Title

Defining competency for Royal Australian and New Zealand College of Obstetricians and Gynaecologists training. An exploratory study of Victorian Integrated Training Program coordinators' understanding of competency.

Running Title

Understanding competency in RANZCOG training.

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Competing interests

Rebecca A Szabo is a RANZCOG fellow and training supervisor. The authors declare that they have no competing interests.

Funding

This research received no specific grant from any funding agency in the public, commercial or not-for-profit sectors.

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Article type : Original Article

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Key Words

Medical education, competency based medical education, obstetrics, gynaecology/gynecology, teaching, learning.

Manuscript Word Count

2554

Abstract Word Count

248

Figure Count

3

Table Count

2

Abstract

Background

Competency based medical education (CBME) is increasingly employed by postgraduate training programs worldwide, including Obstetrics and Gynaecology. Focusing on assessment of outcomes rather than time-in-training, and utilising a well-defined curricular framework, CBME aims to train doctors capable of meeting the needs of modern society. When this study was undertaken, in 2019, the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) had a time-based curriculum and was due to undergo a curriculum review starting 2020.

Aims

To explore Victorian RANZCOG Integrated Training Program (ITP) coordinators' understanding of the concept of competency and how it is taught and assessed within RANZCOG training.

Materials and Methods

A qualitative, grounded theory design using semi-structured interviews was employed. Victorian RANZCOG ITP coordinators from inner & outer metropolitan, and regional sites, were approached to participate. Transcripts were coded and analysed using thematic analysis.

Results

Themes identified were: Competence, Vision and Innovation, Structures, ITP Coordinator Role and Teaching and Learning. Competence was defined as a combination of independent practice and understanding of ones' own limits, in addition to required clinical skills and knowledge. Enablers and barriers to achieving competency were identified and associated with structures, human and logistical factors. Victorian ITP coordinators believed the current training program has positive elements but could be further improved.

Conclusions

Several areas for future research were identified regarding understanding of competency, relevant if RANZCOG is to introduce a CBME framework. Replicating this research across all RANZCOG jurisdictions in Australia and New Zealand would be prudent to determine if the themes are universal.

Introduction

Over the past thirty years, postgraduate medical education (PGME) has moved away from time-in-training, Halstedian models towards competency-based approaches in which learning outcomes and expectations are clearly defined.[1-3] Competency based medical education (CBME) differs from traditional time-based training models in that it is outcomes-based and learner-centered. CBME curricula focus on learning expectations and explicit descriptions of the knowledge, skills and attitudes that must be attained at each level of training[1, 4] so that graduates possess the necessary competencies for safe, independent practice at the completion of training.[5] There is a focus on formative, rather than summative, assessment and assessment tasks reflective of day-to-day clinical practice.[6, 7] The emphasis is on attaining competency of defined domains, not time-in-training or number of procedures undertaken.

In Australia and New Zealand, the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) oversees the training of specialist obstetrician/gynecologists (see Figure 1). The first four years of the six-year specialist training program[8] must be undertaken at accredited Integrated Training program (ITP) sites, and is coordinated by ITP Coordinators who have broad responsibilities for: i) planning rotations; ii) planning a teaching schedule; iii) promoting positive workplace culture; iv) supporting training supervisors; and v) ensuring training sites fulfil RANZCOG requirements for accreditation.[9]

RANZCOG assessment of trainee development incorporates a logbook documenting cases as well as attendance at compulsory workshops. Clinical and surgical skills are assessed via the completion of short work-based assessment forms, which generate a numerical grade. There are also summative written and oral examinations. This curriculum and program of assessment remains a largely time-based model despite incorporation of elements of CBME. In 2020 RANZCOG began a review of the training curriculum with the aim of identifying expected competencies at different levels of training, mapping roles and competencies to accepted competency frameworks, and better curriculum integration to ensure knowledge, skills and attitudes are assessed in parallel (S White RANZCOG, 2020, personal communication, 14 June).

The aim of our research was to explore how Victorian RANZCOG ITP coordinators define and perceive trainee competency and how it is taught and assessed within RANZCOG training.

Materials and Methods

Methodology

A prospective, qualitative approach utilising semi-structured interviews was employed. This design allowed for the research question to be answered by exploring Victorian ITP coordinators' experiences and perspectives of what competency is at various RANZCOG trainee levels. Inductive grounded theory was used with thematic analysis to generate themes which form both the results for discussion and scope for future research.

Ethics

Ethics approval was obtained from the Human Research Ethics Committee of the University of Melbourne, Department of Medical Education, Melbourne Medical School, ID 1853058.1.

Sampling

There are eight ITP coordinators in Victoria from seven training site (see Table 1).[9] A purposive sample of ITP coordinators was utilised. This approach was chosen as acknowledgment that coordinators at different sites may have different perspectives of training and competency. A sample size of 4-6 participant, of the total of 8, was chosen on both pragmatic and theoretical grounds. This meant 50% of the total number of Victorian ITP coordinators and 25% of the overall number for Australia and New Zealand were interviewed (see Table 1).

Participants

All participants were RANZCOG Fellows, ITP coordinators and Australian Health Practitioner Regulation Agency registered specialists practicing in Victoria, Australia.

Procedure

Recruitment

Prospective participants were contacted individually through work email addresses. The project invitation, plain language statement and consent form were attached with researcher contact details. A total of eight Victorian ITP coordinators were approached (see Figure 2) - three were based in metropolitan training sites, three at outer-metropolitan training sites and two at regional sites – and of these, five responded and four were interviewed. After written consent was obtained, participants were invited to suggest a mutually convenient time for the semi-structured interview to be conducted by the researcher (HP). Three participants chose a face-to-face interview, and one by phone.

Data collection and analysis

Semi-structured interview questions (see Appendix 1) were formulated (HP & RS) to focus on Victorian ITP coordinators' perspectives on competency within RANZCOG training. Interviews were conducted by a single interviewer (HP), recorded with consent, and then transcribed verbatim (HP) in preparation for analysis. Interviews were analysed using thematic analysis.[10] The lead researchers (HP & RS) read and coded the interview transcripts separately using an inductive, data-driven approach. They then compared results, and agreed on final codes, categories and themes.

Results

Participants identified five main themes: Competency, Teaching & Learning, the ITP Coordinator Role, Structures, and Vision & Innovation. We present the responses here under themed and sub-themed headings with example participant responses provided in Figure 3 and Table 2.

COMPETENCY

Competence is the attainment and maintenance of safe, independent practice

Participants reported a competent trainee possesses surgical and clinical skills, can work independently and is aware of their own limits. It was not enough just to know how to do a procedure; being a competent clinician is more than being a technician, a competent trainee knows 'why'. The demonstrative aspect of competence was knowing, doing, and showing. Significantly, part of being competent is knowing what one does not, but potentially should, know: "there will always be a few things that you are not 100% competent in when you *finish…*" (P4).

Competence requires cognisance and insight

Another element of competency was the concept of being cognisant of ones' own skills and abilities, and scope of practice. Cognisance was flagged as being difficult to teach, but easy to observe. It encompasses having insight into how one is performing procedural, non-procedural clinical and professional skills. Without cognisance, a trainee is not be able to think: *"well,* I *don't* know how to do this, and I must ask for *help"* (P3), further hindering their future development of competence.

Incompetence, dyscompetency and recovering competence

The state of not being competent was acknowledged to exist in differing degrees. Coordinators did not deem the lack of skill in one area, as equating to incompetence. Deficiencies became incompetence when they were conspicuous. Participants asserted the technical aspects of (dys)competency were recoverable.

TEACHING AND LEARNING

Enablers of competency development

Numerous enablers of competency development were identified, relating to teaching style and the learning environment. Teaching time and feedback was vital to trainee development: *"Face to face, hands on, and going* through the ... pro*cedures with them …* [these] are the most effective [teaching methods]" (P2). Consistent role modelling and mentoring was identified to be important, but this was challenging at some sites due to rostering. The learning environment: "*… has to be a safe environment …"*(P4) which allows trainees to make mistakes and receive subsequent teaching.

Barriers to competency development

Elements relating to trainees, consultants, hospitals, healthcare provision and the curriculum were identified as barriers to developing competence. Trainee factors included their intrinsic motivation (to learn) but also dependent on trainees' personal circumstances.

Supervisor and consultant factors included bullying and unprofessional behaviour: "*If you don't feel as though you can say, 'I don't really know what I'm doing here', how can you possibly improve your competency?*" (P4). There was not always time for consultants to stop and give feedback to trainees. In hospitals, decreasing caseloads were seen to be a significant problem: *"… I've* got *consultants who are trying to learn that now because it's been absent from their training. So that means the registrars are not going to get a look in …*" (P1).

Curriculum factors included assuming too much basic knowledge which is never formally taught or tested thereby subverting a structured, step-wise approach to learning.

Supervisor Training

Supervisors observe trainees from both medical and behavioural perspectives over the course of their mentorship, but this was seen as variable depending on the site. Supervisors, too, must learn: *"all the training supervisors are* doing their training super*visor workshop"*(P3). Participants viewed the three- and- six monthly supervisor meetings required by the RANZCOG curriculum as valuable, both as a part of the training program and for continuity of information it provided them as ITP coordinators.

ITP COORDINATOR ROLE

The ITP coordinator role was seen to involve guiding trainees to develop goals for their rotation, collating information from supervising clinicians and managing struggling trainees. ITP coordinators did not see their role as defining competency, rather: "…the competence of the trainee should be within the curriculum *… "* (P2). However, to some extent some have had to define competency in the development of in-house credentialing: "…I think we sort of *just made our own stuff up"* (P4). Recognising dys/incompetency is dependent on training supervisors and other clinical staff speaking out if they see inappropriate trainee behaviour or practice.

STRUCTURES

Lack of connection

Connection between organising bodies was seen as weak: "*there needs to be stronger structures …*" (P1). With the accreditation process hospitals must go through to become RANZCOG ITP sites, the lack of connection was characterised as RANZCOG being described as: "toothless" (P3) and "faceless" (P3). A lack of connection and cooperation was also perceived as a barrier to progress: "we do need a big rework of our whole program and how we achieve it." (P1). A lack of communication was also present between ITP training sites: "supervision across *hospitals just doesn't occur*" (P1). This was a problem especially if there were any trainee issues: "I will ....have a *discussion about any concerns… But nobody else does that*" (P1).

RANZCOG

The RANZCOG curriculum was seen as providing more of a guide to achieving competency. The curriculum was perceived as relevant to current practice but it doesn't encapsulate competent practice: *"The curriculum needs to be* updated*…"* (P1). RANZCOG has the influence to define competent practice. Coordinators desired a defined framework with some content changes. The curriculum was seen as containing at least some of the necessary

concepts but no way to really ensure that trainees reached competency in any of these domains: "... it should be more of a minimum standards kind of *structure…"* (P3).

VISION AND INNOVATION

Tracking the development of competency

Participants agreed changes to the curriculum could bring improvement. A sub-theme was the need for more: *"checks* and *balances"* (P3) - detailed learning frameworks, workshops and tools to allow a step-by-step learning process for trainees were desired. Embracing new technologies and techniques, such as simulation, and looking to the O&G curricula in other countries, such as the United Kingdom and the Netherlands, were posited.

More than one hospital site had introduced in-hospital credentialing, which helped guide consultants when dealing with trainees they did not know. It formalised assessment decisions, which encouraged consultants to attend calls rather than assuming that their registrar was competent to handle it, and also to provide teaching: "[the credentialing has] given some of our consultants a nudge in the teaching direction *..."*(P4).

Discussion

This research explored Victorian RANZCOG ITP coordinators' perspectives of the concept of competency and how it is currently taught and assessed within RANZCOG training. This study is timely as RANZCOG are currently undertaking a curriculum review (S White RANZCOG, 2020, personal communication, 14 June) looking at implementing a CBME style framework modeled on CanMEDS [11] and there is a global trend towards the adoption of CBME curricula[12].

For study participants, competency was seen to equate to demonstrably safe, independent practice, with the trainee equipped with skills to remain competent and aware of their own limitations, and this aligns with definitions of competency within the CBME literature.[13] Further, ITP coordinators clearly delineated incompetency/dyscompetency (termed 'deficiency') congruent to the CBME literature [4]. Notably, communication and behavioural skills, which are typically transmitted as a part of the 'hidden curriculum' of medicine,[14] were identified as being harder to teach and correct than clinical and surgical skills.[15, 16] These findings suggest a framework encompassing competency in communication and professional skills, alongside clinical and procedural skills, is important.

Within the current RANZCOG training program, ITP coordinators both collate and interpret feedback from supervisors (and others) so are actively defining what a competent trainee is, rather than having a specific definition or CBME framework. This meant trainee competency, and by implication dyscompetency, are open to interpretation [4, 17]. This is the opposite of current CBME practice [6, 18], and participants themselves noted competency is not well described in the current training curriculum. The subjective opinions of experts is desirable, and harnessing this expertise in formative assessment is to the benefit of trainees.[6] However, without a clear framework to guide supervisors, what is being assessed may be inconsistent with the educational outcomes of the training program.[19] Other factors such as workplace culture[20] and lack of faculty development[21] can also contribute to unreliable assessment. Ideally, educational frameworks and assessments should align with the clinical reality training programs and supervisors are attempting to provide the learner with; adequate structure in assessments gives relevance to feedback and assists individuals tasked with providing feedback a clear frame of reference.

The vision of Victorian ITP coordinators interviewed largely centered on two main concepts; 1) having more 'checks and balances' in place to ensure competency; and 2) the need for more support and innovation to assist trainees to develop competency in practical, surgical,clinical and professional domains. Checks and balances took the form of a call for more formative assessment, although there was a fear that too much assessment could result in evaluation fatigue.[22] Simulation was posited as an innovation that could assist trainees to develop competency in a stepwise fashion and maximise patient safety. Although the initiation of simulation programs is challenging and requires initiative, good leadership and financial support[23], simulation based medical education (SBME) is supported by a wealth of evidence in terms of both health outcomes and educational efficacy for teaching and assessing work based competency[24].

A limitation of this study was that it was only undertaken in Victoria, therefore it is possible that the findings do not accurately represent ITP coordinators' views from other RANZCOG jurisdictions. While the objective of the study was exploratory and not to produce nationally representative results, we provide adequate contextual description allowing readers to determine whether the findings resonate with their experiences of the current RANZCOG specialist training program. Although only four (of a total of 8) Victorian coordinators were interviewed, the findings are nonetheless valuable. Additionally, the sample size is legitimised by the findings from other qualitative interview-based studies that have demonstrated how a small sample size can provide data sufficiency and produce reliable results from which to derive theory [25, 26]. Several areas for future research were identified regarding understanding of competency in RANZCOG training, relevant if RANZCOG is to introduce a CBME framework. Replicating this research across all RANZCOG jurisdictions in Australia and New Zealand would be prudent to determine if the themes are universal.

To our knowledge, this is the first study to investigate RANZCOG ITP coordinators' perspectives on the concept of competency. Competency and dyscompetency were readily defined and based on lived experience, rather than stemming from existing RANZCOG definitions. Some elements of competency, namely professional and interpersonal skills, are more difficult to teach and assess than others, such as surgical skills. Whilst the ability of training supervisors to make assessments about trainee clinical competency was impeded by site-specific factors, it was also perceived there could be more communication both within and between sites regarding trainee ability. If RANZCOG are to develop a CBME framework with well-defined competencies, competency and dyscompetency will need to be clearly defined. Ideally this should be informed by how these concepts are already perceived by ITP coordinators and training supervisors. This research could potentially inform the curriculum review process and definitions of what makes a competent RANZCOG trainee and Fellow.

Acknowledgements

We would like to thank the study participants for their time in contributing to this research.

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Figures

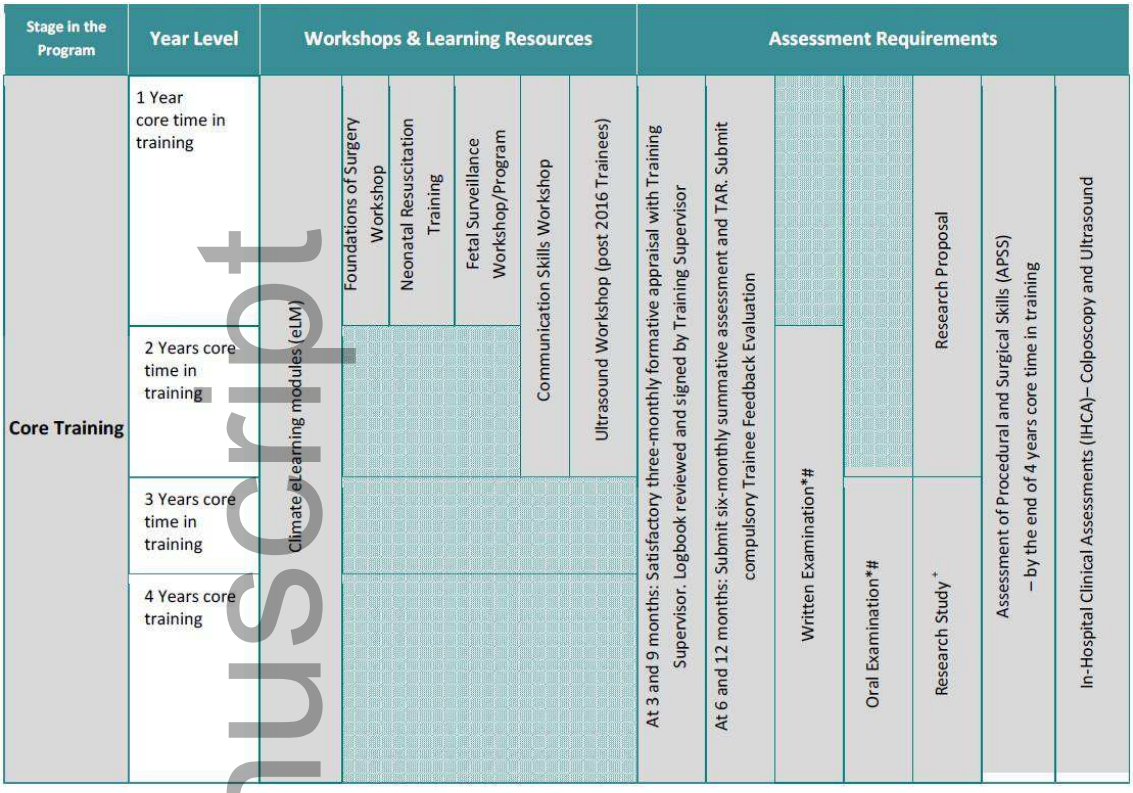

Figure 1: RANZCOG Core Training Overview, 2013 onwards [8]

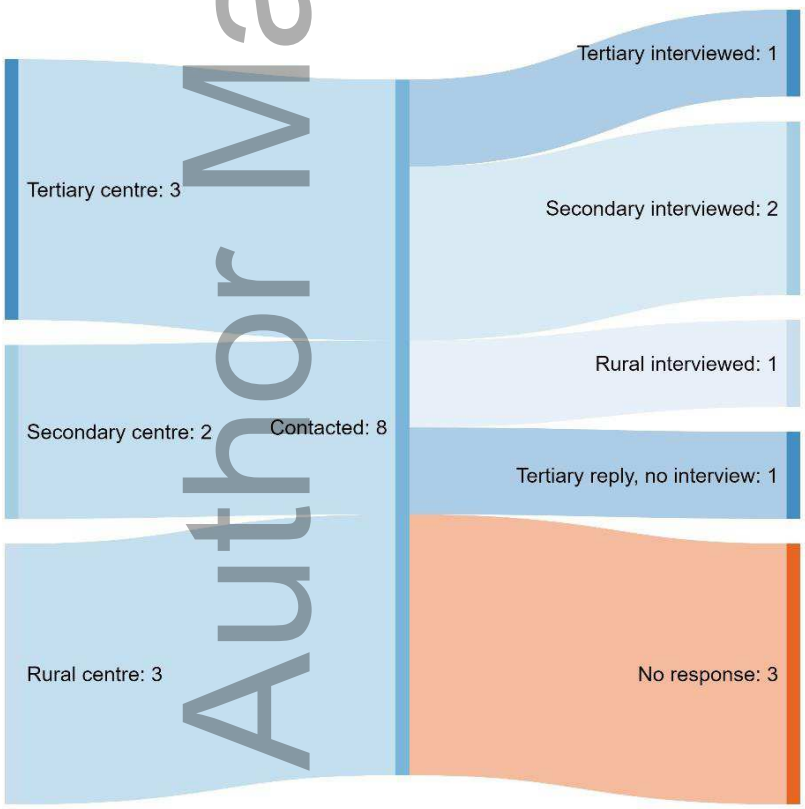

Figure 2: The recruitment process

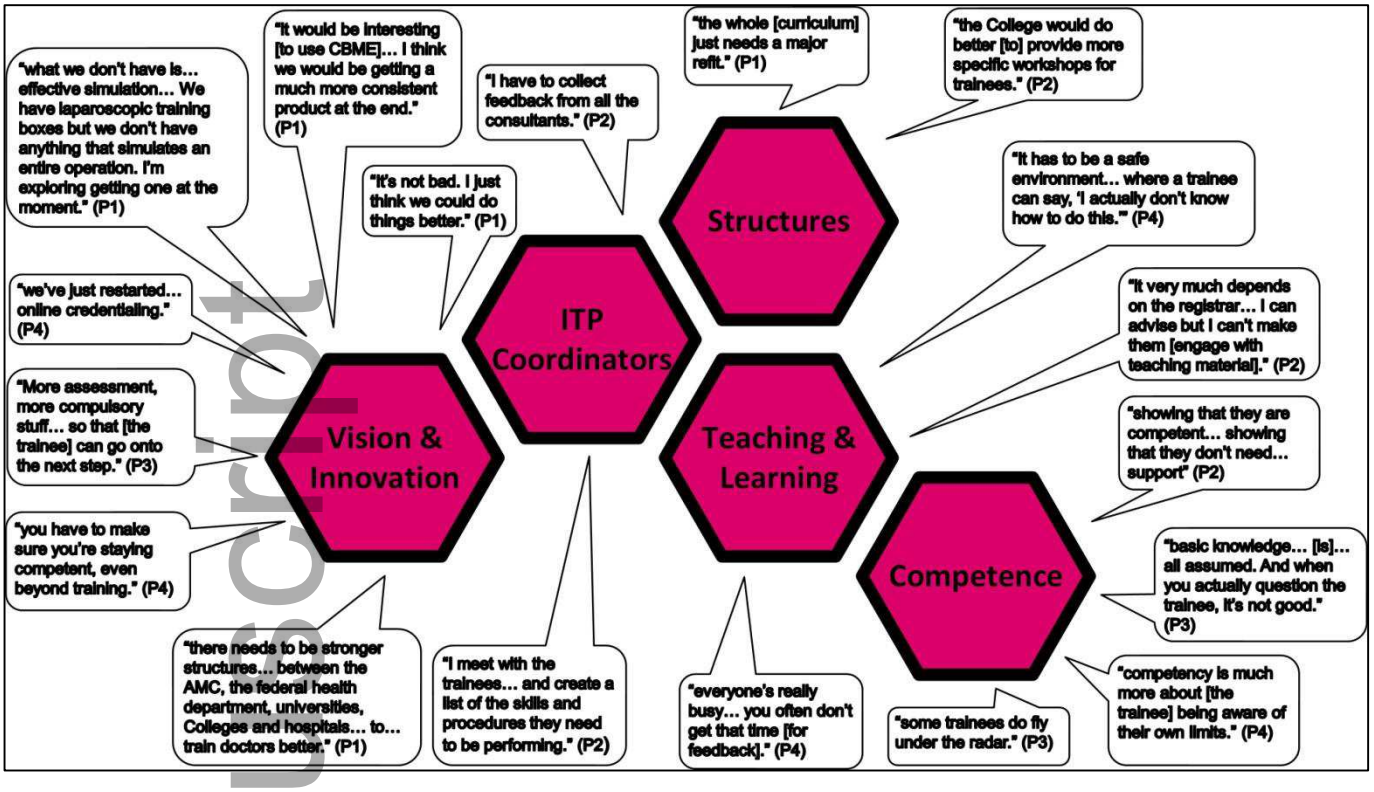

Figure 3: Results expressed as themes with participant quotes

Tables

Table 1. Number of RANZCOG ITP training sites and coordinators [9]		
Location	**ITP training site**	**ITP coordinator/s***
Total	29	31
New Zealand	3	3
Australia	26	28
ACT	1	1
NSW	9	10
SA/NT	1	1
QLD	5	5
TAS	1	2
VIC	7	8

*Some sites have more than one coordinator either job sharing or due to multiple facilities within a site

Table based on Fellowship of RANZCOG Specialist Training Program Handbook – Companion 2020[9]

Table 2. Themes and Sub-themes		
Overarching theme	**Sub-theme and categories**	**Sample of coded text**
Competency	Competence is the attainment and maintenance of safe, independent practice	"the ability to be solo without direct backup" (P1). *"Why are we doing this procedure? Is this the right procedure* for the patient?... Are we going to achieve what she wants? What are *the aims? And if we can't achieve it, what are the options?"* (P3) "the utopian view is that the training program would have you all turn out competent at everything we want you to be able to [do]. But there will always be a few things that you are not 100% competent in when you *finish…* And *that's* your job to work out what they are, and how you are gonna fix it" (P4)
	Competency requires cognisance and insight	*"… if they try to do something without having that knowledge, I* would deem that to be more incompetent than not knowing how to *do it"* (P3). *"well,* I *don't* know how to do this, and I must ask for *help"* (P3)

	Incompetence, dyscompetency and recovering competence	*"it's* pretty rare for someone to be incompetent across the board. *It's usually a deficiency…"* "…… *if a trainee can't do a basic history, examination and differential diagnosis, and they're in the training program, that* would be basic incompetence, because that would be what you do *right from medical school."(P3)* *"extending* [competence] to include ... professionalism, interpersonal interactions ... those aspects are much harder to *recover than technical aspects. Most problem trainees that I've seen, they haven't been technical issues, they've been behavioural or personal factors"* (P1). Regarding dyscompetency "people with problems in [interpersonal areas] areas usually have very little insight. So, I *think they're much harder to work on"* (P1).
Teaching and Learning	Enablers of competency development – teaching time and feedback Learning environment	*"there* has to be good role models. So, like [X, recently graduated consultant], just in that transition, happy to show them, still got all the *skills…* so *that's* terrific. So, you need *that…* range of experience in *teaching"* (P4). "if [a procedure] was going a bit awry and I had to take over *... it* gives you an opportunity to have a teaching experience, because *you can say, 'well, that didn't go quite well, what was going on there ...?'*" (P4).
	Barriers to competency development – trainee and supervisor factors Hospital and healthcare factors	"I think not everyone makes it a conducive environment to *assessing and developing of competencies. If you don't feel as though you can say, 'I don't really know what I'm doing here',* how can you possibly improve your competency?" (P4). "most jobs are busy, *everyone's* really busy *...you don't* have time to sit down and say, *'actually,* you did that *really well' …. Even when it's good … you often don't get that time*" (P4).

	Curriculum factors	"*... we're doing a lot of medical treatments, for* example, instead of surgery ... and perhaps the type of operation, for example the laparoscopic hysterectomy. *I've* got consultants who are trying to *learn that now because it's been absent from their training. So* that means the registrars are not going to ge*t a look in ...*" (P1). *"... everything is out there, it's there for people to grab and take and assimilate ... but it has to be the trainee* who is diligent and resourceful to find *things ...* there is no requirement for them to have that knowledge *... Unless you are forced to do it, you won't do it"* (P3).
	Supervisor training	Supervisors, too, must learn: *"all the training supervisors are doing their training supervisor workshop every three years... and that's...* [about giving] *objective feedback"* (P3).
ITP coordinator role	ITP coordinator role	*"The* registrar might be allocated to a few different consultants ... therefore I have to collect all the feedback from the other *consultants to see what they think of their registrar's level"* (P2). "… so, we looked at [the College competency guidelines], and ... we *haven't* really used them to be honest! I think we sort of just *made our own stuff up"* (P4). *"The* registrar might be allocated to a few different consultants ... therefore I have to collect all the feedback from the other *consultants to see what they think of their registrar's level"* (P2).
Structures	Lack of connection	"*there needs to be stronger structures ... or ... frameworks* between the AMC and the federal health department, universities, *Colleges and hospitals... what we have now has just arisen over time ....*" (P1).

		Regarding connection and accreditation RANZCOG described as "toothless" (P3) and "faceless" (P3). "we do need a big rework of our whole program and how we achieve it. And *that'll* be very *challenging. 'Cause it involves individual hospitals signing up to that …. They often ignore the College, and the College doesn't have* enough teeth to enforce things" (P1). "I will contact the hospital [the problem trainee is] going to and *just have a discussion about any concerns… But nobody else does* that" (P1).
	RANZCCOG	*"The curriculum needs to be updated…* [training sites] provide most of the [curriculum material], probably more than the *curriculum states. But… the* whole [curriculum] just needs a *major refit"* (P1). "*… we have a prescribed curriculum in* the RANZCOG, and since it changed in 2013, some trainees *don't* even need to do a hysterectomy properly. *It's changed a lot, become very modality based…. So, the College has* changed our perception of what is competent, by changing the curriculum" (P3). "*There's* a lot of free texting [in the curriculum] ... it should be more of a minimum standards kind of *structure…"* (P3). "*there's no simulation* curriculum, and yet *we're* being assessed [by RANZCOG, as a part of the accreditation process] for having *simulation with it not being part of the curriculum, so I think it's ridiculous"* (P1). *"How* the College ensures *it's* producing competent graduates? *Basically…* so, *I'm* guessing, *there's the collection of the feedback assessments, summative assessment…* [these] will give the *College an idea about the competence of the trainee"* (P2).
Vision and	Tracking the	*"checks* and *balances"* (P3)

innovation	development of competency	"More *assessment, more compulsory stuff needs to be out there…* like a part one exam before they can attempt the part two exam" (P3) "*… for* example, we have clinical assessments for ultrasound and *colposcopy, where an external person comes in… Maybe we* could do something like that for surgery. And that would maybe remove that potential, *ah…* collusion between trainees and supervisors and hospital consultants to just sign things off for the sake of it" (P1). "[the credentialing has] given some of our consultant a nudge in the teaching direction ... it means they have to turn up, they have to watch … And they by default teach. Because if they have to say *to that trainee, "I'm not signing it off", then a conversation happens about why not"* (P4).

Appendix 1

Semi- structured interview schedule

Project: Understandings of trainee competency amongst Integrated Training Program coordinators in obstetrics and gynaecology training in Victoria

1. What is competent/what does competency look like?
- What are the essential elements of competency?
- Does this vary at different levels of training?

2. How do you know when a trainee is competent?
- What does the trainee do that tells you that they are competent?
- How does competency relate to independent practice?
3. What tools/methods/assessment approaches do you use to define competency?
- How do you find these useful?
- Are there other methods that you have attempted to use? What were these?

4. What factors do you think facilitate the development of competency amongst trainees?
- What are the barriers to the development of competency?
5. Do you use 'competency guidelines' from the College?
- If so, how?
- To what extent is teaching and learning structured within the College?
- How does the College ensure that it produces competent graduates?
- What is the role of ITP coordinators in this?

6. In observing practice, how much/how often is enough to:
- Assess where the trainee is at;
- Trust the trainee to perform duties independently
- Determine competence?
7. How to you determine when a trainee is not competent?
- What do you do?
- How do you communicate this to the College?
- What evidence do you need to justify this decision?
- Is competency recoverable?
- Are there avenues are there to assist a trainee who is not competent, to develop competence?

Tables

Table 1. Number of RANZCOG ITP training sites and coordinators [9]		
Location	**ITP training site**	**ITP coordinator/s***
Total	29	31
New Zealand	3	3
Australia	26	28
ACT	1	1
NSW	9	10
SA/NT	1	1
QLD	5	5
TAS	1	2
VIC	7	8

*Some sites have more than one coordinator either job sharing or due to multiple facilities within a site

Table based on Fellowship of RANZCOG Specialist Training Program Handbook – Companion 2020[9]

Table 2. Themes and Sub-themes

Overarching theme	Sub-theme and categories	Sample of coded text
Competency	Competence is the attainment and maintenance of safe, independent practice	"the ability to be solo without direct backup" (P1). *"Why are we* doing this procedure? Is this the right procedure for the patient?... Are we going to achieve *what she wants? What are the aims? And if we can't achieve it, what are the options?"* (P3) "the utopian view is that the training program would have you all turn out competent at everything we want you to be able to [do]. But there will always be a few things that you are not 100% competent in when you *finish…* And *that's* your job to work out what they are, and how you are gonna fix it" (P4)
	Competency requires cognisance and insight	*"… if they try to do something without having that* knowledge, I would deem that to be more incompetent *than not knowing how to do it"* (P3). *"well,* I *don't* know how to do this, and I must ask for *help"* (P3)
	Incompetence, dyscompetency and recovering competence	*"it's* pretty rare for someone to be incompetent across *the board. It's usually a deficiency…"* "….. *if a trainee can't do a basic history, examination and differential diagnosis, and they're in the* training program, that would be basic incompetence, because that would be what you do right from medical *school."(P3)* *"extending* [competence] to include ... professionalism,

		interpersonal interactions … those aspects are much harder to recover than technical aspects. Most problem *trainees that I've seen, they haven't been technical issues, they've been behavioural or personal factors"* (P1). Regarding dyscompetency "people with problems in [interpersonal areas] areas usually have very little *insight. So, I think they're much harder to work on"* (P1).
Teaching and Learning	Enablers of competency development – teaching time and feedback Learning environment	*"there* has to be good role models. So, like [X, recently graduated consultant], just in that transition, happy to show them, still got all the *skills…* so *that's* terrific. So, you need *that…* range of experience in *teaching"* (P4). "if [a procedure] was going a bit awry and I had to take over *… it gives you an opportunity to have a teaching experience, because you can say, 'well, that didn't go quite well, what was going on there …?'*" (P4).
	Barriers to competency development – trainee and supervisor factors Hospital and healthcare factors Curriculum factors	"I think not everyone makes it a conducive environment to assessing and developing of competencies. If you *don't feel as though you can say, 'I don't really know what I'm doing here', how can you possibly improve* your competency?" (P4). "most jobs are busy, *everyone's* really busy *…you don't* have time to sit down and say, *'actually,* you did that *really well' …. Even when it's good … you often don't* get that time" (P4). "*… we're doing a lot of medical treatments, for example,*

		instead of surgery ... and perhaps the type of operation, for example the laparoscopic hysterectomy. *I've* got *consultants who are trying to learn that now because it's* been absent from their training. So that means the *registrars are not going to get a look in ...*" (P1). *"... everything is out there, it's there for people to grab and take and assimilate ... but it has to be the trainee* who is diligent and resourceful to find *things* ... there is no requirement for them to have that knowledge ... *Unless you are forced to do it, you won't do it"* (P3).
	Supervisor training	Supervisors, too, must learn: *"all the training* supervisors are doing their training supervisor *workshop every three years... and that's...* [about giving] *objective feedback"* (P3).
ITP coordinator role	ITP coordinator role	*"The* registrar might be allocated to a few different consultants ... therefore I have to collect all the feedback from the other consultants to see what they think of their *registrar's level"* (P2). "… so, we looked at [the College competency guidelines], and ... we *haven't* really used them to be honest! I think we sort of *just made our own stuff up"* (P4). *"The* registrar might be allocated to a few different consultants ... therefore I have to collect all the feedback from the other consultants to see what they think of their *registrar's level"* (P2).

Structures	Lack of connection	"*there needs to be stronger structures … or …* frameworks between the AMC and the federal health *department, universities, Colleges and hospitals… what we have now has just arisen over time ….*" (P1). Regarding connection and accreditation RANZCOG described as "toothless" (P3) and "faceless" (P3). "we do need a big rework of our whole program and how we achieve it. And *that'll* be very *challenging. 'Cause it involves individual hospitals signing up to that …. They often ignore the College, and the College doesn't have* enough teeth to enforce things" (P1). "I will contact the hospital [the problem trainee is] going *to and just have a discussion about any concerns… But* nobody else does that" (P1).
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		process] for having simulation with it not being part of *the curriculum, so I think it's ridiculous"* (P1). *"How* the College ensures *it's* producing competent graduates? *Basically…* so, *I'm* guessing, *there's the* collection of the feedback assessments, summative *assessment…* [these] will give the College an idea about *the competence of the trainee"* (P2).
Vision and innovation	Tracking the development of competency	*"checks* and *balances"* (P3) "More assessment, more compulsory stuff needs to be *out there… like a part one exam before they can attempt* the part two exam" (P3) "*… for example, we have clinical assessments for* ultrasound and colposcopy, where an external person *comes in… Maybe we could do something like that for* surgery. And that would maybe remove that potential, *ah…* collusion between trainees and supervisors and hospital consultants to just sign things off for the sake of it" (P1). "[the credentialing has] given some of our consultant a nudge in the teaching direction ... it means they have to turn up, they have to watch … And they by default teach. *Because if they have to say to that trainee, "I'm not* signing it *off", then a conversation happens about why not"* (P4).

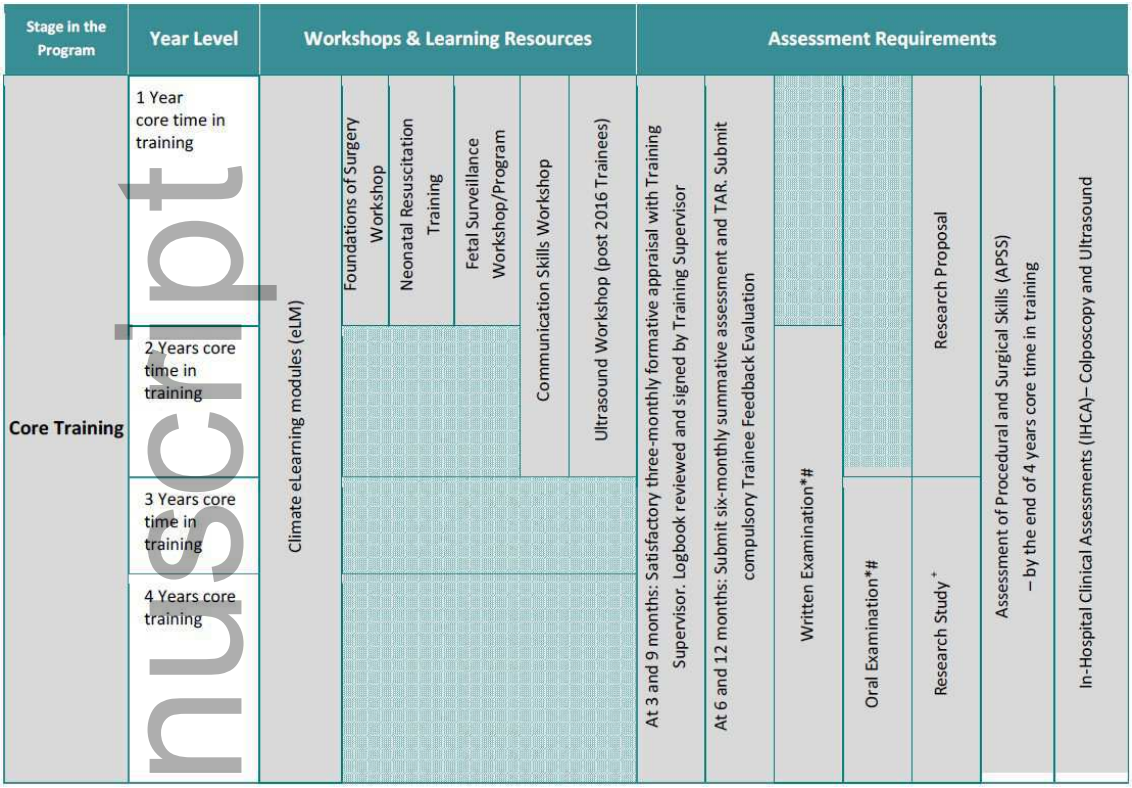

Figure 1: RANZCOG Core Training Overview, 2013 onwards [8]

Figures

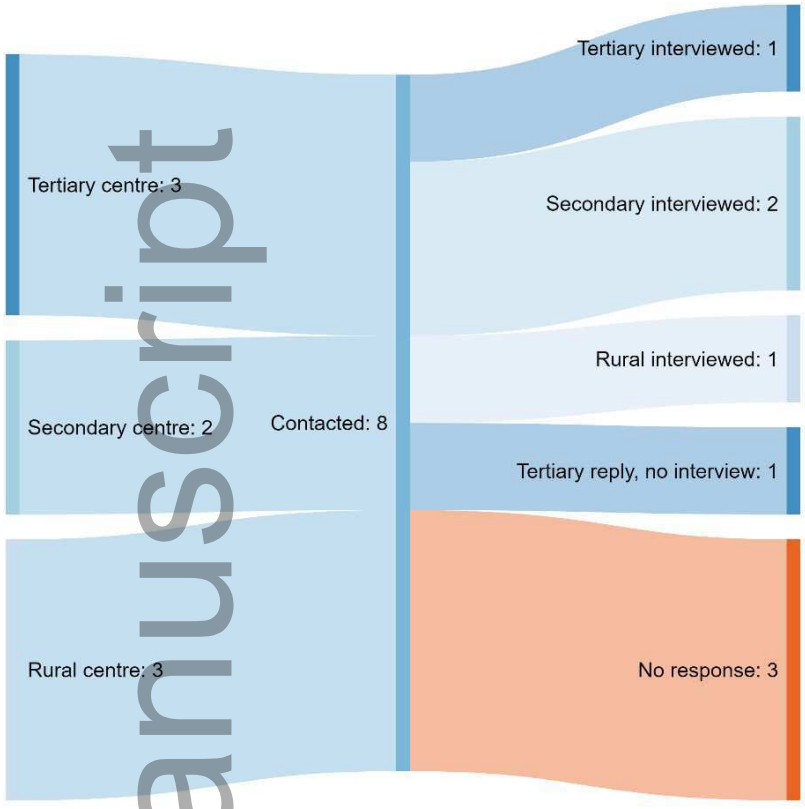

Figure 2: The recruitment process

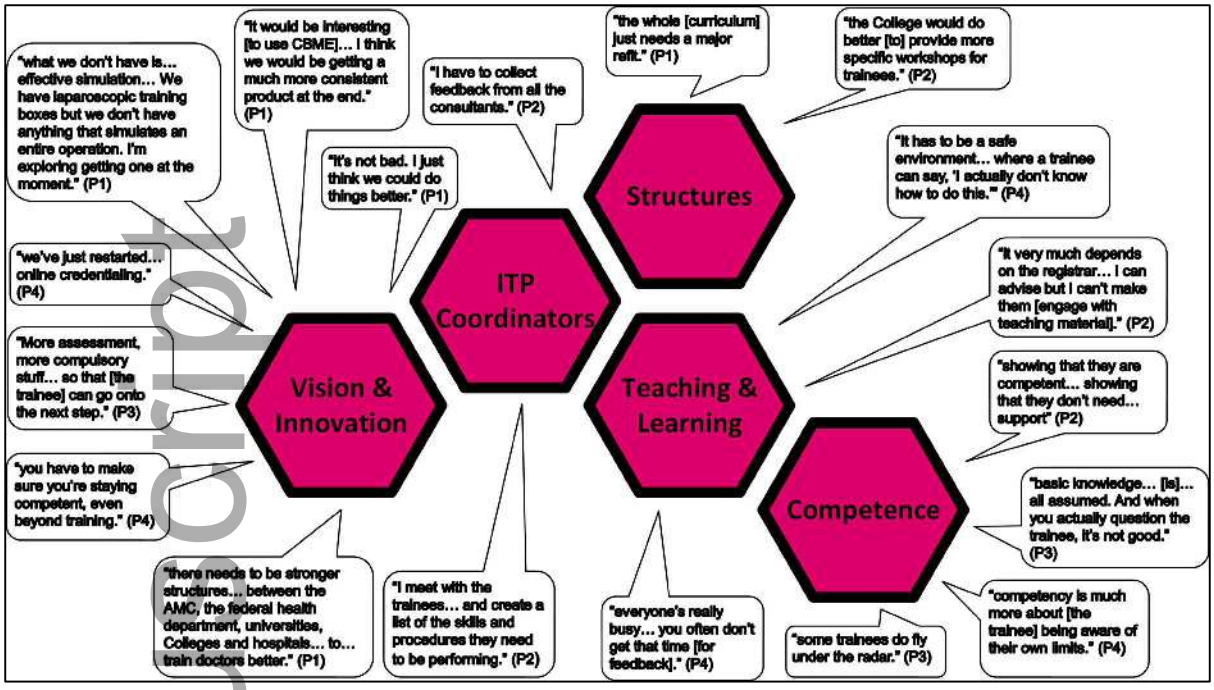

Figure 3: Results expressed as themes with participant quotes