist anaesthetists involved in education, asking them to define “excellence” in anaesthesia. They found that alongside knowledge and skills, many personal attributes were also ranked highly. They conclude that the achievement of excellence in anaesthesia is likely to depend on the successful interplay of individual’s personal qualities and the environment in which they work.</td>
</tr>
<tr>
<td>Wadman M C. et al</td>
<td>A comparison of emergency medicine resident clinical experience in a rural versus urban emergency department</td>
<td>Rural and Remote Health, 2010; 10(2): 1442</td>
<td>A North American study in which, using self-reported data from trainees, the authors compared the clinical experience of residents in a rural ED rotation with that of an urban university based ED rotation. Based on data obtained from a small number of residents, the authors conclude that a rural ED rotation provides an active clinical experience with similar volumes and procedures, albeit with lower patient acuity.</td>
</tr>
<tr>
<td>O’Connor D. and Spratt C.</td>
<td>Expanded specialist training; psychiatry supervisors’ feedback</td>
<td>Australasian Psychiatry, 2010; 18(3): 268–269</td>
<td>In this letter to the editor, the authors report on supervisors’ feedback on Expanded Specialist Training Program (ESTP) posts in psychiatry and argue that supervisors held ESTP rotations in high regard but also identified issues, including supervisor payments, trainee indemnity and alternative models of psychotherapy training.</td>
</tr>
<tr>
<td>O’Connor D. and Spratt C.</td>
<td>Australian psychiatry trainees’ reports of expanded specialist training placements</td>
<td>Australasian Psychiatry, 2010; 18(3): 267–268</td>
<td>The authors report on a focus group with trainees who had worked in private settings under the ESTP, identifying both benefits and challenges.</td>
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<td>Wilson T, Sahu A, Johnson D and Turner P</td>
<td>The effect of trainee involvement on procedure and list times: a statistical analysis with discussion of current issues affective orthopaedic training in UK</td>
<td>The Surgeon, 2010; 8: 15–19</td>
<td>UK study, using Operating Room Information system, patient operation notes and a consultant’s logbook data, aiming to examine the effect on time of trainees being involved in orthopaedic lists. The authors conclude that the time taken for a trainee to perform a procedure is significantly higher in comparison to cases performed by a consultant alone.</td>
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<tr>
<td>Dooney N and Osborn K</td>
<td>Rural anaesthesia practice: Attitudes and recruitment following a period of anaesthetic training in rural and regional hospitals. A survey of new consultants</td>
<td>Anaesthesia and Intensive Care, 2010; 38(2): 354–358</td>
<td>The authors aimed to survey attitudes of specialist anaesthetists towards anaesthetic training in rural and regional hospitals and then compare the current workplace of those consultants who had experienced a period of training in rural/regional hospitals with those who did not. Respondents to the survey (53% response rate) held their rural training in high regard and those that had a period of training in a rural/regional area were more likely to subsequently practice in rural areas compared to those who did not have a period of training in rural/regional areas.</td>
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<tr>
<td>Watters D, D’Souza B, Guest G, Wardill D, Levy S, O’Keefe M and Crowley S</td>
<td>Training in the private sector: what works and how do we increase opportunities?</td>
<td>ANZ Journal of Surgery, 2009; 79(3): 138–142</td>
<td>The authors reviewed two models of surgical training in the private sector to identify features that make for successful training. The authors also identified advantages and challenges of training in the private sector.</td>
</tr>
<tr>
<td>Schweizer Y, Spratt C and O’Connor D</td>
<td>Expanding Australian psychiatry training settings beyond metropolitan public hospitals: background and issues</td>
<td>Australasian Psychiatry, 2009; 17(5): 389–393</td>
<td>In this paper, the authors provide an overview of the rationale behind expanded settings in psychiatry training within Australia.</td>
</tr>
<tr>
<td>Reames J, Handel R, Al-Assaf A and Hedges J</td>
<td>Rural Emergency Medicine: Patient Volume and Training Opportunities</td>
<td>The Journal of Emergency Medicine, 2009; 37 (2): 172–176</td>
<td>The authors present a study which compares patient volume and training opportunities within emergency departments in rural versus urban hospitals and conclude that patient volumes per physician FTE do not differ between the two. They argue that opportunities to increase rural ED based emergency medicine training should be explored.</td>
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<tr>
<td>White SM.</td>
<td>The ethics of anaesthesia learning curves</td>
<td>Anaesthesia and Intensive Care, 2009: 37: 824–829</td>
<td>This paper examines the ethics of learning curves in anaesthetic training, with respect to patient consent and the relationship of supervision.</td>
</tr>
<tr>
<td>Clarke R C and Gardner A I.</td>
<td>Anaesthesia trainees' exposure to airway management in an Australian tertiary adult teaching hospital</td>
<td>Anaesthesia and Intensive Care, 2008; 36(4): 513–515</td>
<td>The purpose of this study was to estimate the exposure of trainees to airway management techniques in an Australian tertiary adult teaching hospital. Using extrapolated data, the authors conclude that trainees exposure to airway management techniques is not extensive and argue that experience in certain airway skills may need to be supplemented using techniques such as simulation.</td>
</tr>
<tr>
<td>Phelan P.</td>
<td>Medical specialist education and training in Australia</td>
<td>Medical Journal of Australia, 2007; 187: 687–688</td>
<td>In this opinion piece, the author discusses the new model of subspecialty surgical training within the private sector.</td>
</tr>
<tr>
<td>Watterson L M. et al</td>
<td>The training environment of junior anaesthetic registrars learning epidural labour analgesia in Australian teaching hospitals</td>
<td>Anaesthesia and Intensive Care, 2007; 35(1): 38–45</td>
<td>This study aimed to describe and evaluate training practices and environments provided for registrars who learn epidural labour analgesia in their first year of training, using audit, semi-structured interviews and surveys. The authors argue that the results suggest that current training practices for trainees are inadequate and could be improved by audit and structured workplace learning and assessment activities.</td>
</tr>
<tr>
<td>Wun L. Wong L. Shaw J. Heriot A. Keck J and Vellar D.</td>
<td>The private health sector: a potential surgical training ground?—a study of the perceptions of patients</td>
<td>ANZ Journal of Surgery, 2007; 77 (Suppl. 1) A77</td>
<td>In this abstract the authors describe a prospective study to assess patient perceptions on choice of private healthcare, the role of the surgical resident in a private hospital and surgical training within a private hospital environment. They conclude that patients supported surgical training in private hospitals.</td>
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<tr>
<td>Schenker M. Lees V. McGeorge D. Orton C. and Hancock K.</td>
<td>Aesthetic surgical training in the UK independent sector—the client’s view: Results of a survey on 155 private patients</td>
<td>Journal of Plastic, Reconstructive and Aesthetic Surgery: JPRAS, 2006; 59(11): 1188–1192</td>
<td>This study examined the attitudes of cosmetic surgical patients towards having trainees involved in their care and found that whilst the majority of private patients supported higher surgical training during private consultations, fewer would consider the possibility of cosmetic surgery performed by supervised trainees for reduced fees.</td>
</tr>
<tr>
<td>Dunbabin J.S. McEwin K. and Cameron I.</td>
<td>Postgraduate medical placements in rural areas: their impact on the rural medical workforce</td>
<td>Rural and remote health, 2006; 6: 481–490</td>
<td>In this paper, the authors tracked the career choice and practice location of medical students entering the cadetship program before 1999. They argue that the cadetship program provides an effective link between medical school and rural practice, and providing vocational training opportunities in rural locations is central to this success.</td>
</tr>
<tr>
<td>Rourke J.</td>
<td>A rural and regional community multi-specialty residency training network developed by the University of Western Ontario</td>
<td>Teaching and Learning in Medicine, 2005; 17(4): 376–381</td>
<td>This Canadian study describes a postgraduate vocational training network that aims to give specialty residents the opportunity to complete part of their training in rural and regional settings. The author surveyed residents on their training and concludes that rural and regional training can provide excellent learning experiences.</td>
</tr>
<tr>
<td>Harris M. Gavel P. and Young J.</td>
<td>Factors influencing the choice of specialty of Australian medical graduates</td>
<td>Medical Journal of Australia, 2005; 183(9): 295–300</td>
<td>This paper aims to identify the relative importance of extrinsic determinants of doctor’s choice of specialty through a self-administered postal questionnaire. The authors conclude that experience with discipline-based work cultures and working conditions occurs throughout medical school and the early postgraduate years, and most doctors choose their specialty during these years. They argue that interventions to influence doctor’s choice of specialty need to target these years.</td>
</tr>
<tr>
<td>Crotty B J.</td>
<td>More students and less patients: the squeeze on medical teaching resources</td>
<td>Medical Journal of Australia, 2005; 183(9): 444–445</td>
<td>In this editorial, the author argues for expansion of medical school clinical teaching into the private sector in response to increased numbers of medical school placements and considers some of the issues with regards to this.</td>
</tr>
<tr>
<td>Berntson A. Goldner E. Leverette J. Moss P. Tapper M. and Hodges B.</td>
<td>Psychiatric training in rural and remote areas: increasing skills and building partnerships</td>
<td>Canadian Journal of Psychiatry, 2005; 50(9): 1–8</td>
<td>This paper examines the educational opportunities for psychiatry training in rural and remote areas and explores the necessary adaptation of existing curricula to provide optimal learning in rural and remote environments.</td>
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<td>Authors</td>
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<tr>
<td>Vickery A. and Tarala R.</td>
<td>Barriers to prevocational placement programs in rural general practice</td>
<td>Medical Journal of Australia, 2003; 179: 19–21</td>
<td>This paper describes barriers to prevocational placement programs in rural general practice, including: funding arrangements; service versus training; coordination; resources; professional isolation and workforce supply.</td>
</tr>
<tr>
<td>Greaves JD, Grant J.</td>
<td>Watching anaesthetists work: using the professional judgement of consultants to assess the developing clinical competence of trainees</td>
<td>British Journal of Anaesthesia, 2000; 84: 525–33</td>
<td>In this UK study, an expert panel of consultant and trainee anaesthetists met to systematically analyse the assessment of competence by observing practice.</td>
</tr>
<tr>
<td>Khursandi D.</td>
<td>ANZCA Registrars in training—attitudes to work in rural Australia</td>
<td>Anaesthesia and Intensive Care, 1994; 22(4): 489</td>
<td>In this abstract, the author reports on a study undertaken to canvass the attitudes of registrars to work in areas outside capital cities. The author concludes that exposure to rural practice increases the likelihood that future specialist anaesthetists will consider returning to work in rural areas.</td>
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Appendix B Source documents


Australian and New Zealand College of Anaesthetists, *Specialist Training Program Project Background Information*

Appendix C Membership of the Evaluation Project Advisory Group

Dr James Beit  Supervisor of Training, Toowoomba Public Hospital
Ms Kate Davis*  Administrator, Specialist Training Program, ANZCA
Ms Donna Fahie  Manager, Specialist Training Program, ANZCA
Mr Oliver Jones (Chair)  General Manager, Education Unit, ANZCA
Dr U-Jun (June) Koh  Anaesthetic Trainee
Dr Dennis Millard  Anaesthetic Trainee
Ms Ellen Pascoe  Project Officer, Specialist Training Program, ANZCA
Ms Kate Plunket*  Administrator, Specialist Training Program, ANZCA
Dr Steve Watts  Supervisor of Training, Osborne Park and Hollywood Hospitals
Dr Jo Burnand  Consultant, IECO Consulting

* Kate Davis joined the Evaluation Project Advisory Group replacing Kate Plunket in May 2015.
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To those consultants and trainees who participated in the focus groups and semi-structured interviews, I am very appreciative of your insights and contributions to the evaluation process.

To the members of the Project Advisory Group, including Oliver Jones (Chair), who provided oversight of the project, thank you for your support and advice.

Thank you to Ellen Pascoe, Kate Plunket and Kate Davis for their assistance during the project and also to the ANZCA Library staff for their assistance in the literature search.

Finally, I would like to thank Donna Fahie for the support and assistance provided to me for the duration of the project.

JB