Royal Australasian College of Surgeons
Progress Report 2018
Australian Medical Council

ROYAL AUSTRALASIAN
COLLEGE OF SURGEONS

ACFID
MEMBER

Royal Australasian College of Surgeons

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Contributors to the report

This report has been compiled with significant advice and input from specialty society and training board representatives and RACS office-bearers and staff. Detailed information provided by individual specialty training programs is presented verbatim in Appendix 10. Ms Kathleen Hickey's contributions to the preparation of the report are particularly acknowledged.

Verify report reviewed

The information presented to the AMC is complete, and it represents an accurate response to the relevant requirements.

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List of acronyms

AIDA	Australian Indigenous Doctors' Association
AMC	Australian Medical Council
AOA	Australian Orthopaedic Association
ASC	Annual Scientific Congress
ASE	Academy of Surgical Educators
ASERNIP-s	Australian Safety and Efficacy Register of New Interventional Procedures - surgical
ASM	Annual Scientific Meeting
ASSET	Australian and New Zealand Surgical Skills Education and Training
Au	Australia
BRIPS	Building respect, improving patient safety
BSET	Board of Surgical Education and Training
CCrISP®	Care of the Critically Ill Surgical Patient
CEO	Chief Executive Officer
CIC	Censor-in-chief
CLEAR	Critical Literature Evaluation and Research
CPD	Continuing Professional Development
CV	Curriculum vitae
DBSH	Discrimination bullying and sexual harassment
DOPS	Direct observation of procedural skills
EGM	Executive General Manager
EMST	Early Management of Severe Trauma
FSSE	Foundation Skills for Surgical Educators (course)
IMG	International medical graduate
MCNZ	Medical Council of New Zealand
MiniCEX	Mini clinical evaluation exercise
MOU	Memorandum/a of understanding
MSF	Multi-source feedback
NSW	New South Wales
NZ	New Zealand
NZAPS	New Zealand Association of Plastic Surgeons
NZBPRS	New Zealand Board of Plastic and Reconstructive Surgery
OPBS	Orthopaedic Principles and Basic Science (Examination)
OWR	Operating with respect (course)
PRS	Plastic and Reconstructive Surgery
PRSSP	Plastic and Reconstructive Surgical Science and Principles (Examination)
PSEC	Prevocational and Skills and Education Centre
QLD	Queensland
RACS	Royal Australasian College of Surgeons
RACSTA	Royal Australasian College of Surgeons Trainee Association
SA	South Australia

SET	Surgical Education and Training
STP	Specialist Training Program
TIPS	Training in Professional Skills
TOR	Terms of reference
VIC	Victoria
WA	Western Australia

Standard 1: The context of training and education

Areas covered by this standard: governance of the college; program management; reconsideration, review and appeals processes; educational expertise and exchange; educational resources; interaction with the health sector; continuous renewal.

Summary of significant developments

With the appointment of a new Chief Executive Officer (CEO), Mary Harney, in October 2017, a comprehensive review of RACS' governance and operational structures commenced. The review incorporated extensive consultation with RACS Council, and RACS staff, state and territory and New Zealand committees, specialty societies, and specialty training boards.

In response to the review findings, improvements to RACS organisational and governance structures have commenced. Priorities include improving the effectiveness and efficiency of RACS with a focus on delivering value to Fellows, trainees and International Medical Graduates. A new Executive Leadership Team has been established incorporating the Deputy CEO position, held by John Biviano, with three new roles. Emily Wooden, Chief Operating Officer, and Susan Wardle, Executive General Manager (EGM) Partnerships, have commenced, and the appointment of a new EGM Education is pending, with the appointment of Robin Buckham as the interim EGM Education. With the creation of these senior positions, there have been corresponding changes to the reporting lines of some departments. Education activities across the continuum of learning are now grouped under the direction of the EGM Education. The new organisational structure is described in the RACS Executive Leadership Team plan (Appendix 1).

Changes to committee structures are being undertaken to enable a more streamlined and focussed approach to governance. The Board of Regional Chairs and the Governance and Advocacy Board have been merged into a new Advocacy Board. With a broad vision to promote advocacy across RACS, the new board brings together state, territory and New Zealand chairs and specialty representatives (from the nine key surgical specialities) with other relevant groups.

Benefits from these changes are likely to include better alignment of RACS' structure to strategic priorities, bringing key functions and expertise together (e.g. Education), and being more inclusive of New Zealand and Australian regions and enhancing the focus of activities to Fellows, trainees and IMGs.

RACS' management and the specialty societies and speciality training boards have consulted and continue to interact to share information and develop collaborative projects. The President and the CEO have met with all 13 specialty societies. The Dean of Education regularly attends meetings of the speciality training boards and convened a selection workshop involving all specialties in April 2018.

Significant activities include:

- Discussion of the amalgamation of the Board of Surgical Education and Training and the Education Board has commenced. See progress against Condition 1.
- An evaluation framework has been instigated to monitor implementation and outcomes of the Building Respect, Improving Patient Safety Action Plan. Relevant evaluation is to be implemented in three phases over ten years, with the final phase planned for implementation in 2026. Governance and reporting of findings, including recommendations for program adjustment, are through RACS Council.

The first annual external review of the complaints handling process has been completed by an Independent Complaints Process Reviewer. The external review and oversight of the process provide assurance that RACS' handling of discrimination, bullying and sexual harassment (DBSH) complaints has been undertaken appropriately and that due process has been addressed. An annual report is provided to RACS Council and published on the RACS website.

An internal review of the management of the complaints area, with a focus on risk management will commence in July 2018.

- A collaborative initiative with St Vincent Health Australia (SVHA) is working towards a model for the sharing of information on complaints made about Fellows, trainees and IMGs. SVHA has recently implemented their ETHOS system.
- Consistent with other medical colleges, and to allow for review and evaluation, from September 2018, RACS will cease ISO accreditation. A decision to re-accrediting with ISO will be considered in 2019.
- A review of the digital platform is about to commence.
- Significant advocacy has been undertaken in the areas of excessive fees and out of pocket costs, impact of private health insurance, rural health and indigenous health.

Recommendations for improvement

AA	Broaden the definition of conflict of interest to include reflection on an individual's demography, committee roles, public positions or research interests that may bias decision making in areas such as selection or specialist international medical graduate assessment

No significant developments

Activity against conditions

Condition 1	Review the relationships between Council, the Education Board, the Board of Surgical Education and Training and the specialty training boards to ensure that the governance structure enables all training programs to meet RACS policies and AMC standards. To be met by: 2019

Consultation on the governance structure for training, with the focus on amalgamation of the Board of Surgical Education and Training and the Education Board, has commenced. The Censor-in-Chief is leading a working party to determine options; a proposed restructure of the two boards will be discussed with the Speciality Training Boards and Societies in October 2018.

Condition 2	RACS must develop and implement a stronger process for ongoing evaluation as to whether each of these programs remain consistent with the education and training policies of the College. To be met by: 2020

The speciality training boards have expressed willingness to work with RACS' management to align specialty regulations with RACS' education and training policies. The conditions of the service agreements between RACS and the specialty societies will be integral in achieving this condition. Discussion on updating the agreements will commence in late 2018.

Consistent use of the Surgical and Education and Training (SET) policies by the specialty training boards will also be reviewed as the overarching evaluation framework for education is developed in 2019 (Condition 17).

Condition 3	Develop a common policy that makes it explicit that all specialty training boards must develop and implement defined reconsideration, review and appeals policies which clearly outline the processes for each of the three phases. To be met by: 2018

The RACS Appeals Mechanism policy (V5, 2014. See Appendix 2) is the common policy adhered to by all specialty training boards, and referenced in all training regulations. It should be noted that some appeals are managed directly by the Australian Orthopaedic Association (AOA) applying the same principles as described in the RACS Appeals Mechanism.

The RACS Appeals Mechanism is currently under review to streamline the process to provide greater clarity. The revised policy will more clearly encompass and define reconsideration and review as the first two stages related to any issues raised by SET trainees or IMG surgeons under supervision. Formal appeal would be available when matters have not been resolved.

At the February and June 2018 meetings of the Board of Surgical Education and Training (BSET), the specialty training board chairs discussed the AMC condition requiring clearly outlined processes for reconsideration and review, noting the AMC considered the AOA and Neurological Society of Australia (NSA) processes as exemplars. The boards were asked to ensure that specialty regulations articulate process for reconsideration and review, adhering to the principles described in the RACS Appeals Mechanism.

Each speciality training board will confirm that they have articulated defined processes for reconsideration, review and appeal in their regulations at the BSET meeting in October 2018. (See Appendix 10 for specialty training program responses).

Condition 4	Provide evidence of effective implementation, monitoring and evaluation of the: (i) Reconciliation Action Plan (ii) Building Respect, Improving Patient Safety Action Plan (iii) Diversity and Inclusion Plan. To be met by: 2021

Reconciliation Action Plan (RAP) (Australia)

There are 21 actions arising from the RACS Reconciliation Action Plan 2016-2017(Au), of which 17 have been completed with four continuing to progress, including:

- The appointment of senior Torres Strait Islander Professor Martin Nakata (James Cook University, Townsville) as an education adviser to RACS.
- Making available $130,000 in scholarships annually for Aboriginal and Torres Strait Islanders pursuing careers in surgery.
- Guaranteeing training positions for Aboriginal applicants who meet the standard for selection (Refer condition 26).
- Providing cultural competence training for 80 RACS staff.
- Maintaining a focused advocacy campaign to improve ear health outcomes in Aboriginal communities.
- Building relationships with other organisations pursuing reconciliation including the Australian Indigenous Doctors' Association (AIDA), the Leaders in Medical Education (LIME) and National Aboriginal Community Controlled Health Organisation (NACCHO).

Work has begun on the next RAP (2019-2020) (Au) and will focus on working with surgical societies and associations and mainstreaming Aboriginal and Torres Strait Islander health and cultural competence across the breadth of RACS speciality curricula.

Diversity and Inclusion Plan (New Zealand)

The Diversity and Inclusion plan (NZ) was developed as an action arising from implementing the Action plan. It is written to complement the existing Reconciliation Action Plan and Māori Health Action Plan. Achievements for the latter include:

- Annual scholarships are available for Māori doctors and medical students interested in pursuing surgical careers.
- A strong relationship exists with Te Ohu Rata o Aotearoa (Te ORA, the Māori Medical Practitioners Association) and RACS has provided sponsorship for its annual hui–a–tau. Relationships also exist with staff in Māori health units in other organisations such as Health Quality and Safety Commission and other medical colleges.
- Māori health presentations are a requirement in NZ's Annual Surgeons Meeting; and articles are published regularly in the RACS' Surgical News.
- Selection interviews in 2018 for training in New Zealand included assessment of cultural competence scenarios; and a workshop is planned for later this year with NZ training chairs to develop further inclusion of Māori tikanga into selection and training.
- A Māori name for RACS, Te Whare Piki Ora o Māhutonga, and a Māori motif have been approved and are in use.
- Māori welcomes are used at all NZ skills courses and RACS meetings.
- All RACS NZ staff attended Treaty of Waitangi training.

Other actions advanced under the Diversity and Inclusion plan are captured in the evaluation framework of the Building Respect Action Plan.

Building Respect and Improving Patient Safety Action Plan (Action Plan)

RACS has instigated an evaluation framework to monitor the implementation and outcomes of the Action Plan in three phases, over ten years. The evaluation framework includes research questions, indicators, and data sources based on bespoke program logic as the first phase. The evaluation framework will enable RACS to ensure that appropriate data is gathered to measure progress and outcomes of activities contained in the Action Plan. Modifications of the Action Plan may come from this evaluation process.

Statistics and annual updates

Reconsideration, reviews and appeals

The number of reconsiderations, reviews, and appeals that have been heard in the past year, the subject of the reconsideration, review or appeal (e.g. selection, assessment, training time, specialist international medical graduate assessment) and the outcome (number upheld, number dismissed)

The RACS Appeals Mechanism is currently under review to streamline the process to provide greater clarity. During this period of review, there is inadequate data for accurate reporting. See response to Condition 3.

Table 1 Requests for reconsideration

Reason for Reconsideration	Number of reconsiderations	Outcome	
		Upheld	Dismissed
Insufficient data to report			

Table 2 Requests for review

Reason for Review	Number of reconsiderations	Outcome	
		Upheld	Dismissed
Insufficient data to report			

Table 3 Requests for appeal

Reason for Appeal	Number of reconsiderations	Outcome	
		Upheld	Dismissed
Appeal against the decision to dismiss trainee from the Neurosurgery SET program.	1		1
Appeal against the decision to dismiss trainee from the Urology SET program	1	1	
Appeal against an IMG assessment of 'not comparable' to an Australian or New Zealand trained Urologist	1		1

Governance Policies/Procedures

Changes to the following documents since the last progress report, can the changes be described in the table below and the updated documentation attached to this progress report.

Table 4 RACS governance (policies and procedures)

Policies/Procedure	Description of Changes
College Governance Chart	Organisational restructure in progress (Appendix 1)
Conflict of Interest	No change

Standard 2: The outcomes of specialist training and education

Areas covered by this standard: educational purpose of the educational provider; and, program and graduate outcomes

Summary of significant developments

A high level business plan has been developed – the *Education Program of Work 2018-2020* (Appendix 3) – to provide focus for the educational outcomes to be achieved by 2020. The plan defines ten broad areas of work, and the interdependent projects should ensure excellence for the Surgical Education and Training (SET) program, incorporating RACS strategic drivers e.g. the *Building Respect and Improving Patient Safety Action Plan*, and the conditions required for ongoing accreditation by the AMC and MCNZ.

The focus of the plan is to enhance and implement program improvements across the continuum of training and education. This has been commended by the speciality training boards and specialty societies. Further details can be found in the plan.

Recommendations for improvement

BB	Benchmark the graduate outcomes of each of the surgical training programs internationally.

In collaboration with the speciality training board, work on better defining the graduate outcomes of each of the surgical training will be progressed.

As part of the AOA21 project, the orthopaedic training program was benchmarked globally such that the project will be/is best educational practice.

CC	Improve the uniformity of presentation of training program requirements and graduate outcomes for each of the surgical specialties (particularly on the website), taking into account feedback from trainees, supervisors and key stakeholder groups

No significant developments

DD	In conjunction with the specialty training boards, review and report on the reasons for the pervasiveness of post-fellowship training and any potential impact on the appropriateness of the Surgical Education and Training (SET) program.

The pervasiveness of post-fellowship training remains a topic of discussion and ongoing review by specialty training boards. The approach differs between specialities as a result of differing requirements and identified gaps; there is a range of opinions. Post-fellowship training is a deep concern to trainees and is often raised in discussion and through the bi-annual RACS Trainees' Association (RACSTA) trainee survey.

Comments from several specialty training boards have indicated:

- the value in additional structured experience to broaden and deepen training outcomes;
- Suitable post-fellowship training may be within ANZ or overseas;
- the need for ongoing monitoring of the impact of local fellowship posts on SET trainees;

- the need to consider incorporation of training in new technologies into training that may be obtained in post-fellowship years.

Activity against conditions

Condition 5	Define how the College's educational purpose connects to its community responsibilities. To be met by: 2020

Work defining RACS' educational purpose is being conducted in association with defining graduate outcomes and is linked to Conditions 6, 7, 8, 9 and 14. The scope of this work incorporates increased focus on community expectations and feedback to RACS.

It is noted that RACS' responsibilities to its community are woven into the fabric of the Building Respect and Improving Patient Safety and the Diversity and Inclusion plans.

RACS has convened a series of Rural Surgical Training workshops to identify integrated training pathways in order to address deficiencies in rural surgical services. A key aim is to define and implement a set of strategies that will help select, train and sustain a surgical workforce responsive to the specific needs of regional and rural Australia. This work is being undertaken in collaboration with all State and Territory jurisdictions and with the involvement of the specialty training boards, specialty societies and RACSTA.

Condition 6	Broaden consultation with consumer, community, surgical and non-surgical medical, nursing and allied health stakeholders about the goals and objectives of surgical training, including a broad approach to external representation across the College. To be met by: 2021

Each speciality training board has appointed an external community representative. Early indications from the speciality training boards are that these new roles are highly regarded and a valuable addition to the boards' discussions and decision making.

Strategies to broaden consultation with non-surgical stakeholders will be incorporated into the project being undertaken to articulate program and graduate outcomes (Refer to Conditions 5, 7, 8 and 14)

RACS has met with the National Rural Health Commissioner and is also collaborating with the Australian College of Rural and Remote Medicine, the Royal Australian College of General Practitioners and the Rural Doctors Association of Australia to support training of procedural rural general practitioners.

Condition 7	Clearly and uniformly articulate program and graduate outcomes (for all specialties) which are publicly available reflect community needs and which map to the nine RACS competencies. To be met by: 2021

Defining and clearly articulating the program and graduate outcomes underpins the educational development of curricula, assessment and professional development and impacts on current and planned work as described in the Education Program of Works and this document.

It is noted that currently several boards are undertaking curriculum reviews or implementing work based assessments that more clearly identify the expected graduate outcomes. Cardiothoracic, General Surgery, Neurosurgery, Otolaryngology Head and Neck Surgery, Plastic and Reconstructive Surgery (Au and NZ) and Urology are well underway with this activity. Outcomes for Orthopaedic Surgery have been defined within the AOA 21 curriculum

(Refer Standard 3; Conditions 5, 6, and 14)

Statistics and annual updates

Nil required.

Standard 3: The specialist medical training and education framework

Areas covered by this standard: curriculum framework; curriculum content; continuum of training, education and practice, and curriculum structure.

Summary of significant developments

All speciality training boards report their support for competency-based curricula and most have provided details of the curricula (refer Condition 12 and Condition 13 commentary. Also see Appendix 10).

Recommendations for improvement

EE	Develop explicit criteria to consider whether training periods of less than the standard six months can be approved, and ensure that prior learning, time and competencies acquired in non-accredited training are fairly evaluated as to whether they may count towards training.

Several specialty training boards are moving towards accepting fewer than 20 weeks per six-month (26-week) term being recognised as contributing to training. The recommendation aligns to the progress towards implementing flexible training options (See responses to Condition 13 and Appendix 10, Specialty Responses).

For Surgical Education and Training (SET) applicants, experiences in non-accredited posts contribute to achievement of selection pre-requisites and activities scored in CVs. Specific experience acquired in non-accredited positions is not counted towards time in training by all specialities, however, the competencies so acquired may be recognised as the trainee is assessed and progresses within the competency-based training program. Paediatric Surgery and Urology recognise prior learning and trainees can commence in SET 2 or 3. General Surgery regulations allow for recognition of prior learning for trainees who have been on the training program previously. General Surgery is also reviewing flexible training options for trainees who only complete 2-3 months of a term.

FF	Make available to all trainees the learning modules under the Building Respect, Improving Patient Safety (BRIPS) program, once most or all College Fellows are trained

As the mandatory training for supervisors, trainers and senior committee members nears full compliance, the Foundation Skills for Surgical Educators course (FSSE) is being made available to trainees.

The speciality training boards have indicated their active encouragement and support for trainees to complete the FSSE and the Operating with Respect e-learning modules, and Urology has mandated the FSSE for SET 6 (final year) trainees. A dedicated FSSE course for Urology senior trainees was held in 2017 and another is planned for 2018. Senior Vascular Surgery trainees are also attending a dedicated FSSE course. The intention is to also develop a trainee-specific OWR face to face course with RACS Trainees' Association (RACSTA) involvement.

Activity against conditions

Condition 8	Enhance and align the non-technical competencies across all surgical specialties, including a consideration of the broader patient context. To be met by: 2021

Linked to development of generic curriculum and work under Conditions 6,7,8,9 and 14.

Condition 9	As it applies to the specialty training program, expand the curricula to ensure trainees contribute to the effectiveness and efficiency of the healthcare system, through knowledge and understanding of the issues associated with the delivery of safe, high-quality and cost-effective health care across a range of settings within the Australian and/or New Zealand health systems. To be met by: 2021

Aligned to the development of a generic curriculum (see Condition 8).

RACS recognises that understanding the healthcare system covers the issues mentioned and that some medical schools (e.g. Monash) have dedicated subjects within their medical degrees, and such knowledge already gained will be built upon.

Condition 10	Document the management of peri-operative medical conditions and complications in the curricula of all specialty training programs. To be met by: 2021

Progress

The management of peri-operative medical conditions and complications is included in the General surgery SEAM modules, and the curricula of the Neurosurgery, Orthopaedic and Plastic and Reconstructive Surgery (Au) and Otolaryngology Head and Neck Surgery training programs.

Peri-operative management will be explicitly included in the revision of the curriculum for Urology and Plastic and Reconstructive (NZ), both currently in development.

Condition 11	Include the specific health needs of Aboriginal and Torres Strait Islanders and/or Māori, along with cultural competence training, in the curricula of all specialty training programs. To be met by: 2021

Dr David Murray, Chair Indigenous Health Committee, Mr Pat Alley, Chair Māori Health Advisory Group and Professor Martin Nakata, Education Advisor attended the Board of Surgical Education and Training (BSET) meeting in February 2018 to offer support and advice to the specialty training boards. The Chair of BSET requested all specialty training boards to share curricula information with Professor Nakata to enable the Indigenous Health Committee to provide guidance and advice regarding inclusion of cultural awareness training. Specialty information is currently being gathered. In New Zealand a hui (meeting) is being convened with speciality training board representatives to discuss the specific elements related to Māori health.

A funding proposal to develop cultural awareness training has been submitted to the Federal Government under their Specialist Training Program (STP) initiative. Work will commence on developing generic modules to upskill participants on cultural competence.

Condition 12	In conjunction with the specialty training boards, develop a standard definition across all training programs of ‘competency-based training’, and how ‘time in training’ and number of procedures required complement specific observations of satisfactory performance in determining ‘competency’. To be met by: 2020

Progress in competency-based training has been made by specialty training boards as they revise curricula. Increasingly curricula define outcomes and competencies linked to stages of training which are bound by flexible time periods. Some training boards are using behavioural markers to describe a standard of

performance and increasingly, work based assessments are used to determine performance against standards.

General Surgery has approved a move to competency-based training which includes Entrustable Professional Activities (EPA) and Procedure Based Assessments (PBA) and other work based assessments combined with timeframes. Orthopaedic Surgery has adopted a modular approach to progression through training and has introduced 'stages' of training with minimum and maximum completion timeframes; accredited time is no longer used. Work-based assessments progress towards early consultant practice level. Otolaryngology Head and Neck Surgery have similarly introduced three competency-based levels of training with minimum and maximum completion timeframes and progression largely defined by work-based assessment. Behavioural markers describe standards of performance in each stage. Neurosurgery and Paediatric Surgery implemented competency-based curricula several years ago. Plastic and Reconstructive Surgery (Au) has introduced milestones for trainees which articulate the level of competence to be achieved and monitor progress through the program and Urology and Plastic and Reconstructive Surgery (NZ) will incorporate measures to assess competency in their revised curricula. In the Vascular Surgery curriculum, work based assessment is based on seven competencies. Standards are identified for each competency at each set level. Cardiothoracic Surgery supports competency-based training,

Condition 13	RACS has a policy that is applicable to all specialty training programs to remove the overt and hidden barriers to flexible forms of training. RACS must build on the existing policy and processes, and liaise with hospitals to implement flexible training. To be met by: 2018

RACS has contacted all training hospitals to determine if the hospital can offer flexibility and to identify specific training posts in the hospital that could be other than full time. Of the 162 hospitals contacted, 118 (73%) indicated their ability to offer flexible positions, 24 (15%) were unable to do so and responses were not received from 20 (12%). See Appendix 4 for the breakdown of responses by region and speciality.

The hospital responses have been circulated to the speciality training boards. In parallel, some individual boards have made contact with their training units to determine if and where flexible posts can be identified. Neurosurgery, Orthopaedics Surgery (Au and NZ), Paediatric Surgery, Plastic and Reconstructive Surgery (Au and NZ) and Urology have done so. General Surgery and Otolaryngology Head and Neck Surgery NZ have included flexible training as a component of hospital accreditation.

An encouraging cultural change is evidenced by the discussions over several meetings of the Board of Surgical Education and Training, and RACSTA have advocated strongly and effectively to BSET. At the June 2018 meeting of BSET, each specialty training board outlined their progress, reporting on new flexible posts identified for 2019 and discussing the processes and requirements to establish flexible posts. Flexible training continues to be a standing item on each BSET meeting agenda.

Approaches to flexible training differ between specialties, in part due to differences between numbers of trainees and training posts per specialty, flexible training has been embraced by all speciality training boards. This has been reflected in their regulations and post accreditation standards e.g. AOA 2019 training regulations stipulate that training sites with 3 or more posts must make a part-time position available; Paedatric Surgery states that if a hospital has more than 2 training posts, one post must be available as a flexible option.

The intent is to normalise flexible training as an option for trainees but it is recognised that iterative development is required. The success of the measures taken to date will be identified in 2019 when the flexible posts identified this year are utilised.

Statistics and annual updates

Nil required.

Standard 4: Teaching and learning approach and methods

Summary of significant developments

As speciality curricula are revised and developed, new methods of work based assessment, use of simulation and the private sector have offered alternative opportunities for learning.

Recommendations for improvement

GG	Consider options to mitigate the lack of training in some parts of Australia and New Zealand, such as in outpatient settings, endoscopy and aesthetic surgery

To mitigate the lack of access to outpatients, endoscopy and aesthetic surgery, Orthopaedic, General Surgery and Plastic and Reconstructive Surgery training boards are considering utilising private consulting rooms and working with hospitals to ensure alternative arrangements are in place, via training post accreditation criteria. General Surgery is also proposing an accreditation standard for all new post applications whereby the new post must have access to outpatients.

Limited access to endoscopy and colonoscopy is being managed through the introduction of new procedure-based assessments (PBAs) to support training in this area and consideration of introducing basic endoscopy training for trainees in New Zealand to encourage accredited hospitals willingness to allow trainee access to endoscopy suites.

Activity against conditions

Condition 14	For all specialty training programs, develop curriculum maps to show the alignment of learning activities and compulsory requirements with the outcomes at each stage of training and with the graduate outcomes. This could be undertaken in conjunction with the curricular reviews that are currently planned or underway. To be met by: 2021

Some speciality training boards have progressed the alignment of learning activities and required outcomes at each stage of training and this work aligns to Conditions 5, 6,7,8, and 9.

General Surgery and Urology have indicated that as curricula are developed or revised, defined levels of progression to required standards or outcomes will be mapped. Orthopaedic Surgery and Otolaryngology Head and Neck Surgery have curricular frameworks that outline expectation of performance at each stage of learning; learning opportunities have been broadly mapped to the curriculum competencies. There is a comprehensive curriculum map in place for Cardiothoracic Surgery.

Statistics and annual updates

Nil required.

Standard 5: Assessment of learning

Areas covered by this standard: assessment approach; assessment methods; performance feedback; assessment quality

Summary of significant developments

Improvements to the conduct of the Fellowship Examination (FEX) have been implemented in response to feedback received from fellows and candidates.

In April 2018, a workshop for senior examiners was conducted to improve the quality and relevance of the written feedback reports provided to failing candidates and their supervisors post FEX. The emphasis of the workshop was to upskill the senior examiners in writing feedback that is specific and useful in assisting candidates and supervisors to understand and identify areas for improvement. The new approach to writing feedback reports was implemented in May. Once distributed, the examiners' reports were reviewed by the RACS Principle Educator and feedback will be provided to the examiners to continue to improve their skill and the overall process.

Recommendations for improvement

JJ	For all surgical specialties, adopt behaviour-related reporting (i.e. descriptive of the key features) rather than simple scoring for all work-based assessments.

See Standard 4 for information regarding specialty implementation of work-based assessments.

KK	Explore the use of multi-source feedback for all surgical training programs at set points throughout training.

IMGs on pathway to fellowship across all specialties participate in 6-monthly multi source feedback (MSF).

Cardiothoracic Surgery, Orthopaedic Surgery, Paediatric Surgery and Urology are using MSF or 360^{o} evaluation. Most MSF/360^{o} evaluations are used for trainees in difficulty or for SET1 trainees, rather than routinely at this stage. Cardiothoracic Surgery has introduced two 360^{o} evaluations for SET1 trainees.

LL	Review whether the term 'essay-type' is appropriately used in all its current contexts. Where essay-type questions are used, consideration should be given as to whether they could be replaced with short-answer type questions.

Refer response to Condition 15.

Activity against conditions

Condition 15	Respond to the 2016 Review of Assessments Report by Cassandra Wannan by noting whether recommendations have already been implemented, require implementation or are rejected, including a rationale for the latter. To be met by: 2018

The recommendations contained in the Review of Assessments report have been reviewed and considered by the speciality training boards, Court of Examiners and Surgical Science and Clinical Examinations Committee. None of the recommendations has been rejected outright. Some have been implemented and some are yet to be implemented.

In regard to the examinations, six of the seven recommendations are in stages of implementation or have been completed. Recommendation 6, suggesting the use of alternatives to essay questions, will be considered as the electronic format for the FEX written paper is developed.

Following the release of the Review of Assessments report, a number of specialties have taken steps to update their work-based assessment (WBA) processes to ensure that they are aligned with current evidence-based best practice.

General Surgery is moving to toward entrustable professional activities (EPAs) and procedure-based assessments (PBAs); Otolaryngology Head and Neck Surgery has introduced procedure-based assessments (PBAs) is considering entrustable professional activities (EPAs). A number of other specialties have made changes to their assessment processes and forms to better reflect levels of competence required at specific stages of training.

Most specialties have implemented, or are considering, assessment structures in which specific procedures that are required at any given stages of training are clearly defined, and progress toward achieving competency in these procedures is monitored.

The uptake of multi-source feedback (MSF) as an assessment tool remains limited. However, as noted above, some specialties have utilised MSF as an additional assessment tool for trainees in difficulty.

In summary:

- Cardiothoracic and Otolaryngology, Head and Neck Surgery have indicated interest to further develop WBA practices in collaboration with the RACS education department staff.
- General Surgery is moving towards PBAs
- Otolaryngology, Head and Neck Surgery is using PBAs
- General Surgery is moving towards EPAs
- Plastic and Reconstructive Surgery and Urology are using EPAs
- Urology, Orthopaedic, Paediatric and, Cardiothoracic Surgery are using MSF/360^{o} evaluation, mostly in the early stage of training or for trainees in difficulty
- Plastic and Reconstructive has explicitly addressed all recommendations pertaining to WBA.
- Plastic and Reconstructive, Otolaryngology, Head and Neck Surgery and Urology are using DOPS and MiniCEX.
- Orthopaedic Surgery (Au), Otolaryngology, Head and Neck, Paediatric and Vascular Surgery have defined competencies for stages of training.

(See Appendix 10 detail)

Condition 16	Implement appropriate standard setting methods for all specialty-specific examinations (The AMC recognises that at least three specialties are already compliant in this respect). To be met by: 2019

The following specialty specific examinations have predetermined pass scores and construct exams accordingly. Work is in progress with these specialties to review their methodologies and increase accountability:

- Cardiothoracic Surgical Sciences and Principles Examination (CSSP)
- Plastic and Reconstructive Surgical Sciences and Principles (PRSSP)
- Orthopaedic Principles and Basic Sciences (OPBS)

- Paediatric Anatomy and Embryology Examination (PAE) and the Paediatric Pathophysiology Examination (PPE).
- Urology Surgical Sciences Examination

Otolaryngology, Head and Neck and Vascular Surgery use a modified Angoff method, facilitated by RACS staff, to standard set their specialty surgical sciences examinations. General surgery also uses a modified Angoff method for standard setting assessments within the 8 SEAM modules

Statistics and annual updates

Summative assessment activity for the Surgical Sciences, Clinical and Fellowship examinations. The number and percentage of candidates sitting and passing each time they were held

Table 5 Examination pass rates

Examination Activity	Candidates sitting examination	Candidates passed examination	% of candidates passed examination
Generic Surgical Science Examination	31	16	51.6%
Specialty Specific Surgical Sciences Examination	191	162	84.8%
Clinical Examination	275	218	79.3%
Fellowship Examination – all attempts*	327	207	63.3%
Fellowship Examination – annual pass rate#	271	207	76.4%
Fellowship Examination – SET trainees	282	192	65.4%
Fellowship Examination – IMGs	45	15	33.3%

* Total sittings: records numbers of candidates; some candidates sit twice during a year.

Annual pass rate reports on the success rate of the individual candidates (over 1 or 2 sittings) passing Fellowship Exam in 2017.

Standard 6: Monitoring and evaluation

Areas covered by this standard: program monitoring; evaluation; feedback, reporting and action

Summary of significant developments

Evaluation of the Building Respect and Improving Patient Safety and the Diversity and Inclusion plans are ongoing. Feedback leading to evaluation and monitoring of the Surgical Education and Training (SET) program will be a focus of RACS' management and speciality training boards in 2019.

Recommendations for improvement

MM	Explore with trainees how response rates to surveys on training posts could be improved.

No significant developments

NN	Implement the planned New Fellows' Survey to evaluate their preparedness to practise and the annual survey of trainees who leave surgery without completing the program.

An initial Younger Fellows survey was distributed to all Younger Fellows (Fellows in their first 10 years of practice) in March 2018. A presentation on the preparedness for practice and alignment for workforce was delivered in May 2018 at RACS ASC, Sydney.

Activity against conditions

Condition 17	Develop an overarching framework for monitoring and evaluation, which includes all training and educational processes, as well as program and graduate outcomes. To be met by: 2019

RACS' management and speciality training boards collect data from a variety of sources across the breadth of the training program; reports and formats differ. Collated data informatics into standard reports will underpin the development of an overarching framework for monitoring and evaluation. Quarterly overall SET program data is reviewed, providing more dynamic information similar to the 2014 SET evaluation and subsequent 2015-17 data.

At present, Orthopaedic Surgery has a monitoring and evaluation framework in place, and General Surgery is planning to introduce a comprehensive evaluation process.

Condition 18	In conjunction with the specialty training boards, develop a policy to manage the situation whereby a trainee has been inadvertently identified as a result of providing feedback. To be met by: 2018

RACS continues to foster learning environments in which trainees are safe and confident to provide feedback or to complain. The Building Respect and Improving Patient Safety Action Plan is designed to promote safe training environments and to implement cultural change, and it is acknowledged that these goals may be generational. To this end and as part of the Building Respect and Improving Patient Safety Action Plan, considerable work has been undertaken to improve and build confidence in the complaints and reporting process. Following an external review of the process (refer Standard 1: Summary of significant developments), a recommendation to develop a disclosure statement on victimisation has been actioned. The disclosure

statement makes explicit that RACS will not tolerate victimisation. Processes are in place to support the confidentiality of trainees, and the speciality training boards are highly cognisant of the need for confidentiality.

Against this background, the discussion paper "Responding to and supporting trainees who provide feedback" describes seven principles for responding to and supporting a trainee who may feel disadvantaged or vulnerable after providing feedback, or lodging a complaint. These principles were accepted and approved by the Board of Surgical Education and Training in June 2018 as a basis for a contingency plan to address the situation whereby a trainee has been inadvertently identified as a result of providing feedback.

The principles will be published on the RACS webpage – About Respect – and circulated to trainees via RACS Trainees' Association and the speciality training boards. See Appendix 5 "Responding to and supporting trainees who provide feedback"

Condition 19	Establish methods to seek confidential feedback from supervisors of training, across the surgical specialties, to contribute to the monitoring and development of the training program. To be met by: 2019

Currently, the main channel to receive feedback from supervisors is via direct communication to the relevant specialty training board, or training board chair. Supervisors are represented on all training boards. Supervisor feedback is received during training post accreditation.

Neurosurgery has introduced bi-annual supervisors' meetings which have resulted in significant input by supervisors into the structure and management of the training program and assessment tools. Similarly, the Vascular Surgery Training Board conducts two meetings per year, specifically to seek supervisor feedback. The AOA Federal Training Committee routinely seeks feedback twice annually, and at other events e.g. 'Bone Camp', trial exams.

Linked to Condition 17.

Condition 20	Develop and implement completely confidential and safe processes for obtaining—and acting on—regular, systematic feedback from trainees on the quality of supervision, training and clinical experience. To be met by: 2019

The RACS Trainees' Association (RACSTA) Survey, conducted six-monthly is proving to be a valuable source of information on aspects of training, including the quality of supervision and training and clinical experience.

A variety of processes for obtaining trainee feedback has been reported. The trainee representative on each specialty training board is the usual conduit for receiving regular, systemic feedback from trainees. General Surgery and Urology have regulated for feedback on training posts as a component of training post accreditation. Neurosurgery, Orthopaedic Surgery, Otolaryngology Head and Neck Surgery, Plastic and Reconstructive Surgery (Au), and Urology have reported routinely seeking feedback from trainees. Plastic and Reconstructive Surgery (NZ) conduct an annual trainee survey to gather trainees' feedback.

These and other methods to obtain and act upon systemic feedback will be a considered in the development of an evaluation framework (Condition 17).

Condition 21	Develop formal consultation methods and regularly collect feedback on the surgical training program from non-surgical health professionals, healthcare administrators, and consumer and community representatives. To be met by: 2020

To date, the Cardiothoracic Surgery and Urology training boards are the only boards reporting that feedback from non-surgical health professionals and health care administrators is sought. This occurs during training post accreditation.

Condition 22	Report the results of monitoring and evaluation through governance and administrative structures, and to external stakeholders. It will be important to ensure that results are made available to all those who provided feedback. To be met by: 2020

As indicated in Condition 20, the RACSTA Trainee Survey is a major source of trainee feedback on multiple aspects affecting learning environments and trainee wellbeing.

The survey is reported to and discussed by the Board of Surgical Education and Training and the Education Board. The major survey findings are communicated to trainees via RACSTA.

RACS produces an annual Activities Report and the RACS Annual Report. Both are publicly available and the Annual Report is circulated to major stakeholders.

Condition 23	Develop and implement an action plan in response to the 2016 Leaving Surgical Training study. To be met by: 2019

An editorial and article have been published in the ANZ Journal of Surgery exploring the themes presented in the Leaving Training Report, and as precursor to further response to the report:

Truskett P., 2018 *Soil, Seed or the tiller: why do trainees leave?* (Appendix 6)

Forel D., Vandepeer M., Duncan J., Tivey D.R., and Tobin S.A., 2018 *Leaving surgical training: some of the reasons are in surgery* (Appendix 6)

Within separate research, focus groups were held to explore the barriers to a career in surgery, with particular emphasis on women's opinions regarding what might prevent them choosing surgery. Based on the report from the focus groups, a broad survey will be undertaken to further investigate the barriers to entering and continuing in surgical training. Such information will inform RACS responses, including promotion of surgery as a career.

Statistics and annual updates

A summary of evaluations undertaken and the main issues arising from evaluations. RACS' response to issues raised, including how RACS reports back to stakeholders.

Table 6 Evaluation of activities

Evaluation activity	Instigated by	Issues arising	College response to issues
Annual selection review reports for specialty training (2018 intake)	RACS	Identified poor discrimination and possible bias in the Referee Report selection tool. Identified poor discrimination in the Referee Report selection tool.	Annual selection review reports for specialty training boards included a section outlining concerns identified with regards to the Referee Report which may result in bias in selection. Concerns regarding Referee Report selection bias were raised in RACS publications: Surgical News (April 2017 Pg. 10, featured article: "SET Selection Referee Reports" Appendix 7)
Skills courses for SET trainees (ASSET, CCrISP, CLEAR, EMST and TIPS) curriculum review and development	PSEC	Blended learning requirements (online and face-to-face) required review and redevelopment of course curriculum.	Skills course faculty presented with participant feedback reports for quality improvement, revised course curriculum and developed online/pre-course learning modules.
Attrition from SET review	RACS	Internal reports of data regarding trainees who leave SET were affected by varying definitions of withdrawal, attrition and dismissal, and complicated by the RACS' database management system.	Quarterly reports were developed for improved presentation of valid estimates of attrition for senior stakeholders.
Trainees' Association (RACSTA) survey evaluation	RACSTA	Main issues arising from the 5-year review included existence of discrimination, bullying and sexual harassment.	Report prepared for BSET, RACS continued to advocate BRIPS, mandating all Fellows, trainees and IMGs to complete the online module
Clinical and Generic Surgical Science Exam feedback reports	RACS GSSE Exam Committee	Trainees who fail the Clinical or Generic Surgical Science Exams are at risk of being dismissed from the program. Letters of feedback for unsuccessful trainees provided limited information on what areas of their performance they need to focus on to improve their performance on future sittings.	Trainees who fail either exam are provided with improved feedback from to identify areas in their clinical and non-clinical skills and medical knowledge that require improvement. Feedback can now be used to help supervisors guide trainees on their learning goals within the rotation, with respect to identified areas for improvement.

Evaluation activity	Instigated by	Issues arising	College response to issues
RACS examinations standard setting	RACS GSSE Exam Committee	Consolidation of RACS examinations required review of the statistical programs and scripts to ensure consistency in the standard setting approach across exams and quality assurance.	RACS development of a GIT repository to store and version control RACS examination statistical code and procedures.

Standard 7: Issues relating to trainees

Areas covered by this standard: admission policy and selection; trainee participation in education provider governance; communication with trainees; trainee wellbeing; resolution of training problems and disputes

Summary of significant developments

A selection workshop, with representation from all specialities was conducted in April. The attendees heard presentations from RACS staff and international experts, and were able to consider and discuss the concepts presented during breakout sessions. Key outcomes of this meeting were reported to the Board of Surgical Education and Training (BSET) in June 2018. There was agreement to consider modifying existing selection tools, developing and trialling situational judgement tests (SJTs) in selection and to conducting more robust interviewer training. Interest in the link between number of attempts in selection and outcomes of training was expressed by a number of the attendees. Discussions continue with the specialty training boards about development of selection processes, the performance of current selection tools, and exploring the introduction of new tools.

As a result of the workshop, a pilot Selection Interviewer Training Workshop was held in June 2018, prior to conducting selection interviews. The Otolaryngology Head and Neck Training Board worked closely with RACS staff and an external consultant to develop and deliver the pilot. The report on the pilot will be presented at BSET in October with the expectation that there will be wider uptake prior to the 2019 selection process.

In June, the specialty training boards reported on their progress with the Aboriginal and Torres Strait Islander Selection Initiative and were asked to identify suitable representatives to meet with Prof Martin Nakata to share details of their curriculum to help support surgical training as well as the prevocational space. This work only applies to Australia.

Recommendations for improvement

OO	In relation to selection into the surgical training programs: (i) Evaluate the objectives of the selection process to ensure they are both clear and consistent across all surgical training programs. (ii) Develop a process to ensure that updates and changes to entry prerequisites undergo a consultation process, and provide appropriate lead time for prospective applicants to meet them. (iii) Explore the means by which prevocational work performance and technical ability may be more appropriately assessed as part of the selection process. Examine the key discriminators (e.g. academic record, research, experience, interview performance) in the current selection process and whether these are the most relevant for predicting performance both as a trainee and as specialist

Many of the sub-recommendations were discussed at the 2018 Selection Workshop, which reviewed a range of evidence-based best-practice processes in selection for surgical training. As referred to above, workshops with specialty training boards to further develop best-practice selection tools are being planned for the next 12 months.

PP	Implement a program to increase awareness of the presence and role of the RACS Trainees' Association (RACSTA).

No new initiatives have been introduced. The response rate to the RACSTA Trainee Survey and direct contact with RACSTA board members are the indicators of RACSTA's relevance and profile. RACSTA representatives sit on all major RACS educational and training boards and committees and RACSTA input is sought for all multiple key educational activities and initiatives. The current indicators show growing engagement.

Activity against conditions

Condition 24	Further develop the selection policies for each surgical training program, particularly with regard to the provision of transparent scoring of each element in the curriculum vitae and the standardisation in the structure of referee reports. To be met by: 2020

Following the Selection Workshop and through the Board of Surgical Education and Training, all the speciality training boards are reviewing selection practices, including the role and relevance of the CV and referee reports. Considered trial of SJTs by some Boards to evaluate behavioural attributes, and establishing training and standards for interview processes is accepted as important. Concepts of diversity amongst interviewers and containment of unconscious bias were part of the recent piloted interviewer training (see also condition 27)

Annually the selection regulations are reviewed by the Board of Surgical Education and Training.

Condition 25	Clearly document and make publicly available the standard of entry into each surgical training program. To be met by: 2018

The standard of entry is stated and publicly available in speciality selection regulations as follows:

Table 7 Specialty standards of entry into SET

Surgical Specialty	Selection regulation regarding standard of entry
Cardiothoracic Surgery	The minimum standard for selection into the SET Program in Cardiothoracic Surgery is an overall combined and adjusted score of at least 65% in the three (3) selection tools (Item 4.8 *Selection Regulations* 2018).
General Surgery (Australia)	To satisfy the minimum standard for selection, applicants must rank above the fourth quartile (i.e. within the top 75% of ranked applicants). These applicants will be considered suitable for selection (Item 3.2.2 *Selection Regulations* 2018).
General Surgery (New Zealand)	To satisfy the minimum standard for selection; candidates must achieve a combined score of 53 out of 75 combined scores for Curriculum Vitae and Referee Report. Applicants who meet this standard will be offered an interview. All other applicants who do not meet these minimum standards will be deemed unsuitable and informed of the decision (Item 5.5.3 *Selection Regulations* for 2019 Intake).
Neurosurgery	Applicants who satisfy the standard in Regulation 5.7 will be ranked according to their combined score for the Structured Curriculum

Surgical Specialty	Selection regulation regarding standard of entry
	Vitae, Neurosurgery Anatomy Examination and Reference Report (which equates to a score out of 75 points). All other applicants will be deemed unsuitable and will not proceed further in the selection process (Item 5.8 *Selection Regulations* 2018).
Orthopaedic Surgery (Australia)	AOA Selection Regulations do not define a minimum standard of entry beyond eligibility to apply (which requires completion of at least 26 working weeks of orthopaedic surgical experience within the last two years, successful completion of the GSSE and a state-licenced radiation safety course). Applicants are ranked based on a combined score (CV 25% + Referee scores 75%), and invited to interview based on the number of expected posts available in the following year. Applicants not invited to interview will not be considered for selection.
Orthopaedic Surgery (New Zealand)	To receive an interview, Applicants must achieve a combined adjusted score of 30/50 on the Curriculum Vitae and Referee Report. Applicants who achieve this minimum standard will receive an interview. Applicants who do not satisfy these minimum standards will not be eligible for an interview and will be advised accordingly. The Regulations are currently under review for 2019 and this will change. All changes will be published in the Regulations in November 2018. (Item 7.2 *Selection Regulations* 2018).
Otolaryngology Head and Neck (Australia)	Applicants who attend the Semi-Structured Otolaryngology Head and Neck Surgery Panel Interview must achieve a weighted interview score of 28/40 or greater to meet the minimum standard for selection (Item 5.5.1 *Selection Regulations* 2018).
Otolaryngology Head and Neck (New Zealand)	Applicants who attend the semi-structured panel interviews must achieve a weighted interview score of 28/40 or greater to meet the minimum standard for selection (Item 5.3.4 *Selection Regulations* 2018).
Paediatric Surgery	The minimum standard score needed to be appointed to Paediatric Surgery training is 72%. Applicants who do not achieve a combined score of 72% or above will be deemed unsuitable for training and therefore unsuccessful in the selection process (Item 4.5 *Selection Regulations* 2018).
Plastic and Reconstructive Surgery (Australia)	Applicants who have proceeded through and achieved a minimum weighted score of 270 out of 450 points at interview for will be considered eligible for selection. Applicants who are considered eligible for selection interview will be ranked based on a composite score of all three selection tools. The maximum score possible in 2018 is 1000 points (Item 2.2.3 *Selection Regulations* 2018).
Plastic and Reconstructive Surgery (New Zealand)	The SET Selection requirements are publically available on the RACS website via the SET Selection Regulations and state eligibility requirements and the selection process (referee and candidate structured interviews).
Urology	The minimum standard for selection will be the Overall Selection Score of the applicant whose ranking is 5 places below the number of available training positions (Item 7.9 *Selection Regulations* 2018).

Surgical Specialty	Selection regulation regarding standard of entry
Vascular Surgery	Applicants who satisfy the minimum standards for selection and the eligibility conditions will be ranked. The ranking will be determined by applying weightings to the selection tools, providing an overall score out of 100, rounded to the nearest whole number (Item 7.2 *Selection Regulations* 2018). Applicants who attend the Semi-Structured Vascular Surgery Panel Interview must achieve a weighted interview score of 25/40 or greater to meet the minimum standard for selection (*Selection Regulations* to be published for 2020 intake.

Condition 26	Develop a policy that leads to the increased recruitment and selection of Aboriginal and Torres Strait Islander and/or Māori trainees in each surgical training program. To be met by: 2019

After much dialogue, there has been a gradual and encouraging shift in cultural mindset to align with contemporary community expectations. All specialty training boards support or endorse the RACS Aboriginal and Torres Strait Islander Surgical Trainee Selection Initiative policy. RACS continues to promote the importance of this initiative in a collaborative fashion.

The majority of specialty training boards have reserved positions in their training programs for candidates (meeting standard of entry) who have self-identified as Aboriginal or Torres Strait Islander, or Māori. This includes Cardiothoracic, General, Otolaryngology Head and Neck Surgery Paediatric Surgery, Urology, Orthopaedic (Au) and Plastic and Reconstructive Surgery (Au).

The approach in New Zealand differs. Orthopaedic, Otolaryngology Head and Neck, Plastic and Reconstructive and General Surgery support Māori doctors to have the knowledge, skills and experiences that will assist them to gain entry to training and by giving recognition to knowledge of Māori tikanga in selection scores. This is on the advice from several cultural advisors that this approach is culturally acceptable, where an affirmative 'selection pathway' approach would not be.

The New Zealand Board of Plastic and Reconstructive Surgery (NZBPRS) has initiated dialogue with the New Zealand Association of Plastic Surgeons (NZAPS) regarding a scholarship for Māori and Pacific Island Doctors and medical students to attend the NZAPS Annual Scientific Meeting (ASM) to increase awareness of PRS as a future career.

Condition 27	Promote and monitor the Diversity and Inclusion Plan through the College and specialty training boards to ensure there are no structural impediments to a diversity of applicants applying for, and selection into, all specialty training programs. To be met by: 2019

As only gender and indigenous identification (self-reported) are recorded as part of the selection process, these are the aspects of diversity currently monitored and reported. Significant progress has been made to recruit and select indigenous candidates (refer to Condition 26 response).

Work continues to identify the barriers to medical students choosing a career in surgery and to understand the reasons for female attrition from the training program. This work will inform the identification of any structural impediments and will help to promote greater diversity in selection.

There is recognition for the need to identify and recognise "rurality" in applicants in order to promote surgical training aligned to a rural pathway. General Surgery has indicated it will implement such an initiative.

Diversity and inclusion and containment of unconscious bias will be components of selection interviewer training.

Monitoring of progress on the Diversity and Inclusion plan is ongoing

Condition 28	Increase transparency in setting and reviewing fees for training, assessments and training courses, while also seeking to contain the costs of training for trainees and specialist international medical graduates. To be met by: 2019

Specialty training boards and RACS publicly advertise fees on their websites

Greater transparency in setting and reviewing fees will be a focus in 2019. It is noted that some progress has been made, with Neurosurgery, Orthopaedic Surgery, Plastic and Reconstructive Surgery (Au) and Urology reporting that costing exercises have been undertaken. These boards report that fees are set on a cost recovery basis, and that trainees have been advised of the process.

Condition 29	Address trainee concerns about being able to raise issues and resolve disputes during training by ensuring there are mechanisms for trainees to do so without jeopardising their ongoing participation in the training program. To be met by: 2019

Refer to responses for Condition 3 and 18

Statistics and annual updates

Additional annual performance data is available in the *2017 Activities Report* (Appendix 8)

Trainees entering, completing and currently in training

- The number of trainees, including Indigenous and Māori trainees entering the training program, including basic and advanced training;
- the number of trainees, including Indigenous and Māori trainees who completed training in each program; and
- the number and gender of trainees undertaking each college training program.

Table 8 Number of trainees entering training program

Training program	ACT	NSW	NT	QLD	SA	TAS	VIC	WA	NZ	O/S	Total
Cardiothoracic Surgery	-	5	-	-	-	-	2	-	1	-	**8**
General Surgery	3	27	2	22	4	-	25	6	15	1	**105**
Neurosurgery	-	-	-	3	1	-	3	1	-	-	**8**
Orthopaedic Surgery	-	15	-	11	3	-	16	1	10	-	**56**
Otolaryngology Head and Neck Surgery	-	7	-	6	4	-	3	1	4	-	**25**
Paediatric Surgery	1	2	-	1	-	-	-	-	-	-	**4**
Plastic and Reconstructive Surgery	-	5	-	3	3	-	2	4	3	-	**20**
Urology	1	4	1	5	-	-	9	-	2	-	**22**
Vascular Surgery	-	1	-	1	2	-	1	1	2	-	**8**
Aboriginal and Torres Strait Islander and Māori trainees											

Table 9 Number of trainees completing training program

Training program	ACT	NSW	NT	QLD	SA	TAS	VIC	WA	NZ	O/S	Total
Cardiothoracic Surgery	-	2	-	-	-	-	-	-	1	-	**3**
General Surgery	1	21	2	7	7	1	21	3	11	1	**75**
Neurosurgery	-	2	-	2	-	1	3	-	-	3	**11**
Orthopaedic Surgery	-	17	-	9	4	1	10	4	7	2	**54**
Otolaryngology Head and Neck Surgery	-	4	-	4	2	-	4	-	3	-	**17**
Paediatric Surgery	-	-	-	-	-	-	1	-	-	1	**2**
Plastic and Reconstructive Surgery	-	2	-	2	2	-	6	-	2	2	**16**
Urology	-	3	-	5	-	1	5	-	2	2	**18**
Vascular Surgery	-	2	-	1	1	-	1	-	-	1	**6**
Aboriginal and Torres Strait Islander and Māori trainees											

Table 10 Number and gender of trainees undertaking each training program

Training program	Male	Female	Unspecified	Total
Cardiothoracic Surgery	33	8	-	41
General Surgery	279	155	-	434
Neurosurgery	36	12	-	48
Orthopaedic Surgery	250	33	-	283
Otolaryngology Head and Neck Surgery	58	28	-	86
Paediatric Surgery	14	17	-	31
Plastic and Reconstructive Surgery	69	30	-	99
Urology	77	25	-	102
Vascular Surgery	36	11	-	47

Selection into training

Changes to policies and/procedures

Policy / Procedure	Description of changes
Selection in to training	Specialty regulations are updated and approved by the Education Board annually (See attached summary table).

Standard 8: Implementing the program – delivery of education and accreditation of training sites

Areas covered by this standard: supervisory and educational roles, and training sites and posts

Summary of significant developments

The Foundation Skills for Surgical Educators (FSSE) and Operating with Respect (OWR) courses are intended to equip surgical supervisors with skills in training, assessment, giving feedback, supporting trainees in difficulty, addressing instances of unacceptable behaviour ('speaking up') and maintaining respectful work and learning environments. These skills add to the provision of supports to supervisors. The speciality training boards and specialty societies have worked extensively with RACS staff to communicate and encourage compliance by supervisors and trainers, and this has been successful in achieving compliance of the mandatory requirement to complete the FSSE and OWR.

Through advocacy and collaboration with the speciality training boards, specialty societies and government jurisdictions, progress is being made towards expanding training into rural settings.

Recommendations for improvement

QQ	Develop a policy that is adhered to by all specialty training boards which stipulates the minimum advanced notice required prior to requiring commencement of new rotations and which also minimises the number of interstate /international rotations.

Nothing to report.

RR	Work with the jurisdictions to assist in preventing the loss of employment benefits when trainees transfer between jurisdictions.

Nothing to report.

SS	Consider how to expand the surgical training programs in rural and regional locations.

Thirty-nine RACS training board and specialty representatives (from seven specialties) attended the first in a series of Rural Training workshops in March 2018. The focus of discussion was how to ensure training was fit for purpose to provide the community with surgeons capable, and with a desire to work in rural and regional areas.

In June 2018 the President, RACS Councillors and the CEO met with Professor Paul Worley in his capacity as National Rural Health Commissioner.

RACS is convening a summit of federal and state workforce jurisdictional representatives planned for 15th September 2018 to drive improvements in recruiting and maintaining a rural and regional surgical specialist workforce and in defining rural training pathways taking into consideration the specific needs of each State and Territory. In addition, RACS is working closely with the Australian College of Rural and Remote Medicine, the Royal Australian College of General Practitioners and the Rural Doctors Association of Australia including providing review of the rural generalist pathways curricula for general practitioners.

TT	Support collaboration amongst the specialty training boards to develop common accreditation processes and share relevant information.

Nothing to report.

Activity against conditions

Condition 30	Mandate cultural safety training for all supervisors, clinical trainers and assessors. To be met by: 2020

Refer to response to Standard 3; Condition 11.

Condition 31	In conjunction with the specialty training boards, finalise the supervision standards and the process for reviewing supervisor performance and implement across all specialty training programs. To be met by: 2021

The *Standards for Supervision* document was approved at the June meeting of the Board of Surgical Education and Training (BSET).

The Surgical Supervisors Policy will be updated to include the Supervisor Responsibilities Matrix from the *Standards for Supervision* document with a note to reflect that although the role definitions described for Orthopaedic Surgery (Au) are different, the principles are agreed.

The new Advocacy Board will be consulted on how best to effectively articulate the standards and supporting resources. See Appendix 9: Standards for Supervision document.

Condition 32	Promote the Building Respect, Improving Patient Safety program and encourage the positive participation of all fellows and trainees, including supporting all surgeons to "call out" bad behaviour in work and training. To be met by: 2019

The mandated completion of the OWR eLearning module for all fellows, trainees and IMGs has achieved 95% compliance as at 30 June 2018.

The training boards have affirmed their ongoing support for the Building Respect and Improving Patient Safety Action Plan as evidenced by their active involvement and support of the RACS initiatives to ensure their trainees, IMGs, supervisors, trainers complied with the mandatory requirements.

Table 11 SET and IMG supervisors' and trainers' completion of OWR and FSSE face-to-face course

	Completed exempt*/enrolled#	Not Completed	Total
OWR course†			
SET and IMG Supervisors	446	151	**452**
FSSE course			
SET and IMG Supervisors	446	6	**452**
Trainers	2,331	154	**2,485**
Total FSSE course participants	**2,777**	**160**	**2,937**

Notes: ***Exempt**: have completed an equivalent course; #**Enrolled**: enrolled in course to delivered in 2018; †**OWR course**: trainers are exempt from attending this course.

Condition 33	In the hospital and training post accreditation standards for all surgical training programs include a requirement that sites demonstrate a commitment to Aboriginal and Torres Strait Islander and/or Māori cultural competence. To be met by: 2019

A revision of the RACS standards for post accreditation will include reference to the requirement of Condition 33 will be undertaken next year.

It is noted that Plastic and Reconstructive Surgery and Neurosurgery have reported that changes are already planned for post accreditation regulations to include specific reference for training sites to demonstrate a commitment to Aboriginal, Torres Strait Islander and Māori cultural competence.

Statistics and annual updates

Accreditation activities including sites visited, sites / posts accredited or not accredited.

Table 12 Site accreditation activities

Number of Sites/Posts	ACT	QLD	NSW	NT	SA	TAS	VIC	WA	NZ	Total
Visited	2	31	30	5	18	7	60	16	51	**220**
Accredited	2	37	35	9	30	11	67	24	100	**315**
Not accredited	0	2	1	1	1	0	0	0	0	**5**

Standard 9: Continuing professional development, further training and remediation

Areas covered by this standard: continuing professional development; further training of individual specialists; remediation

Summary of significant developments

The New Zealand Association of General Surgery (NZAGS) is developing a pilot program of practice visits which will attract CPD points for reflective practice. It is likely the pilot will be conducted in late 2018.

AOA is currently working towards addressing the recommendations of the Medical Board of Australia Framework within the AOA CPD Program.

AOA and RACS are partnering to pilot a practice visit program with senior Fellows, it is anticipated the pilot will commence in early 2019.

RACS is about to commence a comprehensive review of the RACS CPD Program, in line with the new MBA 'Professional Performance Framework'. This will also involve the potential development of a new IT platform for CPD.

Recommendations for improvement

UU	Implement a mechanism for the newly established CPD Audit Working Group to provide more robust feedback to Fellows, with a particular focus on the breadth of surgeons' individual practice.

A surgical audit working party has been established to review standards for surgical audit both as a quality assurance activity and to define a minimum standard of audit for CPD compliance.

RACS has reported and published on the role of morbidity and mortality meetings.

VV	As part of the reflective practice category consider including cultural competence as an area of reflection.

Participation in cultural competence activities has been included as an activity under Category 4 – Reflective Practice in the RACS CPD Program. RACS is also undertaking a review of the cultural competency education it provides, and is encouraging other education providers to have their activities approved within the RACS program.

WW	Explore the College's role in identifying the poorly performing fellow.

The surgical audit working party work and the morbidity/mortality papers will assist identification of poor clinical performance, be that at local hospital, network or specialty level. Work is ongoing to assist or remediate the poorly performing fellow.

Activity against conditions

There are no conditions for reporting.

Statistics and annual updates

The number and proportion of college fellows participating in and meeting the requirements of the college's continuing professional development programs.

Table 13 Fellows participating in and meeting the RACS CPD program requirements

Number of Fellows			Fellowship participating in CPD					
Australia	New Zealand	Other	Australia		New Zealand		Other	
			Total no.	Total %	Total no.	Total %	Total no.	Total %
5179	820	348					16	

Table 14 Non-fellows participating in and meeting the RACS CPD program requirements

Australia		New Zealand		Other	
Total no.	Total %	Total no.	Total %	Total no.	Total %

Standard 10: Assessment of specialist international medical graduates

Areas covered by this standard: assessment framework; assessment methods; assessment decision; communication with specialist international medical graduate applicants

Summary of significant developments

RACS has undertaken a number of new initiatives to provide greater support for specialist international medical graduate surgeons. RACS; Clinical Director of IMG Assessment and Support attended a Medical Board of Australia forum on Assessment of Specialist International Medical Graduates at which recommendations ensuing form the recent Deloitte Access Economics' report and commence discussion about updating the MBA Good Practice Guidelines for IMG assessment.

Recommendations for improvement

XX	Provide greater support for specialist's international medical graduate surgeons working towards specialist/vocational registration, and including access to educational resources, such as examination revision course, and other resources that are accessible to trainees.

RACS has established an eLearning IMG Orientation Program. This program will benefit overseas trained surgeons, who (potentially) become IMG surgeons under supervision by introducing them to the Australian health care system, improving their knowledge and understanding of the best practice methods and by making their transition to the Australian health care system and progression towards Fellowship as seamless as possible

The five modules covered in the program are:

1. Australia and Health Care
2. Culturally Responsive Health Care
3. Aboriginal Health Care
4. Surgical Safety
5. RACS Specialist Pathway

From March 2018, IMGs who have accepted a specialist pathway must complete the RACS eLearning module "IMG Orientation Program" prior to commencing clinical assessment.

RACS has also developed video resource regarding the clinical component of the Fellowship Examination (FEX). The aim of this video is to provide comprehensive relevant information to IMG surgeons about the Fellowship Examination. It is envisaged that this resource will provide candidates with information regarding the format of the examination and candidate performance expectations. An aim of this resource is to improve IMG pass rates at FEX, which have been less than the Surgical Education and Training (SET) trainee pass rates.

Both eLearning resources are available to all IMGs who have accepted a specialist pathway and can be accessed by the IMGs logging into their portfolios.

YY	Make information available to future applicants that may allow them to assess the likelihood of their application achieving substantially or partially comparable status prior to them making a substantial financial payment that historical evidence might suggest is unlikely to succeed.

RACS has undertaken a 5-year analysis of the outcomes of IMG assessments in Australia and has published information on the RACS website to enable IMGs to self-assess the likelihood of their application achieving substantially or partially comparable status prior to making an application. The information to guide IMG applicants is available on the RACS website.

Condition 34	All College and Specialty Training Board SIMG assessment processes and associated documentation must reflect the Medical Board of Australia and Medical Council of New Zealand guidelines by ensuring that both training and post-training experience are appropriately considered in assessments of comparability. To be met by: 2019

The International Medical Graduates Committee (IMGC) is currently reviewing IMG policies to ensure that both training and post-training experience are appropriately considered in assessments of comparability, and that there is consistency between specialties.

The IMGC is currently considering the categories of post-training fellowship position/s completed by the IMG which would be considered by the specialty training boards for assessment. The aim is to establish a set of criteria which will be used by the specialty training boards to address identified gaps in the IMG's pathway to fellowship.

Condition 35	Develop and adopt alternative external assessment processes, such as workplace-based assessments, to replace the Fellowship Examination for selected specialist international medical graduates. To be met by: 2020

There has been much progress by RACS in the development of a Work Based Assessment (WBA) tool which could replace the Fellowship Examination for selected specialist IMGs.

The IMGC, Principle Educator and Clinical Director have developed a list of competencies to be assessed during WBAs and the type of assessments to be utilised in order to make an assessment.

A WBA course will run in August 2018 to train assessors on the standards to ensure quality assessments are undertaken during the planned pilots of WBA training.

The pilots will include six IMGs who are currently on a specialty pathway, two assessors from the same surgical specialty and an external assessor. Pilots of WBA training will be delivered in the second half of 2018.

Statistics and annual updates

The numbers of applicants and outcomes for Specialist IMG assessment processes for Fellowship for the last 12 months, broken up according to the phases of the specialist international medical graduate assessment process.

Table 15 New Applicants undertaking specialist international medical graduate assessment

Number of new applicants since last progress report:	Australia	New Zealand
1 August 2017 – 31 July 2018	65	-

Table 16 Number of specialist international medical graduates assessments for Fellowship (1/08/2017-31/07/2018)

Phase of IMG assessment	Australia	New Zealand
Initial Assessment	N/A	N/A
Interim Assessment Decision: • Not Comparable	27	-
• Partially Comparable	29	-
• Substantially Comparable	15	-
Ongoing Assessment	56	2
Final Assessment	28	2
Total:	**155**	**4**

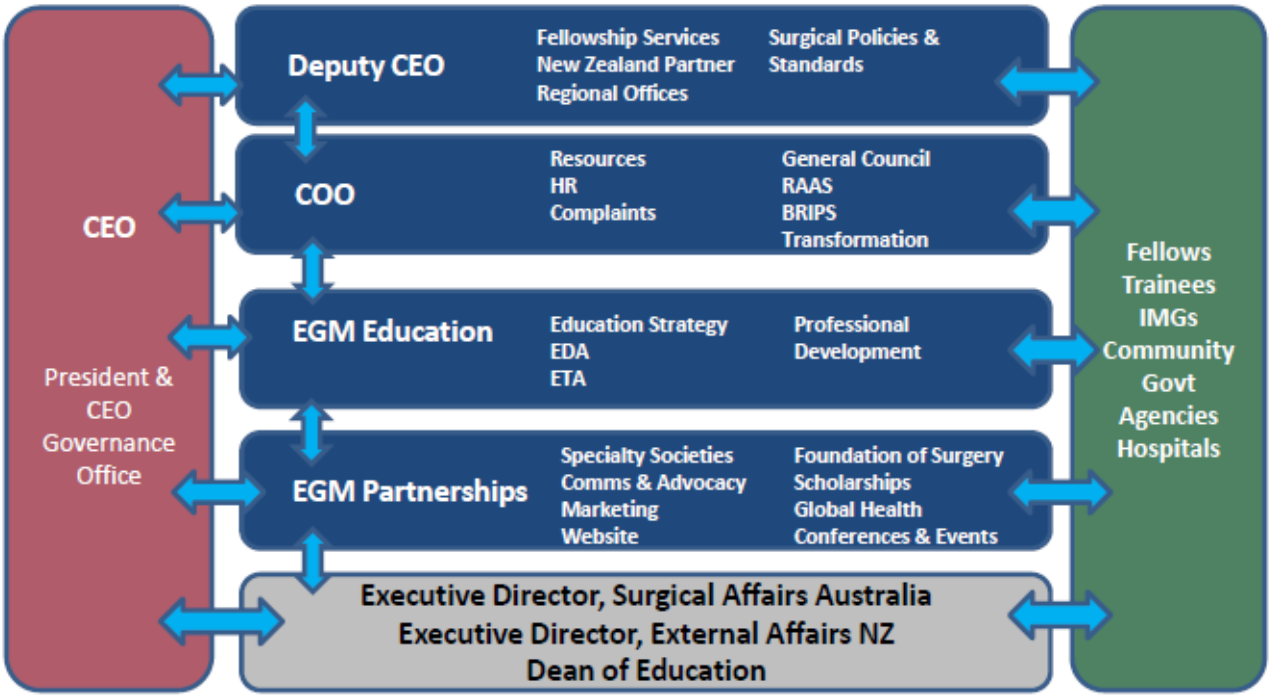
Appendices

Summary of appendices

APPENDIX 1

RACS Executive Leadership Team

RACS executive leadership team



Note to Appendix 1:

Abbreviation	Title	Incumbent
CEO	Chief Executive Officer	Ms Mary Harney
Deputy CEO	Deputy Chief Executive Officer	Mr John Biviano
COO	Chief Operating Officer	Ms Emily Wooden
EGM Education	Executive General Manager Education	Ms Robin Buckham (interim appointment)
EGM Partnerships	Executive General Manager Partnerships	Ms Susan Wardle

APPENDIX 2

Policy: REL-GOV-11 Appeals Mechanism

(Version 5 . September 2014)

Division	**Relationships & Advocacy**	**Ref. No.**	**REL-GOV-011**
Department	**Governance Support**		
Title	**Appeals Mechanism**		

1. PURPOSE AND SCOPE

This policy sets out the mechanism for appeal by any person, or organisation (the appellant) adversely affected by a decision of the College that is inconsistent with approved College policy.

An appellant who has been directly and adversely affected by a decision that is inconsistent with approved College policy and/or procedure may apply to the Chief Executive Officer (CEO) of the College to have the decision considered by the Appeals Committee.

An appeal to the Appeals Committee cannot result in a re-making by the Appeals Committee of the appealed decision. Rather, a successful appeal will result in the referral of the matter back to a College body for the making of a fresh decision subject to any terms and conditions imposed by the Appeals Committee.

2. KEYWORDS

Appeal; Policy; Procedure; Decision; Recommendation; Reconsideration; Committee; CEO;

3. BODY OF POLICY

3.1 Internal Review

3.1.1 An appellant may, prior to lodging an appeal, by direct request to the original decision maker, seek a review of any decision made by a College Board or Committee. A review may be requested where there is evidence that approved policy or procedure was not correctly applied or that there are pertinent matters of fact that existed at the time but were not known to the decision maker that may have persuaded the decision maker to reach an alternate decision.

3.1.2 An appellant may request copies of documents on which the decision was based. The College committee or board will provide such information within four weeks of receipt of a written request, subject to obligations of privilege, privacy and confidentiality which may apply.

3.1.3 Any request for an appeal against a decision must be made within three months of receipt of notice of the decision and will initially be processed as a review. The College aims to complete the review process within six (6) weeks and will notify the appellant of the outcome.

3.1.4 On receipt of notification from the College of the outcome of the review the appellant may:

i) Accept the decision and the result of the internal review; or

ii) Within two (2) weeks request in writing that the Executive Director for Surgical Affairs (EDSA) convene a hearing of the Appeals Committee.

iii) If no correspondence is received within two (2) weeks this will constitute acceptance of the review.

3.2 Appeal Initiation

3.2.1 The Appeal Request to the EDSA must include:

i) The prescribed appeal fee, and

ii) Details of the specific decision that is being contested, and

iii) The Grounds of Appeal, based on the allowable Grounds of Appeal (see 3.3), and

iv) Details of how the decision being appealed does not conform to approved College policies and/or procedures, and

v) Documented and verifiable evidence in support of the Grounds of Appeal

3.3 Grounds of Appeal

3.3.1 The Decisions which may be considered by the Appeals Committee are:

a) Decisions of the Education Board, Board of Surgical Education and Training, Court of Examiners, Surgical Training Boards (incl. the Australian Orthopaedic Association Board of Orthopaedic Surgery) and Regional Subcommittees of Surgical Training Boards in relation to selection, in-training assessment, and examination of trainees.

b) Decisions of Boards and Committees in relation to application for admission to Fellowship.

c) Decisions of Boards and Committees in relation to the specialist assessment and clinical assessment of International Medical Graduates (IMGs).

d) Decisions of the Board of Professional Development and Standards in relation to the Continuing Professional Development Program.

e) Decisions of the Education Board on the advice of the Board of Surgical Education and Training in relation to accreditation of hospitals and posts for training, or supervisors of training.

f) Decisions of the College in relation to the accreditation of Post Fellowship Education and Training programs and Accreditation of Courses.

g) Decisions of Complaints Committees - Council and RegionalDecisions of the Treasurer in relation to the financial status of Fellows, trainees, or other persons.

h) Such other decisions of the College, its Boards or Committees as the Council may determine from time to time.

3.3.2 An appeal may only be made on one or more of the following grounds:

a) That an error in law or in due process occurred in the formulation of the original decision.

b) That relevant and significant information existing at the time of the original decision, and which should have been known to the decision maker was not considered or not properly considered in the making of the original decision.

c) That the original decision was not one at which a rational decision-maker could have arrived in good faith.

d) That irrelevant information was considered in the making of the original decision.

e) That the original decision was made for an improper purpose.

3.4 Acceptance of Appeals

3.4.1 Requests for appeals are not accepted where the appellant is seeking an exemption from approved College policy.

3.4.2 The EDSA shall, within four (4) weeks of receipt of a properly initiated appeal in accordance with section 3.2 of this policy, advise the appellant and the original decision maker that an appeal will be heard. This advice will include:

a) The date, time and place of the hearing (which shall not be less than 6 weeks from the date of notice).

b) The right and expectation of the appellant to appear before the Appeals Committee

c) The right of the appellant to be accompanied by a legal representative to act as an advisor.

d) The right of the appellant to have a support person present.

e) All relevant documentation held by the College, subject to obligations of privilege, privacy or confidentiality which may apply.

3.4.3 Acceptance of an appeal does not prevent the decision under appeal from remaining in effect until the appeal is heard and determined.

3.5 Submissions to the Appeals Committee

3.5.1 In any appeal, the appellant will carry the onus of proof to establish the grounds of the appeal.

3.5.2 At least 4 weeks prior to the hearing the appellant will provide the College with written submissions and copies of any documents and records upon which he/she wishes to rely. This written submission must be within the context of the original submission for an appeal, and cannot introduce new grounds of appeal. A copy of the submission will be made available to the original decision maker.

3.5.2 At least 4 weeks prior to the hearing the original decision making authority will provide the Office of the EDSA with written submissions and copies of any additional documents and records relevant to the decision made, being the subject of the appeal. A copy of the submission will be made available to the appellant.

3.5.3 Both the appellant and the original decision maker may lodge a rebuttal submission up to 2 weeks before the scheduled appeal date.

3.5.4 The Appellant's submissions and the Decision maker's submissions will be provided to the Appeals Committee and no further material will be accepted after this time

3.5.5 Should the appellant have late documentation that he/she wishes to present to the Appeals Committee but is prohibited by 3.5.5 they may elect to cancel the scheduled meeting and convene a new appeal at a later date. In this situation the fee for the scheduled appeal will be forfeited and a new fee payable prior to a new hearing date being set.

3.6 Appeals Committee Composition

3.6.1 An Appeals Committee will be convened comprising the following members, who must not have been a party to the decision to which the appeal relates, or have any known conflict of interest:

- Three persons who are not Fellows of the College.
- The Vice President of the College, or delegate
- One Fellow of the College (from a specialty not involved in the subject matter of the appeal).

3.6.2 The Chair is nominated by Council or its delegate, from the non-Fellow members of the Appeals Committee.

3.6.3 Council has delegated the appointment of Committee members (in accordance with this policy) to the Executive Director for Surgical Affairs (Australia).

3.6.4 A quorum for meetings of the Appeals Committee will be the Chair and three other members. All members of the Appeals Committee shall be entitled to vote on decisions and the outcome of the appeal shall be decided on the basis of a majority vote. In the event of a tied vote, the Chair will exercise a casting vote.

3.6.5 A Council nominated Solicitor shall be the Legal Adviser to the Appeals Committee.

3.6.6 The College In-house Counsel shall be the legal advisor to the relevant decision maker.

3.6.7 Other College staff may also attend at the invitation of the EDSA.

3.7 Rules for Conduct of Meetings of the Appeals Committee

3.7.1 Subject to these rules, the Appeals Committee must act according to the rules of procedural fairness. The Appeals Committee is not bound by the rules of evidence and, subject to these rules and rules of procedural fairness may inform itself on any matter and in such manner as it thinks fit.

3.7.2 The Appeals Committee shall be entitled to consider all relevant information which it thinks fit and may invite any person to appear before it, or to provide information. Witnesses are not compellable.

3.7.3 The Appeals Committee shall conduct its affairs with as little formality as possible and in accordance with the procedures set out in these rules, but otherwise, subject to these rules, shall have full power to regulate its conduct and operation.

3.7.4 An appellant has the right and responsibility to appear before the Appeals Committee and to advocate orally the merits of the appeal himself /herself as represented through written submissions.

3.7.5 The appellant has the right to be advised by a legal representative or support person. Legal advisors and/or support persons may not act as advocates for the appellant but the legal advisor (if any) may be invited to address the Appeals Committee regarding any particular legal issue that the Appeals Committee believes cannot adequately be addressed by the appellant.

3.7.6 A representative(s) of the relevant decision maker is expected to attend and address the Appeals Committee on matters relevant to the appeal and will be given equal opportunity to comment on submissions of the Appellant and the Decision maker. The College In House Counsel may not act as an advocate but may be invited to address the Appeals Committee regarding any particular legal issue that the Appeals Committee believes cannot adequately be addressed by the original decision maker.

3.7.7 Hospitals sponsoring International Medical Graduates (IMG) for an Area of Need position may appeal on behalf of the IMG and will be designated as the appellant.

3.8 Decisions of the Appeals Committee

3.8.1 An Appeals Committee may, upon considering all submissions:

a) Confirm the decision which is the subject of the appeal or

b) Revoke the decision and refer the decision to Council or an appropriate Board or Committee for the making of a fresh decision (upon such terms or conditions as the Appeals Committee may determine).

3.8.2 Amongst other things, a decision of the Appeals Committee cannot:

a) Elevate the appellant above others in a competitive assessment for selection to the SET program without reference to the scoring process;

b) Recommend a pathway to Fellowship for an IMG without reference to a new IMG Assessment Panel;

c) Revoke the clinical or examination assessment of a trainee and replace the assessment with an assessment of its own, or

d) Award a Fellowship to any appellant.

3.9 Reporting

3.9.1 The Appeals Committee will issue a written decision, with reasons for the decision, no more than eight weeks after the completion of the appeal hearing

3.9.2 The decision of the Appeals Committee takes effect from the date of forwarding of the decision to the parties by the EDSA.

3.9.3 Where the appellant is successful (ie, the decision under appeal is revoked), 50% of the appeal fee paid will be refunded.

3.9.4 The Executive Director for Surgical Affairs will report to Council annually on the activities of the Appeals Committee, including the number of appeals lodged and the results of appeals and any recommendations to Council from the Appeals Committee.

4. ASSOCIATED DOCUMENTS

Approver CEO
Authoriser Council

APPENDIX 3

Education Program of Work 2018-2020

EDUCATION PROGRAM OF WORK 2018 - 2020

Red text = AMC conditions to be satisfied in 2018 report

Ref	Program	Objectives	Outcomes	Link to AMC Condition:	Ref	High Level Tasks / Projects:
1	SET Relationships	1. To improve the current relationships, with more emphasis on collegiality, collaboration and shared responsibility.	Willingness of RACS, STBs and Societies to engage.	1, 2, **3**, 4	1.1	CEO and President roadshow
		2. To build greater mutual assurance and trust.	Collaboration on the implementation of the education program of work and delivery of AMC conditions.		1.2	Relationships and governance revised leading to greater efficiencies
			Assurance that SET policy is being consistently maintained.		1.3	MOUs and service agreements re-negotiated.
2	Surgical Supervisors	1. To professionalise and add status to the supervisor role.	An engaged and skilled cohort of supervisors.	19, 20, 30, 31, 32, 33	2.1	Supervisor standards/roles defined and agreed by BSET (complete June 2018).
		2. To define standards for supervisors and review supervisor performance.	Supervisors lead colleagues who teach and train SET trainees.		2.2	Implementation of OWR in 2018.
		3. To support supervisors in providing optimal learning environments for trainees and IMGs through understanding of, and stronger emphasis on, regular, routine performance feedback, and improved performance-management of trainees.	Change management is supported and implemented through supervisors.		2.3	Development of educational resources as required, building on FSSE and OWR.
		4. Establish feedback processes from supervisors/trainees	Advocacy with hospitals and networks is active and productive.		2.4	Cultural safety training (D&I and Indigenous Health).
			Supervisor standards implemented		2.5	Advocate for protected time for supervisors
3	Trainees	1. To determine the factors which promote or inhibit choosing surgery as a career.	Diversity and inclusion become the norm and flexible training is accepted and accessible.	**13**, **18**, 27, 28, 29, 32	3.1	Undergrad survey in progress.
		2. To develop support mechanisms, enabling early interventions.	Transparency in training and associated fees.		3.2	Attrition monitored and reported.
		3. To determine the early indicators of trainees' success.			3.3	Specialties promote flexible training opportunities
		4. Review and evaluate JDocs Framework.			3.4	Selection standards encourage equity of access for minority and disadvantaged groups
		5. Evaluate supports such as "boot camps" and trainee induction workshops.			3.5	Associated research on "early years" to commence mid year. Will also note JDocs influence
		6. To advocate for, and support, trainee wellbeing initiatives	Trainees learn and work in enviroments that support their wellbeing and resilence.		3.6	Advocate for protected teaching time
		7. To enable trainees to raise issues and provide feedback.	Hospitals adhere to OH&S legislation		3.7	Liaison and advocacy with hospitals and jurisdictions.
					3.8	Develop processes to protect and support trainees
4	International Medical Graduates	1. To better support IMGs on their pathway to FRACS, and improve the process of assessment.	More efficient IMG progress on pathway to Fellowship through better supervision and oversight.	34, 35	4.1	Review of IMG assessment and interview process.
		2. To develop alternative work based assessment processes to reduce reliance on the Fellowship Examination for selected IMGs shown to be performing well.			4.2	Development of WBAs; revised clinical assessment.
					4.3	Training for Clinical Supervisors.
					4.4	Working with STBs to implement changes to IMG assessment processes.
5	Graduate Outcomes	1. To define the SET graduate outcomes and the expectations of new graduates.	Well-rounded surgeons, who meet community expectations, contribute to the efficiency, quality and safety of healthcare and who work with, and for, a diverse community.	5, 6, 7 8, 9,	5.1	Survey of new graduates
		2. Enable new surgeons to be confident to work in most communities	Clear statements define graduate and program outcomes.		5.2	Statements include RACS education purpose as related to community views and needs.
		3. Relate program outcomes to community need.			5.3	Graduates aware of their expected broader roles in health system.
					5.4	Program outcomes responsive to community needs re workforce, including regional/rural practice.

EDUCATION PROGRAM OF WORK 2018 - 2020

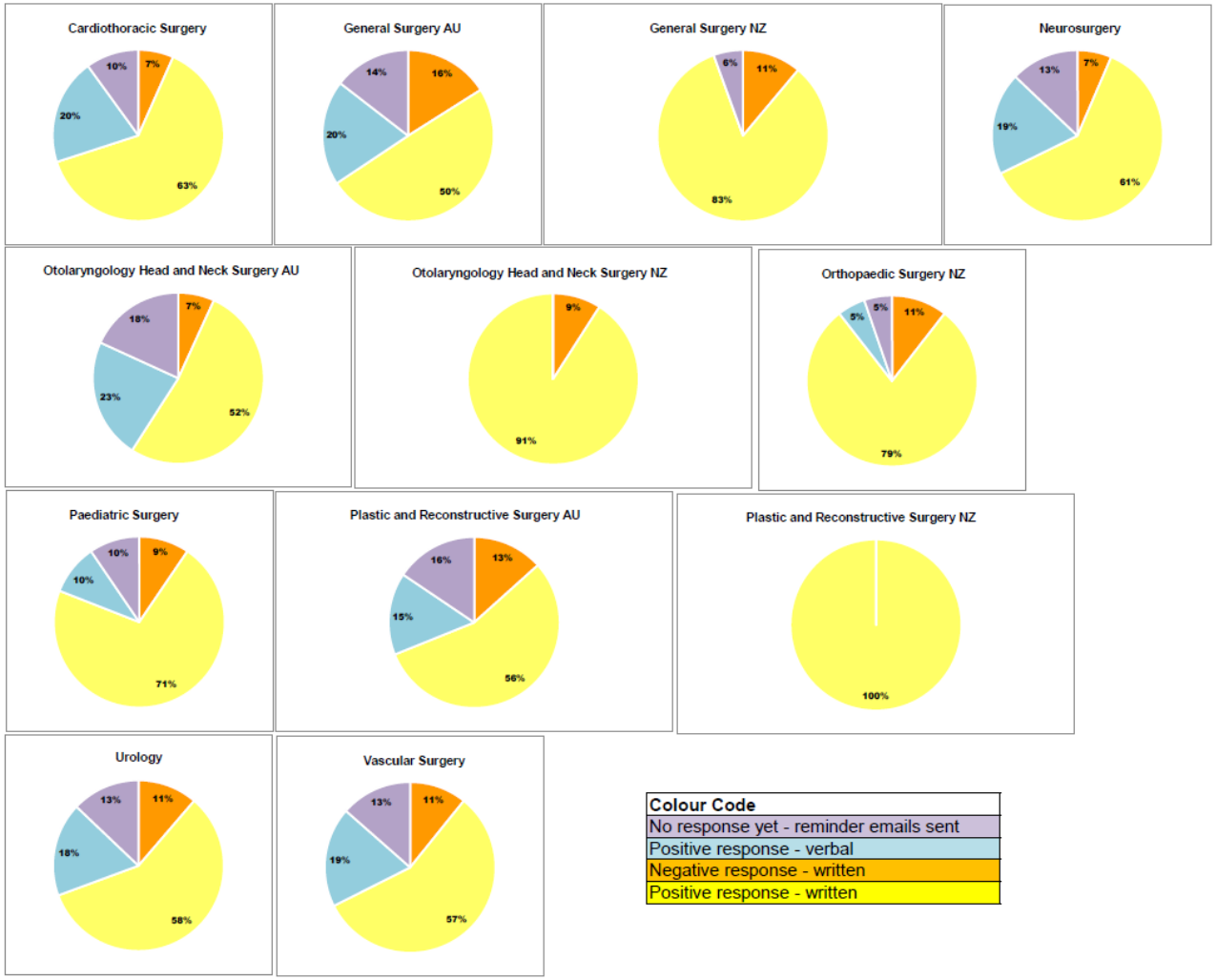
Red text = AMC conditions to be satisfied in 2018 report

Ref	Program	Objectives	Outcomes	Link to AMC Condition:	Ref	High Level Tasks / Projects:
6	Fellowship Examination	1. To ensure better preparation for the FEX, and improved sign off criteria related to work based assessment. 2. To improve Snr Examiners' written feedback reports providing consistent and relevant information for the trainee and their supervisor. 3. To determine the factors that impact on multiple fail candidates and the comparatively poorer performance of IMGs.	Improved FEX pass rates for trainees and IMGs - reducing the number of candidates who sit two or more times. Certification by FRACS represents completion of the entire SET program	12, 14	6.1	Initial review of FEX feedback reports for presentation to Senior Examiners in April.
					6.2	Implement revised FEX feedback reports in May.
					6.3	Implementation of improved sign-off June - October.
7	Assessment	1. To pilot, implement and evaluate WBAs 2. To determine a definition and utility of CBME in SET 3. To respond to the 'Review of Assessments' report	Improved programmatic assessment of trainees throughout their training. Improved work-based assessments, leading to the early detection and remediation of underperformance. Better use of WBAs throughout SET, to guide training. Evaluation of WBAs and approaches to assessment inform CBME. Response is complete, considerd and actioned.	12, 14, **15**, 16	7.1	Response to Review of Assessments Report. Present to BSET in June 2018
					7.2	Standard setting for SSEs (AMC16) to be implemented by 2018
					7.3	Research into WBA. Direct board representation required
					7.4	New WBAs including EPAs developed and piloted with boards
					7.5	Research project findings presented to BSET
					7.6	Assessments developed for broader generic/professional curriculum
8	Curriculum	1.To develop a generic professional curriculum. 2. Develop suitable assessments. 3. Implement the generic curriculum progressively. 4. Specialty curricula are linked to stages of training and mapped to outcomes	Greater emphasis of professional competencies is embedded into SET Cultural competency is achieved Roles in the health care system are understood Specialty curricula are well-defined	8, 9, 10, 11,14	8.1	Presentation of draft-module/s at BSET (Oct 2019)
					8.2	Develop assessment processes (June 2019)
					8.3	Ongoing work to pilot and implement in 2019.
					8.4	Integrate into BRIPS education as appropriate. e.g. FSSE for senior trainees
9	Selection	1. Define and Document minimum standard of entry. 2. Increased number of indigenous trainees. 3. Selection processes are evaluated, with reference to trainee progress in SET. 4. Information about surgical training and careers is widely available	The selection process allows the identification of candidates most likely to succeed in SET. Surgical trainees reflect the diversity of the community. Selection standards, pre-requisites and processes are transparent and understood.	24, **25,** 26, 27	9.1	Evaluation of selection 2013 -
					9.2	Selection Workshop planned (April 14).
					9.3	Presentation of research/workshop findings to BSET (June).
					9.4	Policy changes/implementation (Oct 2019).
10	Monitoring and evaluation	1. Develop an overarching framework for monitoring and evaluation. 2. Develop a reporting structure that promotes data sharing between RACS and the Societies/STBs. 3. Establish feedback mechanisms for trainees and supervisors. 4. Respond to Leaving Training Report. 5. Trainee progress and attrition monitored quarterly. 6. Early Identification of trainees at increased risk. 7. Strategic support for trainees as appropriate.	Feedback mechanisms that provide data on the training programs are established for trainees and supervisors. Relevant and useful data for all internal and external stakeholders, including government, is available.	4,17, 19, 20, 21, 22, 23	10.1	Linked to monitoring and evaluation of Respect and D&I plans. Quarterly reports provided.
					10.2	Develop process for receiving feedback from external stakeholders.
					10.3	Develop process for receiving feedback from trainees and supervisors
					10.4	Address Leaving Training Report Publish related journal articles; One article published
					10.5	Develop an overarching framework

APPENDIX 4

Flexible training posts per specialty and region

Flexible training posts by specialty



Flexible training posts by region

APPENDIX 5

Responding to and supporting trainees who provide feedback

Principles of Management

Responding to and supporting trainees who provide feedback

Principles of Management

1 The trainee is entitled to feel safe in providing feedback

Should a situation arise that threatens or disadvantages the trainee as a result of providing feedback, the Specialty Training Board and RACS management will be responsible for enacting measures to protect the trainee's wellbeing and career progression.

2 The Specialty Training Board and RACS management work in unity to ensure the welfare of the trainee.

The Specialty Training Board is responsible for managing the trainee, and will remain the focal point in this situation. However, to ensure a considered and cohesive response to the situation in the trainee's best interest, Specialty Training Boards will work closely with RACS management to consider a broad range of options and to implement appropriate actions. Such situations may require differing levels of support and intervention and the options could include seeking legal advice, providing psychological support for the trainee, advocating to the unit or hospital, intervention by the Executive Director of Surgical Affairs or the consideration of remedial action or sanctions.

3 Open disclosure and lines of communication are established in a prompt and timely manner

Where anonymity or the individual's confidentiality is breached and as soon as the breach is suspected or identified, the breach must be communicated to the trainee (if not already aware) and their Specialty Training Board. The same process will apply for reporting of repercussions. The source could be the trainee, others associated with the feedback, administrative staff, and seniors in the clinical workplace, RACSTA, the training supervisor or the Board Chair. So the source may be varied and multiple.

Regardless of the source, the priority will be to establish early and open lines of communication between the trainee, the Specialty Training Board and RACS management. The Board will be the initiator of advice to the trainee and RACS management if either is unaware. Should the breach be disclosed or a report provided to RACS management, the Specialty Training Board will be advised, who will then be responsible for advising the trainee.

Once the breach or report is shared between the trainee, the Specialty Training Board and RACS management, discussions should commence without delay. Thereafter, the trainee will be consulted and actively involved in the process to determine the ongoing support and management of their specific situation.

4 The wellbeing and safety of the trainee is managed as a priority.

The primary concern is the wellbeing and safety of the trainee. The Specialty Training Board will take measures to ensure that the trainee is in a safe environment (physical safety) and that their mental health is supported (psychological safety). As needed, assistance from RACS managment will be provided.

Determining the trainee's level of concern either perceived, real or having the potential to affect the trainee, will be a primary consideration. The situation will be discussed with the trainee to gauge if the trainee has been subject to any immediate repercussions and to evaluate the effect on the trainee (e.g. feeling threatened, anxious, stressed, or not concerned). In most circumstances consultation would be undertaken by the Board, but could be conducted by RACS management.

Measures undertaken will be appropriate to the level of concern and the potential for harm, and could range from mentoring or counselling to more serious measures such as immediate removal of the trainee from a training post.

5 Early intervention occurs to minimise any adverse impact on the trainee.

The Board and RACS management will evaluate the extent of the situation, and in the event of inadvertent disclosure of a trainee's identity or breach of confidentiality, the potential for wider dissemination of the trainee's identity. Immediate and early intervention with the unit, colleagues or seniors may mitigate the development of ongoing or serious harm to the trainee's wellbeing, reputation, or career progression. Measures could include mediation, intervention or may require stronger cautionary measures.

6 A support plan for the trainee is developed, including mitigation of potential risks.

Once immediate measures are in place, a plan will be developed to provide medium to longer term support for the trainee. This may be developed in conjunction with medium to longer term measures to minimise the adverse impact on the trainee. The trainee will need to be actively engaged with the process, and take individual responsibility where appropriate (e.g. learning to identify and self-manage stress, being prepared to engage in mediation or to or to transfer.

Consideration will be given to the trainee's continued safety and wellbeing. An analysis of the potential for the trainee to be disadvantaged as a result of the situation should be made and measures implemented as part of the support plan. The potential for disadvantage could include being subject to restrictions on their training experiences, assessment bias, reputational discredit or personal attack all of which could affect the trainee's career progression. The measures implemented should be appropriate to the level of perceived, real or potential disadvantage experienced.

7 A plan for follow up and monitoring is agreed to.

The management plan should include an agreed period/s of follow up to determine if support and interventional measures implemented have been effective, if additional issues have emerged, and if the trainee's wellbeing is stable and has not deteriorated .

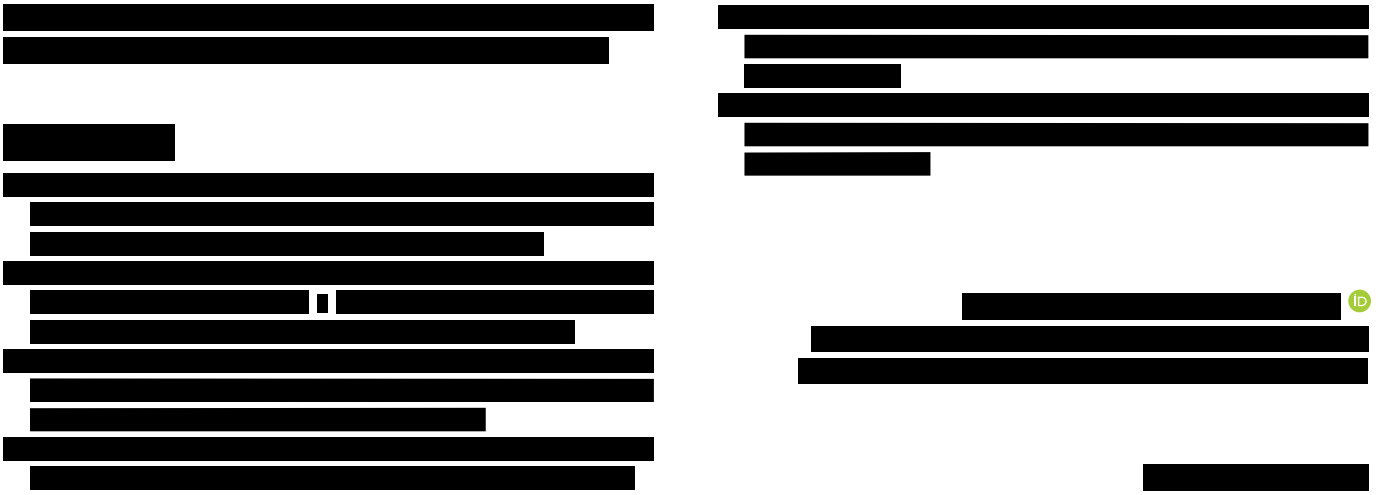
The recent external review of the complaints process has resulted in a Disclosure Statement (pending approval) on victimisation. These proposed principles, specific to the SET situation, will be used in conjunction with the Disclosure Statement.

APPENDIX 6

ANZ Journal of Surgery articles

P Truskett (2018) Soil, Seed or the tiller: why do trainees leave?

D Forel, M Vandepeer, J Duncan, D Tivey and S Tobin (2018) Leaving surgical training: some of the reasons are in surgery



Soil, seed or the tiller: why do trainees leave?

I suspect that most senior surgeons would look upon their period of training with fondness. I recall listening to my supervisors who would often talk in respectful terms of their teachers and the vast volume of surgery they did and the long hours they worked. They seemed to have worked many more hours than I did as a trainee and did far more surgeries. I also look upon my days of training with similar fondness. The work was hard and there is a recollection of self-doubt during early training. Would I make the grade? But I did feel safe and well supported by my mentors. There was also a great deal of clinical and emotional support from my fellow registrars. There may be a good reason for this. We knew each other very well. Selection in those days was hospital based, so we had worked together for some time before we were selected into training. We often went to the same medical school as there were only two medical schools in New South Wales at that time: Sydney University and the University of New South Wales. Many of our mentors we knew from our time were as medical students. We had a good idea of what to expect. We had no real expectation or even knowledge of the College. There was a vague curriculum that really only dictated our rotations, length of training and provided a log book with minimum numbers per term. We were expected to know the scope of our specialty and face an exam at the end of our 'time-based' training that was conducted by the College. But of course, the senior surgeons tend to retain good memories as with time we suppress the bad memories. It is a coping mechanism. The recollections of the 'good old days' do not necessarily inform the present.

Things are quite different today with national or state-based selection and large rotations, sometimes interstate or international in smaller specialties, to places where the trainee may have no real familiarity or connection. It can be a significant dislocation. There is also a well-defined intensive College training program in each specialty with defined time limits for task completion. It is easy to understand how a trainee may become overwhelmed by the training requirements and feel very alone if sent to a strange environment. Data from College activity statement indicate that trainees are leaving their training programs.[1] Why is this happening?

In 2015, the College commissioned the Ardnell group to undertake an external review to better understand why trainees have voluntarily left surgical training.[2] This report was published in April 2016. The Ardnell report is available on the College website and should be read by all surgical trainers. In this issue, Deanne *et al.* use this report as a platform and have produced a review to look at surgical trainee attrition.[3] The Ardnell study identified 337 trainees who left the training program from 2008 to 2014. This represented 15% of the training cohort. Of these, 62% resigned by choice. Of those who voluntarily left their training program, two-thirds were women. This gender imbalance was particularly concerning. Many trainees indicated that their reasoning for resigning was multifactorial, but there were three main factors that influenced a decision to leave surgical training:

- Inflexibility in the training program
- An unacceptable culture in which to learn
- The practise of surgery required an unacceptable lifestyle.

The other important aspect regarding the voluntary leavers is that they were not the underperformers. They were proceeding well in their training.

In many ways, it is entirely acceptable for trainees to leave if it is their perception that surgery is not for them. It is sad that they had to work so hard to gain selection to the program only to find that surgery did not suit them. Could this possibly be a problem of selection? There have been prospective American studies that have looked at the perceptions of a surgical life as a selection tool perhaps reflective of emotional intelligence and resilience.[4,5] Although these studies have demonstrated a reduction in trainee attrition, these factors cannot be used in isolation. It is clear from the Ardnell report that some trainees have been derailed by being placed in an environment of poor surgical culture. Furthermore, this culture is not necessarily reflective of the seniority or gender of the consultants. Some

of the narratives in the Ardnell report are chilling; some describing deliberate depersonalisation, bullying and public demeaning. These activities are known to lead to burnout, which clearly lead to dissatisfaction.[6] It is interesting how a bad culture can be perpetuated long after the original protagonist has left. Such a culture will not dissipate; it takes recognition, strong leadership and a lot of hard work to change bad behaviour that has become normalized.

Our training Boards must continue to explore flexible training. Part of the difficulty here is separating the 'service' component from the 'training' component of surgical training. Too often decisions are made on a rule-based process and not on evidence. It would be interesting to see how education may be enhanced by appropriate flexibility. Surely, a 'competency-based' training program should allow for this. The other issue relating to flexibility is a sudden unexpected assignment to a training post that geographically separates a trainee from their family and domestic commitments. There should be no excuse for this. It should be possible that an SET 2 trainee and above could be provided with their rotations at least 12 months in advance or even for their entire program. A newly appointed SET 1 is more problematic, because of the short time between appointment and commencement, but there should be an attempt made to avoid distant placement. There will be contingency issues but they would be an exception rather than the rule. Realistic notice even if the posting is interstate or international can be planned for by a trainee.

Concerning as the Ardnell report appears, it was commissioned on a cohort of leavers that predates the College's 'Building Respect Improving Patient Safety' program. Let us hope that the critical issues raised by our disenchanted trainees will be addressed by our change in culture.

So, is the trainee, the training or the trainer the cause for attrition? Perhaps it is all three, but where a toxic surgical culture exists, things really have to change or we might lose the right to train.

References

1. Royal Australasian College of Surgeons. Activity reports. 2016. [Cited 12 Dec 2017.] Available from URL: https://www.surgeons.org/government/workforce-and-activities-reports/
2. Ardnell Group. Ardnell report. 2016. [Cited 15 Dec 2017.] Available from URL: https://www.surgeons.org/media/25492594/ardnell-report.pdf
3. Forel D, Vandepeer M, Duncan J, Tivey DR, Tobin SA. Leaving surgical training: some of the reasons are in surgery. *ANZ J. Surg*. 2018; doi: 10.1111/ans.14393.
4. Kelz R, Mullen J, Kaiser L. Prevention of surgical resident attrition by a novel selection strategy. *Ann. Surg*. 2010; **252**: 537–43.
5. Burkhart R, Thorley R, Guinto D, Yeo CJ, Chojnacki KA. Grit: a marker of residents at risk for attrition. *Surgery* 2014; **155**: 1014–22.
6. Lin T, Liebert C, Tran J, Lau JN, Salles A. Emotional intelligence as a predictor of resident well-being. *J. Am. Coll. Surg*. 2016; **223**: 352–7.

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SPECIAL ARTICLE

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Leaving surgical training: some of the reasons are in surgery

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Abstract

In 2014, the Royal Australasian College of Surgeons identified, through internal analysis, a considerable attrition rate within its Surgical Education and Training programme. Within the attrition cohort, choosing to leave accounted for the majority. Women were significantly over-represented. It was considered important to study these 'leavers' if possible. An external group with medical education expertise were engaged to do this, a report that is now published and titled 'A study exploring the reasons for and experiences of leaving surgical training'. During this time, the Royal Australasian College of Surgeons came under serious external review, leading to the development of the Action Plan on Discrimination, Bullying and Sexual Harassment in the Practice of Surgery, known as the Building Respect, Improving Patient Safety (BRIPS) action plan. The 'Leaving Training Report', which involved nearly one-half of all voluntary 'leavers', identified three major themes that were pertinent to leaving surgical training. Of these, one was about surgery itself: the complexity, the technical, decision-making and lifestyle demands, the emotional aspects of dealing with seriously sick patients and the personal toll of all of this. This narrative literature review investigates these aspects of surgical education from the trainees' perspective.

Introduction

The demands of becoming and being a surgeon are significant; they impact the individual's sense of wellness, potentially leading to imperfect learning within surgical education and training (SET), as well as the impaired quality of surgical health care. A systematic review of qualitative studies assessing what it means to be a surgeon revealed a gap between the idealization that surgeons are highly skilled professionals and the reality of a typical working day.[1] Orri *et al.* identified that the emotional and relational dimensions of surgical practice can contribute to an individual's internal tensions. Ignoring these dimensions of surgery, or not adequately preparing trainees to deal with them, may result in individual's questioning whether surgery is a career for them and, for some, to make the decision to leave surgery.

Trainee loss is a significant concern for surgical colleges worldwide. A meta-analysis of 22 studies found that the international attrition rate in general surgery trainees is 18%, with over half of these being voluntary.[2] Within the Australian and New Zealand context, the Royal Australasian College of Surgeons (RACS) has assessed attrition rates. An internal RACS evaluation of 2144 trainees embarking on the SET Program from 2008 to 2014 identified 337 individuals (15%) who did not finish the program, either because of dismissal, failure at hurdle examinations or choice. Forty-five recommenced with the same or another specialty. Of the remaining 292, some 56% chose to leave (resigned), with women 2.5 times more likely to resign.[3]

To investigate the reason behind such major career decisions, RACS commissioned an external group with medical education expertise to design and conduct a survey and interview study of the group.[3] Eighty respondents out of the 162 who chose to leave (resigned) responded. This was a significant response (one-half) from doctors who were no longer involved with the SET program. Their reasons were cumulative and varied. For most, there was a significant amount of time between considering and ultimately leaving training. Three major themes were identified: (i) inflexibility in the training programme; (ii) an unacceptable culture in which to learn; and (iii) having commenced surgical training, surgery was judged the wrong career choice.[3]

These losses to the RACS SET Program occurred following a competitive selection process designed to identify trainees who could perform well in training and as future surgeons. Therefore,

significant voluntary attrition is a concern for RACS as it may indicate issues with trainee selection, expectations or the training environment. The challenge is to understand why trainees decide surgery is not the career for them as well as ensuring that training is a positive and empowering experience for those who complete the programme.

This narrative literature review summarizes key aspects regarding the complexity of surgical training that lead to trainee loss and how both the trainee and trainer can be proactive in establishing protective strategies to reduce these losses.

Causes for withdrawal as part of overall attrition

The third theme identified in the RACS survey of trainees who left surgical training[3] is relevant to understanding the complexity of surgical life and why previous RACS trainees felt surgery was the wrong career choice for them. Reasons proffered by respondents included the experience of adverse events, feeling they lacked technical competence, concerns of failure related to complex operations and the risk of burnout and health issues as a result. Some trainees also felt that surgeons were not positive role models and that their lifestyle was not something to which they could aspire. One interview participant stated that their reason for leaving was '*…a combination of being a lifestyle choice as well as getting more of a realisation of what the job and lifestyle of a surgeon was actually like*'.[3] These reasons are reflected in the international literature, which is summarized below:

Burnout: Burnout is defined as emotional exhaustion, depersonalization and a decreased sense of personal accomplishment that can distort career decisions, impact well-being, negatively affect patient care and may contribute to a decision to leave surgical training.[4] The incidence of burnout in surgical trainees across specialties ranged from 28% to 69%,[5–8] and over half of those classified with burnout considered dropping out of training.[7]

Factors found to be associated with burnout in surgical trainees included high workload and working hours,[7,9] difficulty in balancing professional and private life and not taking part in extracurricular activities.[6,9] Other important factors included patient aggression, lack of gratitude from seniors, being assigned a level of responsibility perceived to be too high, working in units where senior surgeons did not support trainees or their patient care, working in units where regular staff meetings were not scheduled, perceiving patient expectations to be unrealistic and poor peer collaboration.[5,6,8,9]

Lifestyle as a trainee: In 2017, Khoushhal *et al*. meta-analysed 10 studies that reported reasons for attrition. This included a total of 10 371 general surgery trainees from the United States, and the most common cause of voluntary attrition was found to be an uncontrollable lifestyle.[2] Another study of 2033 general surgery trainees, not included in Khoushhal *et al*.'s meta-analysis, also reported lifestyle factors, including the strain of work, excessive hours and the stress it puts on family life, as the most significant reasons for withdrawal.[10]

Health and personal considerations: Health and personal considerations identified by Khoushhal *et al*. included trainees own health, family or spousal factors, financial burden, poor performance and imminent dismissal.[2] Sullivan *et al*. found that trainees who withdrew from training considered training to be too long, expressed dissatisfaction with the personality required to become a good surgeon and felt the personal cost of surgery was too great. In addition, those who left training were less satisfied with their operative experience, felt their skills were not level appropriate, reported feeling 'in over their head' and that their work volume left them fearful they would hurt someone.[10] Overall, the trainees who withdrew were dissatisfied with the training programme and felt they were not the correct fit for surgery.[10]

Inability to ask for support: Sullivan *et al*. report that those who left training were less likely to ask their peers for help for fear of negative judgement; they perceived a lack of respect from attending physicians, were less likely to interact with attending physicians (consultant surgeons) socially, did not report having camaraderie with their peers and felt they could not rely on other trainees for support when needed.[10]

Potential reasons for considering leaving training

In addition to the abovementioned studies, two further international studies were identified that surveyed current general surgery trainees asking whether they had considered leaving training and why;[11,12] 32% of trainees had considered leaving training in one study (18% considered leaving very seriously and 14% somewhat seriously),[12] and 58% considered leaving seriously in the other study.[11] Both studies found trainees more likely to consider leaving in their first and second postgraduate year (46% and 41%, respectively).[11,12]

Ginther *et al*. found that the most significant factors associated with thoughts of leaving was poor work–life balance (71%), concerns about future unemployment or underemployment (46%) and poor quality of life (44%).[12] Furthermore, Gifford *et al*. identified sleep deprivation (50%), undesirable future lifestyle (47%) and excessive work hours (41.4%) as the reasons trainees considered leaving training.[11]

In addition, both the Ginther *et al*. and Gifford *et al*. studies investigated factors that prevented surgical trainees from leaving, effectively supporting the completion of the surgical programme. In both studies, the most significant factor that prevented trainees leaving was support from family or partners (14% of responders[12] and 65% of responders[11]). Other reported reasons for not leaving included enjoyment of work (42%), having invested too much time to quit (34%), support from other trainees (64%) and the perception of being better rested (59%).[11,12] It is important to note that, despite considering leaving throughout their training period, many trainees will go on to become successful surgeons.

Factors associated with the complexity of surgical life

Orri *et al*.'s meta-synthesis of surgeons' perspectives about factors affecting their practice and well-being included 51 studies that documented over 1000 surgeon interviews. This review identified

the following themes of a career in surgery that trainees may not be aware of prior to commencing surgical training.[1]

Surgeon image and identity: The importance of upholding a certain image and identity was reported by the surgeons interviewed as not being addressed in their education. Surgeons reported feeling the vulnerability of their professional identity given that it was so strongly linked to their surgical outcomes.

Rules and guidelines: Surgeons found that rules and guidelines often did not fit the surgical model and, in some cases, were a hindrance. Surgery often takes an unpredictable course, and the ability to accommodate this with flexibility and innovative practices is vital for a successful surgeon.

Emotional involvement: Errors and adverse events were perceived by surgeons as a major source of unpleasant emotions, physiological stress, cognitive dysfunction and a range of negative feeling that may have a harmful effect on their practice.

Difficulty communicating with patients: In some cases, patients are unable or unwilling to consent to an 'operative plan' because of their unrealistic expectations, unquestioned faith and need for extensive explanations or non-compliance.

Team relations: Surgeons generally described a family-like atmosphere in the operative room, but conflicts may occur, particularly with regards to training surgeons. The influence of rank and power can become problematic, with issues surrounding image and leadership being prominent. The need to discuss and critique the performance and success of their peers and trainees may cause concerns for a surgeon's reputation and create conflict. The surgeons interviewed seldom reported turning to other surgeons for emotional support.[1]

Can trainees considering leaving be identified?

Given what is known about the reasons for leaving or considering leaving, as well as the insight from the work by Orri *et al.*, is it possible to predict the characteristics of surgical trainees who are most at risk of attrition?[13–16]

A prospective National Study on the Expectations and Attitudes of Residents in Surgery was initiated in 2007 across the United States and was designed to identify characteristics that may predict which trainees are most at risk of non-completion. All postgraduate year one trainees took part in a 68-item survey that focused on questions regarding demographics, choice of residency programme, expectations for surgical training and personality.[16] Of the 1048 general surgery interns who began training in 2007, over 80% participated. Linkage data were available for 836 of these interns, and 672 went on to complete residency. The survey identified that the female gender was the independent risk factor most strongly associated with attrition, with women being 1.4 times more likely to leave training. For men, the most important predictor of attrition was training programme size, with 23% of men withdrawing from larger programmes compared with 16% from smaller programmes.[16]

Quillin *et al.* investigated whether there is a link between learning style and attrition.[14] They examined a 14-year database of surgical trainee learning style assessments, along with operative log data, examination results and reasons for leaving surgical training before completion. Individual learning styles were assessed using the Kolb Learning Style Inventory[17] (LSI), which is a validated, self-assessment tool. Individuals were categorized by learning style, and a total of 441 LSIs were completed by 126 trainees during the study period (1999–2012).[14] The authors characterized the learning styles of general surgery trainees, finding that the majority were action-based learners. Those at most risk of attrition were trainees who the inventory suggested learned by observation. In addition, these individuals had a less robust operative experience as they were rated less 'hands on'.[14]

Grit, defined as perseverance and passion for long-term goals, has been shown to predict trainee well-being.[18] Salles *et al.* measured grit using the Short Grit Scale, a validated measure of perseverance, over 2 years in 115 trainees. Risk of attrition was also measured by asking two questions: (i) at this point in time, how likely is it you will complete residency training in your current specialty? and (ii) in the past month, how often have you thought of leaving your current residency programme? Actual attrition was also measured. After controlling for trainee age, gender, ethnicity and marital status, the authors found that grit was not a predictor of completion.[15]

To successfully cope with emotional and relational demands of surgical life requires self-reflection and an individual's capacity to regulate their own emotions and those of their patients and colleagues, allowing them to manage stressors and work effectively with others. This is related to the concept of emotional intelligence, and Lin *et al.* investigated its relationship to wellness in surgical trainees.[13] This single-centre study of 73 trainees identified that high emotional intelligence has a strong positive predictive value for wellness. Furthermore, emotional exhaustion, depersonalization and depression were lower in those with a high index for emotional intelligence, and the authors concluded that prospectively measuring emotional intelligence may identify individuals who can cope and even thrive in surgical training.[13]

Coping strategies are used by surgical trainees

Surgical trainees are subjected to potential prolonged sleep deprivation and high job demands, with only some control over their work schedules and tasks.[19] While there are several studies describing coping strategies used by medical professionals,[20–26] techniques specifically used by surgical trainees to help them cope with their lengthy training period are less well described. Four studies were identified that discuss strategies used by trainees to help them cope with stress and burnout.[19,27–29] Descriptions of the coping strategies employed by trainees is provided in Tables S1 and S2.

Popular coping strategies identified in the literature include participation in activities outside of surgical residency, including engaging in enjoyable activities, taking time out, making time for hobbies weekly or more often and exercise.[19,27,29] Discussing concerns with colleagues; talking to family, friends and/or partners about concerns; and consulting others were also reported as helpful stress-coping strategies.[19,27,29] To a lesser extent, religion, praying or belief in a faith were also reported as coping mechanisms.[19] 'Supports' such as high alcohol use and tobacco smoking must be

considered 'strategies' that adversely impact health. An American study found that low alcohol use had a significant correlation as a protective strategy against burnout.[19] As for the use of alcohol as a coping measure in Australia and New Zealand medical professionals, a systematic review commission by Beyond Blue failed to identify any published literature.[30]

The use of mentorship as a coping strategy varied. As the frequency of contact with mentors increased, emotional exhaustion decreased and personal achievement increased.[19] Mentor type was also important; senior trainee or classmate mentors significantly decreased emotional exhaustion, while classmate or faculty member mentors significantly increased personal achievement.[19] Fellows or physicians other than a faculty member were the least beneficial in terms of reducing burnout and marital satisfaction.[19] Another recent study ranked same-sex mentorship to be a significant positive influence on women in surgery, leading the authors to conclude that early exposure to organizations that support women in surgery can positively influence career choices.[31]

In summary, the coping strategies that trainees adopt are varied, and there does appear to be an active engagement by some trainees in managing the demands and stressors of undertaking surgical training.

Programmes and interventions to prevent voluntary withdrawal

Given the positive impact of coping strategies gained by individuals, can these benefits to well-being be extended to all trainees through structured programmes? Eight studies were identified that assessed the effectiveness of various initiatives to improve trainee retention.[32–39] They included providing methods for identifying and coping with stress,[32–34,36] wellness programmes that promote a positive work–life balance[35,38] and mentorship.[37,39] Programme details and a summary of their findings is provided in Tables S1 and S2.

All of the programmes and interventions identified were useful in improving surgical trainee well-being to varying degrees. Particularly successful stress coping interventions were values affirmation, mental practice and self-awareness; briefly, these interventions involve:

Values affirmation: a short stress-reducing writing exercise whereby participants select 2–3 core values important to them from a list of 12 (including family and friends, sports, music and religion) and write a discussion piece to explain their choices.[36]

Mental practice: a systematic form of mental rehearsal where participants imagine themselves performing an action without performing the physical movements.[32]

Lack of self awareness: this was noted by Hochberg *et al*. as failing to recognize the signs and symptoms of stress and depression among surgical trainees, and they concluded that medical educators should provide trainees with the necessary tools to identify emotional and psychological impairment as part of their formal training.[33]

Discussion

Surgery is a complex profession that places significant demands on individuals both during and post-training. This review has revealed that there are numerous reasons for withdrawal from surgical training. Many relate to what surgery 'is' and that potential trainees are unaware of this or find this unacceptable. Of note are issues around lifestyle (i.e. absence of balance in work–life relationship), dissatisfaction with the workplace culture, feeling unsupported and personal reasons such as family or spousal pressure and health or financial issues that result in individuals deciding that surgery is not for them.

Attributes that were found to correlate with the increased likelihood to complete training were male gender, being enrolled in smaller training programmes and being an active learner. High emotional intelligence was also found to have a strong positive predictive value for wellness. Perhaps tailoring trainee placement and mentorship programmes based on withdrawal risk profiling, in order to mitigate potential attrition and provide early intervention where required, may be a way forward for surgical training programmes.

However, irrespective of risk profiling, the stress of training will remain. The most popular techniques used by surgical trainees to avoid or cope with stress and burnout were speaking to colleagues, family and friends about their concerns and taking time out to do hobbies or enjoyable activities. The challenge is to identify those who lack such support and help them foster relationships or offer a viable alternative.

Organizational strategies that are designed to help surgical trainees cope with training and reduce attrition include methods for identifying and coping with stress, wellness programmes to promote positive work–life balance and mentorship activities. Bittner *et al*. conducted similar recommendations on individual coping strategies, which included cultivating and maintaining healthy personal relationships and spiritual practices; seeking medical and/or mental health care when needed or directed; maintaining appropriate nutrition and physical fitness; and striving to establish and sustain work–life balance.[4]

Limitations to this review are that many of the findings reported have been based on studies that have used surveys. Given that response rates varied, there may be response bias to questions regarding reasons for withdrawal, individual strategies used to cope with stress and the benefits of different organizational programmes and interventions. There may be differences between respondents and non-respondents, which limit the generalizability of the responses. In addition, despite the assurance of anonymity, some respondents may have altered their responses for fear of career repercussions. Ideally, identified strategies that have shown promise should be tested in comparative studies, preferably randomized, to confirm their benefits and determine whether they reduce attrition rates in surgical trainees.

It is important to note that many of the studies included in this review were from US general surgery programmes. Whether the results derived from trainees from one country or specialty are representative of those from other countries or specialties is unknown. However, the general themes emerging from the literature are similar to those identified in the study of those trainees who left (resigned) the RACS SET Program.[3]

This review has covered withdrawal from the perspective of retention of trainees in the programme by investigating what

individual- or programme-implemented coping strategies are effective. However, it is possible that the problem of 'leaving' might also be attributed to trainee selection, and some focus should also be placed on the recruitment of trainees. Although characteristics can be shown to correlate with or predict completion, care must be exercised to prevent reinforcing potential gender and racial biases. RACS has committed to its 'Diversity and Inclusion Plan' to reduce such biases.[40]

The 'complexities' of surgical training and a surgical career are not well researched; the question raised by another review is whether the problem of withdrawal stems from whether trainees are unaware of the challenges of surgical residency or if the wrong trainees are being selected.[41] Indeed, Orri *et al*. suggested that open dialogue is needed to inform those considering surgery as a career and that succeeding as a surgeon cannot rely solely on technical excellence. A surgeon is required to work as part of a team with all involved in the delivery of surgical care.[1]

The RACS SET Program was established during 2007–2008 and requires trainees to demonstrate clinical skill, patient care and professional judgement across nine competency domains, which include professional relationships and being moral and ethical. Elements within these dimensions should prepare the young surgeon for the complexity of surgical life and build aspects of their emotional intelligence to complement their technical skills. Evaluation of the emotional and relational dimensions of training programmes is required to ensure that these aspects of surgery are taught effectively to support the individuals and provide them with protective strategies to allow navigation through the complexities of their working and personal lives as a surgeon.

Conclusion

Withdrawal from surgical training is costly and undesirable for both individuals and programmes. Surgical trainees use various strategies to help them to cope with the demands of their intensive training, and choosing to leave is the strategy used by some. It is important that surgical colleges and programmes develop a culture whereby trainee work–life balance and well-being are promoted. Interventions that foster this, as identified from the literature, include the provision of stress identification and management strategies to all surgical trainees through their curriculum. There are notable roles for training and career mentorship and the provision of wellness programmes; promotion of social interaction and inclusion with peers; and psychological support and development of the individual including their values and self-awareness.

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Conflicts of interest

None declared.

References

1. Orri M, Farges O, Clavien P-A, Barkun J, Revah-Lévy A. Being a surgeon—the myth and the reality: a meta-synthesis of surgeons' perspectives about factors affecting their practice and well-being. *Ann. Surg.* 2014; **260**: 721–9.
2. Khoushhal Z, Hussain MA, Greco E *et al*. Prevalence and causes of attrition among surgical residents: a systematic review and meta-analysis. *JAMA Surg.* 2017; **152**: 265–72.
3. Ardnell Group. A study exploring the reasons for & experiences of leaving surgical training, edn. [Cited 12 Sep 2017.] Available from URL: www.surgeons.org/media/25492594/ardnell-report.pdf
4. Bittner JG 4th, Khan Z, Babu M, Hamed O. Stress, burnout, and maladaptive coping: strategies for surgeon well-being. *Bull. Am. Coll. Surg.* 2011; **96**: 17–22.
5. Chaput B, Bertheuil N, Jacques J *et al*. Professional burnout among plastic surgery residents: can it be prevented? Outcomes of a national survey. *Ann. Plast. Surg.* 2015; **75**: 2–8.
6. Chati R, Huet E, Grimberg L, Schwarz L, Tuech JJ, Bridoux V. Factors associated with burnout among French digestive surgeons in training: results of a national survey on 328 residents and fellows. *Am. J. Surg.* 2017; **213**: 754–62.
7. Elmore LC, Jeffe DB, Jin L, Awad MM, Turnbull IR. National survey of burnout among US general surgery residents. *J. Am. Coll. Surg.* 2016; **223**: 440–51.
8. van Vendeloo SN, Brand PL, Verheyen CC. Burnout and quality of life among orthopaedic trainees in a modern educational programme: importance of the learning climate. *Bone Joint J.* 2014; **96-B**: 1133–8.
9. Businger A, Stefenelli U, Guller U. Prevalence of burnout among surgical residents and surgeons in Switzerland. *Arch. Surg.* 2010; **145**: 1013–6.
10. Sullivan MC, Yeo H, Roman SA *et al*. Surgical residency and attrition: defining the individual and programmatic factors predictive of trainee losses. *J. Am. Coll. Surg.* 2013; **216**: 461–71.
11. Gifford E, Galante J, Kaji AH *et al*. Factors associated with general surgery residents' desire to leave residency programs: a multi-institutional study. *JAMA Surg.* 2014; **149**: 948–53.
12. Ginther DN, Dattani S, Miller S, Hayes P. Thoughts of quitting general surgery residency: factors in Canada. *J. Surg. Educ.* 2016; **73**: 513–7.
13. Lin DT, Liebert CA, Tran J, Lau JN, Salles A. Emotional intelligence as a predictor of resident well-being. *J. Am. Coll. Surg.* 2016; **223**: 352–8.
14. Quillin RC 3rd, Pritts TA, Hanseman DJ, Edwards MJ, Davis BR. How residents learn predicts success in surgical residency. *J. Surg. Educ.* 2013; **70**: 725–30.
15. Salles A, Lin D, Liebert C *et al*. Grit as a predictor of risk of attrition in surgical residency. *Am. J. Surg.* 2017; **213**: 288–91.
16. Yeo HL, Abelson JS, Mao J *et al*. Who makes it to the end?: a novel predictive model for identifying surgical residents at risk for attrition. *Ann. Surg.* 2017; **266**: 499–507.
17. Kolb DA. *The Learning Style Inventory: Technical Manual*. McBer & Co: Boston, MA, 1976.
18. Salles A, Cohen GL, Mueller CM. The relationship between grit and resident well-being. *Am. J. Surg.* 2014; **207**: 251–4.
19. Sargent MC, Sotile W, Sotile MO, Rubash H, Barrack RL. Quality of life during orthopaedic training and academic practice. Part 1: orthopaedic surgery residents and faculty. *J. Bone Joint Surg. Am.* 2009; **91**: 2395–405.
20. Alosaimi FD, Almufleh A, Kazim S, Aladwani B. Stress-coping strategies among medical residents in Saudi Arabia: a cross-sectional national study. *Pak. J. Med. Sci.* 2015; **31**: 504–9.
21. Anton NE, Montero PN, Howley LD, Brown C, Stefanidis D. What stress coping strategies are surgeons relying upon during surgery? *Am. J. Surg.* 2015; **210**: 846–51.

22. Basinska MA, Dziewiatkowska-Kozlowska K. The strategies of coping with stress in workplace used by surgeons working in different hospitals: a pilotage research. *Pol. Przegl. Chir.* 2012; **84**: 76–81.
23. Lemaire JB, Wallace JE. Not all coping strategies are created equal: a mixed methods study exploring physicians' self reported coping strategies. *BMC Health Serv. Res.* 2010; **10**: 208.
24. Lepnurm R, Nesdole R, Dobson RT, Pena-Sanchez JN. The effects of distress and the dimensions of coping strategies on physicians' satisfaction with competence. *SAGE Open Med.* 2016; **4**: 2050312116643907.
25. Satterfield JM, Becerra C. Developmental challenges, stressors and coping strategies in medical residents: a qualitative analysis of support groups. *Med. Educ.* 2010; **44**: 908–16.
26. Spiliopoulos K, Gansera L, Weiland HC, Schuster T, Eichinger W, Gansera B. Chronic stress and coping among cardiac surgeons: a single center study. *Rev. Bras. Cir. Cardiovasc.* 2014; **29**: 308–15.
27. Aminazadeh N, Farrokhyar F, Naeeni A *et al*. Is Canadian surgical residency training stressful? *Can. J. Surg.* 2012; **55**: S145–S51.
28. Malik AA, Bhatti S, Shafiq A *et al*. Burnout among surgical residents in a lower-middle income country – are we any different? *Ann. Med. Surg. (Lond.)* 2016; **9**: 28–32.
29. Sargent MC, Sotile W, Sotile MO, Rubash H, Barrack RL. Stress and coping among orthopaedic surgery residents and faculty. *J. Bone Joint Surg. Am.* 2004; **86-A**: 1579–86.
30. Health Technology Analysts Pty Ltd for Beyond Blue. The mental health of doctors – a systematic literature review, edn. [Cited 20 Sep 2017.] Available from URL: http://resources.beyondblue.org.au/prism/file?token=BL/0823
31. Faucett EA, McCrary HC, Milinic T, Hassanzadeh T, Roward SG, Neumayer LA. The role of same-sex mentorship and organizational support in encouraging women to pursue surgery. *Am. J. Surg.* 2017; **214**: 640–4.
32. Arora S, Aggarwal R, Moran A *et al*. Mental practice: effective stress management training for novice surgeons. *J. Am. Coll. Surg.* 2011; **212**: 225–33.
33. Hochberg MS, Berman RS, Kalet AL, Zabar SR, Gillespie C, Pachter HL. The stress of residency: recognizing the signs of depression and suicide in you and your fellow residents. *Am. J. Surg.* 2013; **205**: 141–6.
34. Maher Z, Milner R, Cripe J, Gaughan J, Fish J, Goldberg AJ. Stress training for the surgical resident. *Am. J. Surg.* 2013; **205**: 169–74.
35. Salles A, Liebert CA, Esquivel M, Greco RS, Henry R, Mueller C. Perceived value of a program to promote surgical resident well-being. *J. Surg. Educ.* 2017; **74**: 921–7.
36. Salles A, Mueller CM, Cohen GL. A values affirmation intervention to improve female residents' surgical performance. *J. Grad. Med. Educ.* 2016; **8**: 378–83.
37. Vulliamy P, Junaid I. Peer-mentoring junior surgical trainees in the United Kingdom: a pilot program. *Med. Educ. Online* 2013; **18**: 20825.
38. Watson DT, Long WJ, Yen D, Pichora DR. Health promotion program: a resident well-being study. *Iowa Orthop. J.* 2009; **29**: 83–7.
39. Zhang H, Isaac A, Wright ED, Alrajhi Y, Seikaly H. Formal mentorship in a surgical residency training program: a prospective interventional study. *J. Otolaryngol. Head Neck Surg.* 2017; **46**: 13.
40. Royal Australasian College of Surgeons. Building Respect, Improving Patient Safety, edn. [Cited 13 Sep 2017.] Available from URL: https://www.surgeons.org/media/22260415/RACS-Action-Plan_Bullying-Harassment_F-Low-Res_FINAL.pdf
41. Singletary SE. A fire in our hearts: passion and the art of surgery. *Ann. Surg. Oncol.* 2010; **17**: 364–70.

Supporting information

Additional Supporting Information may be found in the online version of this article at the publisher's web-site:

Table S1. Coping mechanisms used by surgical trainees as reported in the literature.

Table S2. Programmes and interventions offered to surgical trainees to improve course retention as reported in the literature.

APPENDIX 7

Surgical News article

N Vallance (2017) SET selection referee reports

FEATURE ARTICLE

SET Selection Referee Reports

Every year the Royal Australasian College of Surgeons (RACS) selects a new intake of Trainees to its Surgical Education and Training (SET) program. This process, where approximately 800 applicants compete to be ranked sufficiently high to be awarded one of the 200-250 places available, commences in January with the opening of the registration period.

MR NEIL VALLANCE
Chair, Surgical Education and Training

By July applicants will have seen their applications progress through a number of stages and will be anticipating the announcement of the first round of appointments to the program. For many it will not be the first time that they have endured the process that is critical to their career planning.

Selection is a major activity across Australia and New Zealand for the RACS Specialty Training Boards, and the Federal Training Committee of the Australian Orthopaedic Association (AOA). The objective of each board is to identify and select the applicants with the greatest potential for training as a surgeon. Those selected will become our future surgical colleagues, delivering surgical care to the healthcare consumers of Australia and New Zealand.

Selection is governed by RACS policies; the Registration for Selection to SET policy and the SET Selection policy. The SET Selection policy is a principles-based policy that incorporates the Brennan Principles (from the 1998 Trainee Selection in Australian Medical Colleges Report) and meets our obligations resulting from accreditation by the Australian Medical Council (AMC) and the Medical Council of New Zealand (MCNZ).

Each specialty training board determines its own selection process that complies with RACS policies, and are contained in published regulations. Administrative support for the selection process is provided by either RACS or specialty society staff (see Table 1). Due to both the unique nature of each country's health systems and the various Service/Partnering/Collaboration Agreements with the specialty societies, some specialties have separate selection processes in Australia and New Zealand.

The past five years has seen a steady broadening of the criteria that each specialty requires an applicant to meet. With a specialty-centric approach, there is no longer a one-size-fits-all approach to CV requirements and interview structure. Each specialty determines how much weight they give to each selection tool, and to the focus within them. For example, the total points available for publications in one

Specialty	Selection administered by	2016 Referee reports collected by
Cardiothoracic Surgery	RACS	RACS
General Surgery Australia	GSA	RACS
General Surgery New Zealand	NZAGS	NZAGS
Neurosurgery	NSA	NSA
Orthopaedic Surgery Australia	AOA	AOA
Orthopaedic Surgery New Zealand	NZOA	NZOA
Otolaryngology, Head and Neck Surgery Australia	RACS	RACS
Otolaryngology, Head and Neck Surgery New Zealand	RACS	RACS
Paediatric Surgery	RACS	RACS
Plastic and Reconstructive Surgery Australia	ASPS	RACS
Plastic and Reconstructive Surgery New Zealand	RACS	RACS
Urology	USANZ	RACS
Vascular Surgery	ANZSVS	RACS

Table 1: Responsibility for selection administration and referee report collections

specialty will be different to another. The way interviews are structured may also be different.

The tool that is common to all specialties however, is referee reports.

The referee report collection period is from late-April until late-May. Most specialties have been using the same online collection service administered by the RACS Surgical Training Department. In 2016, four of the 13 selection processes used a separate system (see Table 1). There were 582 applications requiring 5305 referee reports to be collected by RACS. This equates to over 2000 Fellows participating in the referee process.

Referee reports are the most significant opportunity for individual Fellows who are not otherwise involved in education (e.g. as a member of a board) to influence the quality of surgical training and the future of the workforce. The referee report is aligned to eight of the nine RACS competencies; Collaboration and Teamwork, Communication, Technical Expertise, Judgement - clinical decision making, Medical Expertise, Management and Leadership, Professionalism and Ethics, and Scholarship and Teaching. The reports have between 16 and 20 questions and offer a range of attributes to differentiate between candidates. (See example of a communication question below). As you can see, there is no score, but a range of descriptors of qualities and behaviours.

COMMUNICATION	
❑	Communication with colleagues and team members Fails to keep team members up to date in a timely manner; Poor / inadequate written communication; Poor / inadequate verbal communication; Has poor relationships with peers; Fails to provide clear directions and descriptions of situations to team members; Is defensive or uncompromising when questioned by other staff;
❑	Generally keeps all team members up to date without prompting; Satisfactory written communication
❑	Keeps all team members up to date without prompting; Effective and timely written communication; Effective verbal communication; Has good relationships with peers;
❑	Effective and timely written communication; Effective verbal communication; Keeps all team members up to date without prompting; Has excellent relationship with peers; Always provides clear directions and descriptions of situations; Remains flexible and open when questioned by other staff;

Why is the referee report important and why should it be persevered within the selection process?

A referee can provide accurate information on a candidate's overall 'fit' for surgical education and training and a ▶

surgical career, by accurately recording the standards of medical practice that they have observed in the candidates on the job performance over a period of time. This type of information cannot be gained from an examination or one-off interview. Those tools are less likely to detect undesirable personal traits or skills deficiencies that can influence whether a candidate has the potential to be successfully trained to minimum standards.

A question asked each year when the Specialty Training Boards are reviewing their selection processes is: 'How meaningful are the referee reports as a selection tool?' There isn't a simple answer or definitive statistics to prove that one tool or set of tools are better than another.

It is evident however, that in the last five years the range of scores from referees has been narrowing. In 2016, a third (33%) of all Referee Reports completed in the RACS on-line referee report system by Medical or Surgical Consultants awarded the applicant a perfect score of 100%.

Such scores can mean two things. Our medical schools could be producing graduates of high and uniform standard, whose performance in the workplace is indistinguishable from their peers, with each deserving of perfect scores. However it is more likely that the scores given are not a true reflection of an applicant's ability. Whether because of pressure from the applicant, an altruistic desire to 'boost' the chances of a favoured colleague getting to interview, or a genuine misapplication of standards of performance, scoring in a tight band at the top end of the range reduces the effectiveness of this tool in selection. It also reduces the ability of the true 'star performer' to stand out.

Predictive Utility of Referee reports

The RACS Education Research and Development Department has found that when used correctly the referee report has predictive utility as a selection tool. There is evidence that those attaining higher referee report scores also achieve higher scores on the Clinical Examination (CE), the Generic Surgical Sciences Examination (GSSE) and the Fellowship Examination (FEX).

What can be done?

It is probable that by now many of you have been approached by aspiring surgical Trainees who have requested your permission to nominate you as a referee. If you have said yes then this is your opportunity to shape the future of the surgical community.

Each Specialty Training Board has a minimum number of referee reports that need to be received for an applicant to ensure validity of the tool. Individual boards will select a set of referees from the list provided by each applicant. For those specialties that use the RACS on-line system you will receive an email request when collection commences on Thursday 27 April, concluding Wednesday 24 May. Reminders will be sent to you until the report is completed. As soon as you complete your report the reminders will cease, with early birds also having the opportunity to go in the draw for an Apple Watch. Towards the last week of the report collection period, referees for applicants without the minimum number of reports required will also receive a phone call from the Surgical Training Department.

If you are asked for a report, carefully consider the questions asked of you. Don't think in terms of the score that will result but about how applicable each statement is to the person you are rating. Resist pressure from others to influence your opinion. All referee reports collected by RACS are confidential; your individual opinions are not shared with applicants, who are advised of their total score only.

There is no doubt that writing a referee report for a prospective trainee is not without its pressures. It does influence the possible career options of young doctors, and can determine who will be your future colleagues. Being a referee is a responsible role, and all that is expected of you is your honest opinion. To those readers called on to perform this role, thank you.

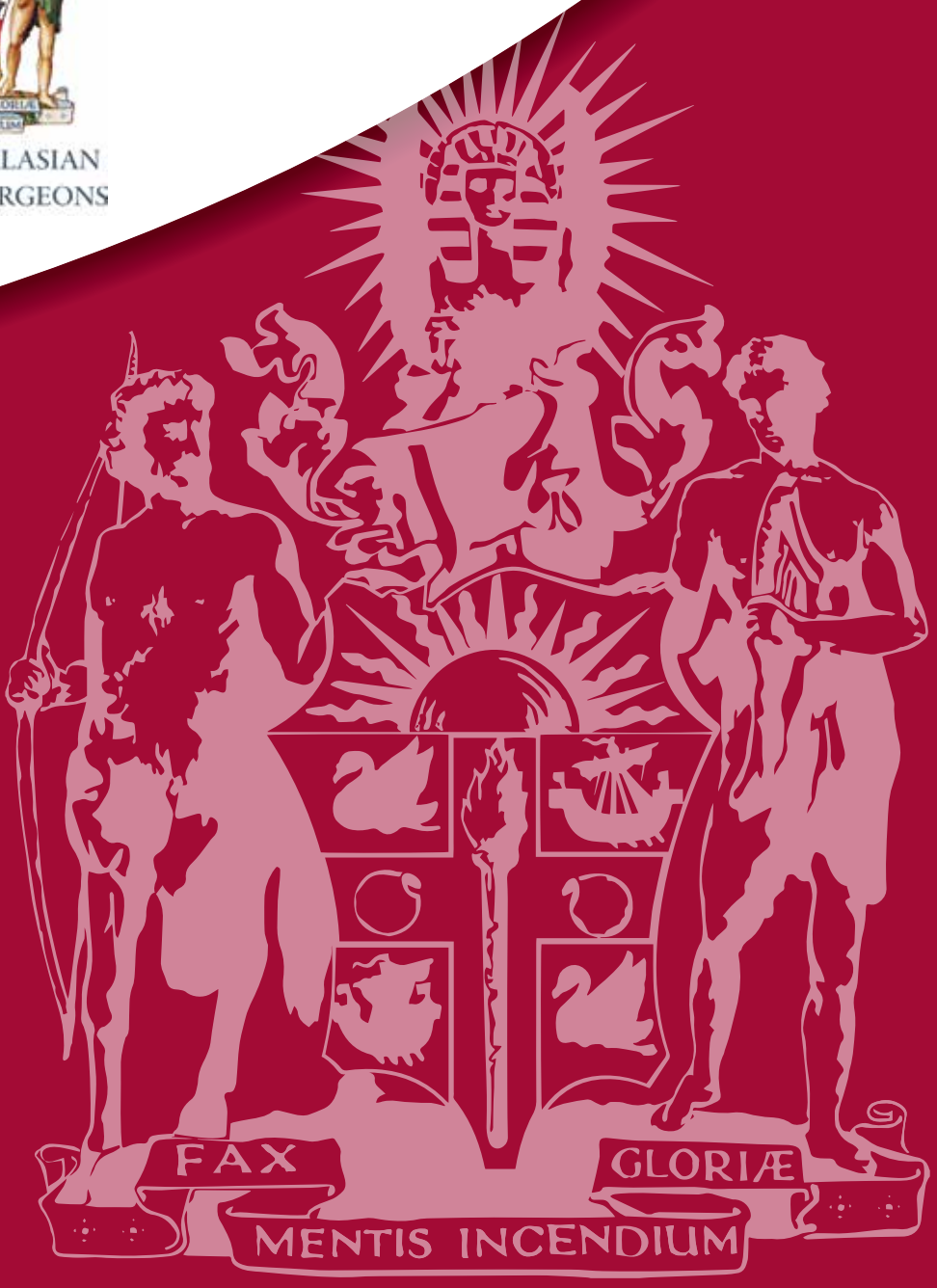
APPENDIX 8

Activities Report 2017

Activities Report

For the period 1 January to 31 December 2017

ROYAL AUSTRALASIAN
COLLEGE OF SURGEONS



Annual Activities Report January – December 2017

Enquiries concerning this report and its reproduction should be directed to: workforce@surgeons.org

FOREWORD TO ACTIVITIES REPORT

The Royal Australasian College of Surgeons (RACS), formed in 1927, is a non-profit organisation training surgeons and maintaining surgical standards in Australia and New Zealand. The College's purpose is to be the leading advocate for surgical standards, professionalism and surgical education in Australia and New Zealand.

RACS works in partnership with specialist surgical societies and associations to train medical doctors to become surgeons and to deliver professional development activities to maintain the surgical skills and standards of our Fellows. We also work with governments, hospitals and other organisations to ensure a well-qualified, experienced and appropriately distributed workforce in Australia and New Zealand.

In 2017, 241 new Australian and New Zealand Fellows were admitted to RACS. This increases the number of active Fellows to over 6300. We also had almost 1200 surgical trainees and 87 International Medical Graduates participate in surgical training over the course of the year.

As part of the RACS Building Respect and Improving Patient Safety Action Plan, there have been additional training requirements added to our Continuing Professional Development Program. We are proud of the achievements we have made in this area to ensure the upskilling of surgical supervisors and trainers, and to promote a respectful culture within surgery.

The Activities Report provides detail of the surgical workforce and its distribution as well as information regarding surgical training and examination results. The report is a document provided for Government departments of health, related agencies and those with an interest in the activities of RACS. The data provided in this report is true and accurate as at December 2017.

Mr John Batten
President
Royal Australasian College of Surgeons

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SECTION FIVE: ACTIVITIES OF CONFERENCE AND EVENTS

SECTION NINE: ACTIVITIES OF RACS SKILLS AND EDUCATION CENTRE

ACRONYMS

~	Not available
ACT	Australian Capital Territory
AOA	Australian Orthopaedic Association
ASSET	Australian and New Zealand Surgical Skills Education and Training
ATLASS	Australia Timor Leste Program of Assistance for Specialist Services
AUS	Australia
CAR	Cardiothoracic Surgery
CCrISP	Care of the Critically Ill Surgical Patient
CE	Clinical Examination
CLE	Clinical Epidemiology
CLEAR	Critical Literature Evaluation and Research
CPD	Continuing Professional Development
EMST	Early Management of Severe Trauma
GEN	General Surgery
GP	General Practitioner
GSSE	Generic Surgical Science Examinations
HECS	Health Education and Clinical Services
HF	Honorary Fellow
IMG	International Medical Graduate
MCNZ	Medical Council of New Zealand
MOPS	Maintenance of Professional Standards
NEU	Neurosurgery
No.	Number
NSW	New South Wales
NT	Northern Territory
NZ	New Zealand
OB & GYN	Obstetrics and Gynaecology
OPH	Ophthalmology
ORT	Orthopaedic Surgery
O/S	Overseas
OPBS	Orthopaedic Principles and Basic Science Examination
OSCE	Objective Structured Clinical Examinations
OTO	Otolaryngology – Head and Neck Surgery
OWR	Operating with Respect
PAE	Paediatric Surgery
PAEE	Paediatric Anatomy & Embryology Examination
PPPE	Paediatric Pathology & Pathophysiology Examination
PGY	Medical Graduate
PIP	Pacific Islands Projects
PLA	Plastic and Reconstructive Surgery
PRSSP	Plastic Surgical Science and Principles Exam
QLD	Queensland
RACS	Royal Australasian College Of Surgeons
RRMA	Rural, Remote and Metropolitan Areas
SA	South Australia
SET	Surgical Education Training
SSE	Surgical Science Examination
SEAM	Surgical Education and Assessment Modules
STST	Short Term Specified Training
TAS	Tasmania
TIPS	Training in Professional Skills
URO	Urology Surgery
VAS	Vascular Surgery
VIC	Victoria
VSEC	Victorian Skills and Education Centre
WA	Western Australia
WFD	Workforce Distribution

INTRODUCTION

The Royal Australasian College of Surgeons Activities Report outlines the developments and demographic data for the year 2017. As with previous reports, the purpose is to provide a comprehensive review of RACS activities throughout the year.

This report details activity in the following nine sections:

- Section One: Skills Training
- Section Two: International Medical Graduates
- Section Three: Surgical Education And Training
- Section Four: Examinations
- Section Five: Workforce Distribution
- Section Six: Professional Development and Standards
- Section Seven: RACS Global Health
- Section Eight: Conference And Events
- Section Nine: Skills And Education Centre

Each section reviews the purpose of and key findings in the data. This is followed by the data in table and graphical format where possible. Each of the nine sections in this report and the data selected has been provided to facilitate a review of activities. All data presented is for the year 2017, unless otherwise stated.

KEY DEVELOPMENTS FOR 2017

The number of female surgeons in active practice increased by 7% in the last year, with women making up 12% of the active surgical workforce and more than 20% of the cohort who obtained RACS Fellowship in 2017.

The number of individual female SET applicants increased by 10%, and comprised almost one-third of all individual applicants. There were 255 applicants who were offered a trainee position in 2017. Just over 30% of successful applicants were female, a 6% increase from 2016.

There were almost 4000 participants who attended Professional Development programs in 2017, more than double the number of participants compared to 2016. This increase is largely due to the extra number of 'Foundation Skills for Surgical Educators' courses held during the year. As part of the Building Respect, Improving Patient Safety Action Plan, this course is now required to be completed by any Fellow who is a surgical supervisor or trainer. In 2016, 99.6% of Fellows complied with the RACS CPD program.

EXPLANATORY NOTES

The Skills Training Department provides the following short courses:

- Australian and New Zealand Surgical Skills Education and Training (ASSET)
- Care of the Critically Ill Surgical Patient (CCrISP)
- Critical Literature Evaluation and Research (CLEAR)
- Early Management of Severe Trauma (EMST)
- Training in Professional Skills (TIPS)
- Operating with Respect (OWR)

Most of these courses are a mandatory requirement of Surgical Education and Training (SET). Doctors from a variety of medical disciplines are involved as both faculty and participants. These courses incorporate a mix of formative and summative assessment, with participants closely mentored and their performance appraised throughout the courses. Courses that incorporate summative assessment (pass or fail) also have an avenue for feedback to be given to SET and IMG surgical supervisors when required.

Successfully completing the Operating with Respect course is a mandatory requirement for SET Supervisors, IMG Clinical Assessors and key RACS committee members.

Australian and New Zealand Surgical Skills Education and Training (ASSET)

ASSET is a requirement for all SET Trainees (excluding Neurosurgery), who are given first preference to complete the course. The course provides an educational package of generic surgical skills with an emphasis on small group teaching, intensive hands-on practice of basic skills, individual tuition, personal feedback to participants and the performance of practical procedures. Although this course is not formally assessed, attendees are required to attend and interact in all components in order to successfully complete it. Participants are required to complete ten eLearning modules prior to attending the course, and are provided with a suture jig and disposable instruments with which to practice.

Care of the Critically Ill Surgical Patient (CCrISP®)

CCrISP® is a requirement for all SET Trainees, who are given first preference to complete the course. The course focuses on developing systematic skills for managing critically ill patients and promotes the co-ordination of multidisciplinary care where appropriate. The CCrISP® course encourages doctors to adopt a system of assessment to avoid errors and omissions, and uses relevant clinical scenarios to reinforce the objectives. Participants are assessed by their contribution to the various sections throughout the course, as well as their performance in a 45-minute simulated patient scenario.

Early Management of Severe Trauma (EMST)

EMST is a requirement for all SET Trainees, who are given first preference to complete the course. EMST focuses on the management of injury victims in the first one to two hours post-accident, with emphasis on life-saving skills and systematic clinical approach. This course is assessed by contribution to the various sections, a 40-question multiple choice questionnaire paper, and a 15-minute simulated patient scenario.

Critical Literature Evaluation and Research (CLEAR)

CLEAR is a requirement for General, Urology, Neurosurgery, Paediatric and New Zealand Orthopaedic SET Trainees, who are given first preference to complete the course. It is designed to provide tools to undertake critical appraisal of surgical literature and to assist surgeons in the conduct of clinical trials, aiming to make the language and methodology relevant to surgeons and the day-to-day activities in their practice. There is no formal assessment for this course; participants are required to attend and interact in all components in order to achieve certification. A dedicated consultant only course is run each year to cater to Fellows interested in attending.

Training in Professional Skills (TIPS)

TIPS is a requirement for Australian based orthopaedic SET Trainees, who are given first preference to attend. TIPS focuses on patient-centred communication and team-oriented non-technical skills in surgery. Through simulation, participants address issues and events that occur in the clinical and operating theatre environment that require skills in communication, teamwork, crisis resource management and leadership. TIPS is designed to be generic to all specialties of surgical training and relevant to Trainees who have already undertaken 2 to 3 years of surgical training. There is no formal assessment for this course; participants are provided with direct feedback throughout the course and are required to attend all components to achieve certification. TIPS is a requirement for SET Trainees undertaking the Australian orthopaedic training program from 2017. TIPS participants are required to complete the JDocs Communication eLearning module prior to attending.

Operating With Respect (OWR)

The Operating with Respect course was launched in April 2017. OWR is a mandatory requirement for all SET Supervisors, IMG Clinical Assessors and key RACS committee members by the end of 2018. The Operating with Respect course provides advanced training in recognising, managing and preventing discrimination, bullying and sexual harassment. The aim of this course is to strengthen patient safety by enabling participants to develop skills in respectful behaviour and practice strategies in responding to unacceptable behaviour. The course follows the release of the RACS Action Plan on Discrimination, Bullying and Sexual Harassment in the Practice of Surgery.

Faculty

The skills course volunteer workforce comprises of 1183 faculty members. Instructors are represented across all disciplines of medicine and surgery, with 139 (12%) teaching on more than one program. Representation of Fellows teaching on skills courses remains at 51% (N=609) with 3% (N=39) SET Trainees, 1% (N=10) International Medical Graduates and the remaining 38% (N=444) made up of emergency physicians, anaesthetists, physicians, intensivists, general practitioners, clinical epidemiologists and educators. The EMST and CCrISP® faculty include instructors local to Fiji and Papua New Guinea where outreach courses are held.

TABLE ST.1 – Skills training course attendance by month and course

Course		JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	Total 2017	Total 2016	% Change 16/17
CCrISP Instructor Course	Courses	0	0	0	0	0	0	1	0	0	1	0	0	**2**	3	-33.3
	Instructors	0	0	0	0	0	0	7	0	0	8	0	0	**15**	21	-28.6
	Participants	0	0	0	0	0	0	15	0	0	13	0	0	**28**	35	-20.0
CCrISP Provider Course	Courses	0	3	3	2	1	2	3	1	4	3	3	1	**26**	28	-7.1
	Instructors	0	35	36	28	13	27	38	11	57	36	35	12	**328**	379	-13.5
	Participants	0	47	43	31	17	32	44	11	56	48	50	18	**397**	433	-8.3
EMST ADF Course	Courses	0	1	0	0	1	0	0	1	0	0	1	0	**4**	4	0.0
	Instructors	0	9	0	0	10	0	0	10	0	0	10	0	**39**	39	0.0
	Participants	0	15	0	0	16	0	0	16	0	0	15	0	**62**	59	5.1
EMST Instructor Course	Courses	0	0	1	0	0	0	0	0	0	0	1	0	**2**	2	0.0
	Instructors	0	0	8	0	0	0	0	0	0	0	8	0	**16**	15	6.7
	Participants	0	0	15	0	0	0	0	0	0	0	14	0	**29**	31	-6.5
EMST Provider Course	Courses	1	4	8	2	6	8	4	2	3	5	7	2	**52**	63	-17.5
	Instructors	9	38	85	21	60	78	38	20	29	48	69	22	**517**	604	-14.4
	Participants	16	64	125	30	94	119	60	29	41	74	110	32	**794**	1017	-21.9
EMST Refresher Course	Courses	0	0	1	1	0	0	1	0	1	1	1	0	**6**	6	0.0
	Instructors	0	0	11	10	0	0	10	0	10	9	9	0	**59**	62	-4.8
	Participants	0	0	14	15	0	0	12	0	15	13	16	0	**85**	93	-8.6
ASSET	Courses	0	2	3	1	4	3	1	4	2	4	0	0	**24**	19	26.3
	Instructors	0	39	54	18	73	60	18	65	25	71	0	0	**423**	378	11.9
	Participants	0	40	60	20	76	57	20	78	36	77	0	0	**464**	370	25.4
CLEAR	Courses	0	1	1	1	1	1	0	1	2	1	1	0	**10**	11	-9.1
	Instructors	0	4	3	3	4	5	0	4	10	7	5	0	**45**	46	-2.2
	Participants	0	32	16	18	15	31	0	17	53	32	9	0	**223**	304	-26.6
TIPS Instructor course	Courses	0	0	0	1	0	0	0	0	0	0	0	0	**1**	0	–
	Instructors	0	0	0	8	0	0	0	0	0	0	0	0	**8**	0	–
	Participants	0	0	0	14	0	0	0	0	0	0	0	0	**14**	0	–
TIPS Provider Course	Courses	0	1	2	1	1	0	1	0	1	2	1	0	**10**	10	0.0
	Instructors	0	10	21	10	11	0	8	0	10	17	9	0	**96**	90	6.7
	Participants	0	12	24	10	10	0	7	0	8	21	12	0	**104**	118	-11.9
OWR Instructor course	Courses	0	0	1	0	0	0	0	0	1	0	0	0	**2**	1	100.0
	Instructors	0	0	7	0	0	0	0	0	5	0	0	0	**12**	7	71.4
	Participants	0	0	10	0	0	0	0	0	9	0	0	0	**19**	10	90.0
OWR Provider Course	Courses	0	1	1	1	2	1	1	1	2	1	3	0	**14**	0	–
	Instructors	0	5	3	7	10	5	6	4	10	5	15	0	**70**	0	–
	Participants	0	18	17	16	52	17	14	20	36	22	44	0	**256**	0	–
Total	**Courses**	**1**	**13**	**21**	**10**	**16**	**15**	**12**	**10**	**16**	**18**	**18**	**3**	**153**	**147**	**4.1**
	Instructors	**9**	**140**	**228**	**105**	**181**	**175**	**125**	**114**	**156**	**201**	**160**	**34**	**1628**	**1641**	**-0.8**
	Participants	**16**	**228**	**324**	**154**	**280**	**256**	**172**	**171**	**254**	**300**	**270**	**50**	**2475**	**2470**	**0.2**

Note: Number of instructors documented in this table is not the number of individual instructors, but the number of times any member of the faculty taught a course.

TABLE ST.2 – Skills training course attendance by location and course

Course		ACT	NSW	NT	QLD	SA	TAS	VIC	WA	AUS Total	NZ	O/S	Total 2017	Total 2016	% Change 16/17
CCrISP Instructor Course	Courses	0	0	0	0	0	0	2	0	2	0	0	2	3	-33.3
	Instructors	0	0	0	0	0	0	15	0	15	0	0	15	21	-28.6
	Participants	0	0	0	0	0	0	28	0	28	0	0	28	35	-20.0
CCrISP Provider Course	Courses	0	6	0	5	3	0	6	1	21	5	0	26	28	-7.1
	Instructors	0	76	0	60	34	0	78	13	261	67	0	328	379	-13.5
	Participants	0	92	0	74	42	0	94	16	318	79	0	397	433	-8.3
EMST ADF Course	Courses	0	4	0	0	0	0	0	0	4	0	0	4	4	0.0
	Instructors	0	39	0	0	0	0	0	0	39	0	0	39	39	0.0
	Participants	0	62	0	0	0	0	0	0	62	0	0	62	59	5.1
EMST Instructor Course	Courses	0	0	0	0	0	0	2	0	2	0	0	2	2	0.0
	Instructors	0	0	0	0	0	0	16	0	16	0	0	16	15	6.7
	Participants	0	0	0	0	0	0	29	0	29	0	0	29	31	-6.5
EMST Provider Course	Courses	1	15	0	10	4	1	4	3	38	9	5	52	63	-17.5
	Instructors	11	148	0	99	39	10	41	30	378	87	52	517	604	-14.4
	Participants	16	230	0	152	59	11	64	42	574	143	77	794	1017	-21.9
EMST Refresher Course	Courses	0	2	0	1	0	0	1	1	5	1	0	6	6	0.0
	Instructors	0	20	0	10	0	0	10	10	50	9	0	59	62	-4.8
	Participants	0	30	0	15	0	0	15	12	72	13	0	85	93	-8.6
ASSET	Courses	0	6	0	4	2	0	6	2	20	4	0	24	19	26.3
	Instructors	0	110	0	70	30	0	113	29	352	71	0	423	378	11.9
	Participants	0	120	0	79	40	0	121	40	400	64	0	464	370	25.4
CLEAR	Courses	0	3	0	1	0	0	3	0	7	3	0	10	11	-9.1
	Instructors	0	14	0	4	0	0	15	0	33	12	0	45	46	-2.2
	Participants	0	94	0	15	0	0	72	0	181	42	0	223	304	-26.6
TIPS Instructor course	Courses	0	0	0	0	0	0	1	0	1	0	0	1	0	–
	Instructors	0	0	0	0	0	0	8	0	8	0	0	8	0	–
	Participants	0	0	0	0	0	0	14	0	14	0	0	14	0	–
TIPS Provider Course	Courses	0	3	0	1	1	0	3	1	9	1	0	10	10	0.0
	Instructors	0	27	0	8	10	0	31	11	87	9	0	96	90	6.7
	Participants	0	29	0	7	10	0	34	12	92	12	0	104	118	-11.9
OWR Instructor course	Courses	0	0	0	1	0	0	1	0	2	0	0	2	1	100.0
	Instructors	0	0	0	5	0	0	7	0	12	0	0	12	7	71.4
	Participants	0	0	0	9	0	0	10	0	19	0	0	19	10	90.0
OWR Provider Course	Courses	1	3	0	2	1	0	4	1	12	2	0	14	0	–
	Instructors	5	16	0	10	5	0	20	4	60	10	0	70	0	–
	Participants	15	41	0	54	19	0	73	20	222	34	0	256	0	–
Total	**Courses**	**2**	**42**	**0**	**25**	**11**	**1**	**33**	**9**	**123**	**25**	**5**	**153**	**147**	**4.1**
	Instructors	**16**	**450**	**0**	**266**	**118**	**10**	**354**	**97**	**1311**	**265**	**52**	**1628**	**1641**	**-0.8**
	Participants	**31**	**698**	**0**	**405**	**170**	**11**	**554**	**142**	**2011**	**387**	**77**	**2475**	**2470**	**0.2**

Note: Number of instructors documented in this table is not the number of individual instructors, but the number of times any member of the faculty taught a course.

TABLE ST.3 – ASSET faculty by location and specialty

	ACT	NSW	NT	QLD	SA	TAS	VIC	WA	AUS Total	NZ	O/S	Total 2017	Total 2016
CAR	0	1	0	3	1	0	3	2	10	2	0	12	12
GEN	1	46	0	24	13	6	47	9	146	28	2	176	164
NEU	0	1	0	4	1	0	0	1	7	0	0	7	7
ORT	1	19	0	11	2	0	16	2	51	23	0	74	74
OTO	0	5	0	4	2	0	0	4	15	7	1	23	20
PAE	0	4	0	0	1	1	1	1	8	4	0	12	11
PLA	1	6	0	6	3	0	9	1	26	4	0	30	26
URO	1	1	0	2	3	0	6	2	15	4	0	19	20
VAS	0	5	0	2	1	2	4	3	17	1	1	19	14
Sub Total	**4**	**88**	**0**	**56**	**27**	**9**	**86**	**25**	**295**	**73**	**4**	**372**	**348**
IMG	0	0	0	0	0	0	1	0	1	3	0	4	2
SET	0	0	0	0	0	0	6	1	7	1	0	8	7
Other	0	1	0	0	0	0	0	1	2	0	0	2	2
OPH	0	1	0	0	0	0	0	0	1	0	0	1	1
Total	**4**	**90**	**0**	**56**	**27**	**9**	**93**	**27**	**306**	**77**	**4**	**387**	**360**

TABLE ST.4 – CCrISP faculty by location and medical discipline

	ACT	NSW	NT	QLD	SA	TAS	VIC	WA	AUS Total	NZ	O/S	Total 2017	Total 2016
Anaesthesia	0	7	0	5	2	0	9	3	26	21	5	52	51
Emergency Medicine	3	1	0	5	4	1	4	2	20	0	0	20	26
General Practice	0	3	0	1	0	0	0	1	5	0	0	5	4
Intensive Care	2	10	0	5	1	2	3	4	27	3	0	30	29
Internal medicine	0	0	0	0	5	0	0	0	5	1	0	6	6
Surgery	1	30	1	33	9	5	33	17	129	41	13	183	175
Other	0	0	0	0	0	0	0	0	0	0	1	1	5
Total	**6**	**51**	**1**	**49**	**21**	**8**	**49**	**27**	**212**	**66**	**19**	**297**	**296**

TABLE ST.5 – EMST faculty by location and medical discipline

	ACT	NSW	NT	QLD	SA	TAS	VIC	WA	AUS Total	NZ	O/S	Total 2017	Total 2016
Anaesthesia	1	30	2	18	2	2	16	6	77	9	3	89	89
Emergency Medicine	6	40	3	17	15	3	25	23	132	25	0	157	167
General Practice	1	7	1	14	5	2	7	4	41	2	0	43	46
Intensive Care	1	7	1	12	6	1	12	1	41	4	1	46	48
Surgery	4	54	3	23	9	3	31	14	141	25	16	182	191
Other	0	2	0	0	1	0	0	0	3	2	0	5	3
Total	**13**	**140**	**10**	**84**	**38**	**11**	**91**	**48**	**435**	**67**	**20**	**522**	**544**

TABLE ST.6 – CCrISP and EMST attendance by location and pass rate

Course		ACT	NSW	NT	QLD	SA	TAS	VIC	WA	AUS	NZ	OS	Total 2017	Total 2016	% Change 16/17
	Attended	3	108	2	70	24	5	80	32	324	100	1	425	468	-9.2
CCrISP	Pass	2	100	2	62	24	5	75	29	299	98	0	397	457	-13.1
	% Pass	67%	93%	100%	89%	100%	100%	94%	91%	92%	98%	0%	93%	98%	-4.3
	Attended	25	262	10	194	70	11	127	62	761	201	8	970	1200	-19.2
EMST	Pass	21	229	8	179	60	11	111	57	676	194	8	878	1084	-19.0
	% Pass	84%	87%	80%	92%	86%	100%	87%	92%	89%	97%	100%	91%	90%	0.2

TABLE ST.7 – CLEAR faculty by location, specialty and medical discipline

	ACT	NSW	NT	QLD	SA	TAS	VIC	WA	AUS Total	NZ	O/S	Total 2017	Total 2016
CAR	0	1	0	0	0	0	1	0	2	1	0	3	3
GEN	0	3	0	1	0	3	0	2	9	2	0	11	7
NEU	0	1	0	0	0	0	0	0	1	0	0	1	2
ORT	0	3	0	1	0	0	0	0	4	2	0	6	5
OTO	0	0	0	0	0	0	0	0	0	0	0	0	0
PAE	0	0	0	0	0	0	0	0	0	1	0	1	1
PLA	0	0	0	0	0	0	1	0	1	0	0	1	1
URO	0	1	0	0	0	0	0	0	1	0	0	1	1
VAS	0	1	0	0	0	0	0	0	1	0	0	1	1
Sub Total	**0**	**10**	**0**	**2**	**0**	**3**	**2**	**2**	**19**	**6**	**0**	**25**	**21**
CLE	0	2	0	2	0	1	0	0	5	1	0	6	6
Total	**0**	**12**	**0**	**4**	**0**	**4**	**2**	**2**	**24**	**7**	**0**	**31**	**27**

TABLE ST.8 – TIPS faculty by location and medical discipline

	ACT	NSW	NT	QLD	SA	TAS	VIC	WA	AUS Total	NZ	O/S	Total 2017	Total 2016
Anaesthesia	0	1	0	0	1	0	0	0	2	0	0	2	2
Emergency Medicine	0	0	0	2	0	0	2	0	4	0	0	4	4
General Practice	0	0	0	0	0	0	0	0	0	0	0	0	0
Intensive Care	0	0	0	0	1	0	0	0	1	0	0	1	0
Physician	0	0	0	0	0	0	0	0	0	0	0	0	1
Surgery	0	9	0	6	8	0	8	1	32	9	0	41	32
Other	0	2	0	2	1	0	4	1	10	1	0	11	7
Total	**0**	**12**	**0**	**10**	**11**	**0**	**14**	**2**	**49**	**10**	**0**	**59**	**46**

TABLE ST.9 – OWR Faculty by region, specialty and medical discipline

	ACT	NSW	NT	QLD	SA	TAS	VIC	WA	AUS Total	NZ	O/S	Total 2017	Total 2016
CAR	0	0	0	0	0	0	0	0	0	1	0	1	0
GEN	0	1	0	3	1	1	3	0	9	2	0	11	0
NEU	0	1	0	1	0	0	1	0	3	0	0	3	0
ORT	0	0	0	0	0	0	1	0	1	1	0	2	0
OTO	0	1	0	1	0	0	0	0	2	0	0	2	0
PAE	0	0	0	1	0	0	0	0	1	2	0	3	0
PLA	0	0	0	0	0	0	0	0	0	0	0	0	0
URO	0	0	0	0	0	0	0	0	0	0	0	0	0
VAS	0	0	0	0	0	0	0	0	0	1	0	1	0
Sub Total	**0**	**3**	**0**	**6**	**1**	**1**	**5**	**0**	**16**	**7**	**0**	**23**	**0**
Intensive Care	1	0	0	0	0	0	0	0	1	0	0	1	0
Total	**1**	**3**	**0**	**6**	**1**	**1**	**5**	**0**	**17**	**7**	**0**	**24**	**0**

EXPLANATORY NOTES – Australia

The processes for assessing the comparability of International Medical Graduates (IMGs) to holders of RACS Fellowship, and for practice as surgeons in Australia are in accordance with the principles outlined in the following publications:

- RACS – Specialist Assessment of International Medical Graduates in Australia policy
  https://www.surgeons.org/policies-publications/policies/international-medical-graduates/
- RACS – IMG Area of Need Assessment policy
  https://www.surgeons.org/policies-publications/policies/international-medical-graduates/
- Australian Medical Council (AMC) – Standards for Assessment and Accreditation of Specialist Medical Education Programs and Professional Development Programs by the AMC 2015 AMC Standards for Assessment
- Medical Board of Australia (MBA) Guidelines – Good practice guidelines for the specialist international medical graduate assessment process http://www.medicalboard.gov.au/Registration/International-Medical-Graduates/Specialist-Pathway.aspx

International Medical Graduates – Period of Clinical Assessment

The process related to the period of clinical assessment for IMGs are in accordance with the principles outlined in the following publications:

- RACS Clinical Assessment of International Medical Graduates in Australia policy;
  https://www.surgeons.org/policies-publications/policies/international-medical-graduates/

and

- MBA Guidelines – Supervised practice for international medical graduates http://www.medicalboard.gov.au/Codes-Guidelines-Policies.aspx

International Medical Graduates Short Term Training in a Medical Specialty Pathway

Short-term training programs in Australia allow IMGs the opportunity to undertake a short-term training program not available in their country of training with the objective of improving their professional skills and experience. Within the surgical specialty, an IMG approved to undertake a short-term training position/program can develop surgical skills and experience through a work based surgical program provided by the hospital.

The process related to the short-term training program for IMGs are in accordance with the principles outlined in the following publications:

- Short Term Training in a Medical Specialty Pathway policy
  https://www.surgeons.org/policies-publications/policies/international-medical-graduates/
- MBA – Short Term Training in a Medical Specialty Pathway
  http://www.medicalboard.gov.au/Registration/International-Medical-Graduates/Short-term-training.aspx

EXPLANATORY NOTES – New Zealand

In New Zealand, RACS acts as an agent of, and provides recommendations to, the Medical Council of New Zealand (MCNZ) on applications by IMGs for vocational registration in one of RACS' nine surgical specialties. The provision of preliminary advice, an interview or a review occurs only in response to a request from the MCNZ.

The MCNZ holds statutory responsibility for approving the standard for registration and requests that RACS advise whether an IMG's training, qualifications and experience are equivalent to, or as satisfactory as, those of a locally trained doctor registered in the same vocational branch of surgery.

A recommendation on the IMG's suitability for the vocational registration pathway is provided to the MCNZ to advise if the IMG is suitable for the pathway. The recommendation includes whether the IMG should be placed under MCNZ approved supervision, or receive College approved assessment to ensure the IMG is at the required standard. The MCNZ considers this and determines the type of medical registration that will be offered to the IMG and any restrictions or conditions that may be placed on that registration. The MCNZ advises RACS and the IMG of its decision.

If the IMG is required to undertake a RACS approved vocational assessment, RACS is asked to approve the post and the supervisor(s) and the supervisor's reports are sent to RACS and to the MCNZ. Once all assessment requirements have been completed by the IMG, RACS recommends to the MCNZ if the IMG should be approved for inclusion on the vocational register in the relevant specialty.

Admission to Fellowship of the Royal Australasian College of Surgeons is a decision of the College alone and it is not part of the vocational registration assessments for the MCNZ. IMGs who have obtained vocational registration in New Zealand may apply to RACS for admission to Fellowship, and the information from the vocational registration process may be considered by RACS in reaching its decision on that application.

Australia

TABLE IMG.1 – Number of International Medical Graduate applications activated by specialty

Assessment result	CAR	GEN	NEU	ORT	OTO	PAE	PLA	URO	VAS	Total 2017
Specialist recognition	3	11	5	12	7	3	5	2	4	52
Area of need	0	2	0	4	0	0	2	1	0	9
Total	**3**	**13**	**5**	**16**	**7**	**3**	**7**	**3**	**4**	**61**

TABLE IMG.2 – International Medical Graduate countries of training

	Qualification		
Country [a]	Primary	Secondary	Total 2017
Argentina	1	1	2
Armenia	1	1	2
Belgium	1	1	2
Brazil	2	2	4
Canada	1	0	1
China	1	0	1
Denmark	1	1	2
Egypt	1	1	2
France	1	1	2
Germany	1	1	2
India	16	13	29
Iran	1	0	1
Ireland	1	1	2
Malaysia	1	0	1
Pakistan	3	2	5
Philippines	1	1	2
Russia	1	1	2
Saudi Arabia	1	1	2
Scotland	1	0	1
Serbia	2	2	4
South Africa	3	1	4
Sri Lanka	1	1	2
South Korea	1	1	2
Turkey	1	1	2
United Kingdom	14	23	37
United States of America	1	3	4
Zimbabwe	1	1	2
Total	**61**	**61**	**122**

[a] The country in which the IMG gained their qualification (primary qualification and specialist qualification).

TABLE IMG.3 – Number of International Medical Graduates not comparable after initial paper based review

	CAR	GEN	NEU	ORT	OTO	PAE	PLA	URO	VAS	Total 2017
No. of IMGs not comparable	0	2	2	1	1	0	2	1	1	10

Note: IMGs are subject to paper-based assessment only. Interview is not required.

TABLE IMG.4 – Number of applications withdrawn by International Medical Graduates

	CAR	GEN	NEU	ORT	OTO	PAE	PLA	URO	VAS	Total 2017
Before initial assessment	0	2	0	2	0	0	0	0	0	4
Between initial and final assessment	0	1	0	2	1	0	0	0	0	4
Total	**0**	**3**	**0**	**4**	**1**	**0**	**0**	**0**	**0**	**8**

Note: Number of IMGs who notify the college that they no longer wish to proceed with their application for specialist assessment

TABLE IMG.5 – Specialist assessment pathway: International Medical Graduate outcome of initial assessment

Outcome following the college's paper-based review and/or interview as documented in Medical Board of Australia Report 1

Assessment result	CAR	GEN	NEU	ORT	OTO	PAE	PLA	URO	VAS	Total 2017
Substantially comparable	0	6	0	0	5	0	0	1	0	12
Partially comparable	1	2	3	8	1	2	4	0	2	23
Not comparable	2	3	3	4	5	1	4	2	1	25
In progress	0	2	0	2	2	0	0	1	1	8
Total	**3**	**13**	**6**	**14**	**13**	**3**	**8**	**4**	**4**	**68**
Application incomplete as at 31/12/2017	0	0	0	0	0	0	0	0	0	0
Applications activated and processed in 2017	3	9	5	10	5	3	5	1	3	44
Total processed	**3**	**9**	**5**	**10**	**5**	**3**	**5**	**1**	**3**	**44**

Note: If IMG's comparability is based on a limited scope of practice this should be noted.

TABLE IMG.6 – Specialist assessment pathway: International Medical Graduate specialists under oversight / supervision

		Clinical assessment – by specialty									
Supervision/oversight period		**CAR**	**GEN**	**NEU**	**ORT**	**OTO**	**PAE**	**PLA**	**URO**	**VAS**	**Total 2017**
Currently under oversight	≤ 12 months	0	2	0	0	3	1	0	0	0	6
	≤ 24 months	0	2	0	0	0	0	0	0	0	2
Currently under supervision	≤ 12 months	0	3	0	2	3	0	0	0	0	8
	≤ 24 months	1	6	3	13	2	0	2	3	0	30
Completed oversight/supervision		1	4	0	7	2	0	2	0	2	18
Total		**2**	**17**	**3**	**22**	**10**	**1**	**4**	**3**	**2**	**64**

		Clinical assessment – by location of residence										
Supervision/oversight period		**ACT**	**NSW**	**NT**	**QLD**	**SA**	**TAS**	**VIC**	**WA**	**AUS Total**	**NZ**	**Total 2017**
Currently under oversight	≤ 12 months	0	2	0	0	0	0	3	0	5	1	6
	≤ 24 months	0	0	0	0	0	0	2	0	2	0	2
Currently under supervision	≤ 12 months	0	0	1	1	2	0	4	0	8	0	8
	≤ 24 months	2	10	0	7	3	0	6	2	30	0	30
Completed oversight/supervision		0	2	1	6	1	0	5	3	18	0	18
Total		**2**	**14**	**2**	**14**	**6**	**0**	**20**	**5**	**63**	**1**	**64**

TABLE IMG.7 – Area of need pathway: International Medical Graduate outcome of initial assessment

Outcome following the college's paper-based review and/or interview as documented in Medical Board of Australia Report 1

Assessment result	**CAR**	**GEN**	**NEU**	**ORT**	**OTO**	**PAE**	**PLA**	**URO**	**VAS**	**Total 2017**
Substantially comparable	0	1	0	1	0	0	0	0	0	2
Partially comparable	0	0	0	2	0	0	2	0	0	4
Not comparable	0	1	0	1	0	0	0	1	0	3
In progress	0	0	0	0	0	0	0	0	0	0
Total	**0**	**2**	**0**	**4**	**0**	**0**	**2**	**1**	**0**	**9**
Application incomplete as at 31/12/2017	0	0	0	0	0	0	0	0	0	0
Applications activated and processed in 2017	0	2	0	4	0	0	2	1	0	9
Total processed	**0**	**2**	**0**	**4**	**0**	**0**	**2**	**1**	**0**	**9**

TABLE IMG.8 – Area of need pathway: International Medical Graduate specialists under oversight / supervisionn

		Clinical assessment – by specialty									
Supervision/oversight period		**CAR**	**GEN**	**NEU**	**ORT**	**OTO**	**PAE**	**PLA**	**URO**	**VAS**	**Total 2017**
Currently under oversight	≤ 12 months	0	0	0	0	0	0	0	0	0	0
	≤ 24 months	0	0	0	2	0	0	0	0	0	2
Currently under supervision	≤ 12 months	0	0	0	0	1	0	0	0	0	1
	≤ 24 months	0	0	0	1	2	0	1	0	0	4
Completed oversight/supervision		0	0	0	2	1	0	1	1	0	5
Total		**0**	**0**	**0**	**5**	**4**	**0**	**2**	**1**	**0**	**12**

		Clinical assessment – by location of residence										
Supervision/oversight period		**ACT**	**NSW**	**NT**	**QLD**	**SA**	**TAS**	**VIC**	**WA**	**AUS Total**	**NZ**	**Total 2017**
Currently under oversight	≤ 12 months	0	0	0	0	0	0	0	0	0	0	0
	≤ 24 months	0	0	0	1	0	0	1	0	2	0	2
Currently under supervision	≤ 12 months	0	1	0	0	0	0	0	0	1	0	1
	≤ 24 months	0	0	1	0	0	2	0	1	4	0	4
Completed oversight/supervision		0	0	0	1	0	2	2	0	5	0	5
Total		**0**	**1**	**1**	**2**	**0**	**4**	**3**	**1**	**12**	**0**	**12**

TABLE IMG.9 – International Medical Graduate outcome of area of need assessment

Outcome following the college's paper-based review as documented in area of need assessment outcome report or Medical Board of Australia (MBA) Report combined report.

	CAR	**GEN**	**NEU**	**ORT**	**OTO**	**PAE**	**PLA**	**URO**	**VAS**	**Total 2017**
Suitable for area of need position	0	1	0	3	0	0	2	0	0	6
Not suitable for area of need position	0	1	0	1	0	0	0	1	0	3
Total	**0**	**2**	**0**	**4**	**0**	**0**	**2**	**1**	**0**	**9**

TABLE IMG.10 – International Medical Graduate outcome of final assessment

Outcome following the college's final assessment (after the IMG has completed all the requirements in MBA report 1) as documented in Medical Board of Australia Report 2.

		CAR	**GEN**	**NEU**	**ORT**	**OTO**	**PAE**	**PLA**	**URO**	**VAS**	**Total 2017**
Recommended for recognition as specialist	Partially comparable	0	4	1	5	0	0	1	2	2	15
	Substantially comparable	1	6	0	0	1	2	0	0	0	10
Not recommended for recognition as specialist	Partially comparable	1	1	0	8	2	0	0	0	0	12
	Substantially comparable	0	2	0	1	0	0	0	0	0	3
Total		**2**	**13**	**1**	**14**	**3**	**2**	**1**	**2**	**2**	**40**

Note: If IMGs comparability is based on a limited scope of practice this should be noted.

TABLE IMG.11 – International Medical Graduate time for specialist recognition initial assessment

	2017
0-3 months	19
4-6 months	22
7-9 months	3
9 months +	0
Total	**44**

Note: As documented in Medical Board of Australia Report 1.

TABLE IMG.12 – International Medical Graduate time for area of need assessment

	2017
0-3 months	3
4-6 months	6
7-9 months	0
9 months +	0
Total	**9**

Note: As documented in Medical Board of Australia Report 1.

TABLE IMG.13 – International Medical Graduate time for specialist recognition final assessment

	2017
0-3 months	0
4-6 months	0
7-12 months	1
13-18 months	11
19-24 months	1
24 months +	12
Total	**25**

Note: Timeframe to complete all requirements as specified in specialist recommendation. Period is noted from date of commencement of clinical assessment. As documented in Medical Board of Australia Report 2.

TABLE IMG.14 – International Medical Graduate – number and outcome of appeal

Total number of appeals		**2017**
Decision being appealed	Outcome of initial assessment	0
	Outcome of final assessment	0
Original decision	Not comparable	0
	Partially comparable	0
RACS decision	Upheld	0
	Overturned	0

TABLE IMG.15 – Short-term specified training: International Medical Graduate specialist applications by specialty

RACS decision	CAR	GEN	NEU	ORT	OTO	PAE	PLA	URO	VAS	Total 2017
Approved	30	26	14	92	18	5	22	14	8	229
Denied	1	1	1	1	0	0	0	0	0	4
Pending	0	3	0	7	0	0	1	1	0	12
Total	**31**	**30**	**15**	**100**	**18**	**5**	**23**	**15**	**8**	**245**

TABLE IMG.16 – Short-term specified training: International Medical Graduate specialist applications by location

RACS decision	ACT	NSW	NT	QLD	SA	TAS	VIC	WA	AUS Total	NZ	Total 2017
Approved	1	91	4	35	27	2	48	21	229	0	229
Denied	0	2	1	0	0	0	1	0	4	0	4
Pending	0	8	0	1	0	0	2	1	12	0	12
Total	**1**	**101**	**5**	**36**	**27**	**2**	**51**	**22**	**245**	**0**	**245**

TABLE IMG.17 – Number of International Medical Graduate specialists practising in Australia

	Total 2017
Total number of IMGs practicing in Australia with valid assessment	76

Note: IMGs undergoing clinical assessment or IMGs who have completed clinical assessment and are required to complete the College's Fellowship Examination and/or other requirements as stipulated in their specialist recommendation following a document based assessment and interview.

New Zealand

TABLE IMG.18 – Applications for International Medical Graduate specialists

Preliminary advice to the MCNZ following documentation review	CAR	GEN	NEU	ORT	OTO	PAE	PLA	URO	VAS	Total 2017
Likely to be suitable for vocational pathway	1	1	0	3	3	0	1	1	0	10
Unlikely to be suitable for vocational pathway	0	2	0	2	2	1	0	0	0	7
Unable to determine suitability by documentation only	0	1	0	4	1	0	2	0	1	9
Preliminary advise requests not yet completed	0	1	0	0	0	0	0	0	0	1
Total	**1**	**5**	**0**	**9**	**6**	**1**	**3**	**1**	**1**	**27**

TABLE IMG.19 – Interview outcomes for International Medical Graduate specialists applicants

Advice to MCNZ following interview	CAR	GEN	NEU	ORT	OTO	PAE	PLA	URO	VAS	Total 2017
Vocational pathway – supervision (MCNZ approved)	0	5	0	1	2	2	0	1	1	12
Vocational pathway – supervised assessment (College approved)	0	0	1	3	1	1	1	0	0	7
Not suitable for vocational pathway	0	2	0	0	2	1	2	0	2	9
Total	**0**	**7**	**1**	**4**	**5**	**4**	**3**	**1**	**3**	**28**

Applications yet to achieve interview completion	CAR	GEN	NEU	ORT	OTO	PAE	PLA	URO	VAS	Total 2017
Applicants awaiting interviews at end of December 2017	0	0	0	0	0	0	0	0	0	0
Interview process incomplete at end of December 2017	1	0	1	2	1	0	0	0	0	5
Application(s) withdrawn prior to interview 2017	0	0	0	0	0	0	0	0	0	0
Total	**1**	**0**	**1**	**2**	**1**	**0**	**0**	**0**	**0**	**5**

TABLE IMG.20 – International Medical Graduate specialists participating in vocational assessment

IMGs under College approved vocational assessment in 2017	CAR	GEN	NEU	ORT	OTO	PAE	PLA	URO	VAS	Total 2017
For full scope registration	0	3	0	5	0	0	0	0	0	8
For restricted scope registration	0	0	0	0	0	0	0	0	0	0
Total	**0**	**3**	**0**	**5**	**0**	**0**	**0**	**0**	**0**	**8**

College approved vocational assessments completed in 2017	CAR	GEN	NEU	ORT	OTO	PAE	PLA	URO	VAS	Total 2017
To satisfactory standard	1	0	0	0	1	0	0	0	0	2
Not to satisfactory standard	0	0	0	0	0	0	1	0	0	1
Withdrawn from program	0	0	0	1	0	0	0	0	0	1
Total	**1**	**0**	**0**	**1**	**1**	**0**	**1**	**0**	**0**	**4**

TABLE IMG.21 – RACS review of recommendations for International Medical Graduate specialist applicants at the request of the Medical Council of New Zealand

RACS recommendation after review	CAR	GEN	NEU	ORT	OTO	PAE	PLA	URO	VAS	Total 2017
Recommendation altered	0	0	0	0	0	0	0	0	0	0
Recommendation not altered	0	0	0	1	2	0	0	0	0	3
In progress	0	0	0	1	0	0	0	0	0	1
Total	**0**	**0**	**0**	**2**	**2**	**0**	**0**	**0**	**0**	**4**

MCNZ decision of RACS review	CAR	GEN	NEU	ORT	OTO	PAE	PLA	URO	VAS	Total 2017
RACS review accepted by MCNZ	0	0	0	1	1	0	0	0	0	2
RACS review not accepted by MCNZ	0	0	0	0	1	0	0	0	0	1
In progress	0	0	0	1	0	0	0	0	0	1
Total	**0**	**0**	**0**	**2**	**2**	**0**	**0**	**0**	**0**	**4**

EXPLANATORY NOTES

The College is accredited to conduct surgical training in nine specialties. The following specialties conduct bi-national training programs:

- Cardiothoracic Surgery
- Neurosurgery
- Paediatric Surgery
- Urology Surgery; and
- Vascular Surgery.

Separate programs are conducted in Australia and New Zealand for the following specialties:

- General Surgery
- Orthopaedic Surgery
- Otolaryngology – Head and Neck Surgery; and
- Plastic and Reconstructive Surgery.

The number of appointments made in any year is dependent on the number of Trainees finishing the program and the consequent number of vacant accredited posts. The College does not control the number of posts available but accredits posts nominated by jurisdictions. RACS has committed to accrediting any training post that meets the accreditation standards.

Since the introduction of the SET program in 2008 individual specialties have diverged from a common categorisation of Trainee SET level. Consequently this report is based on 'years in training' and doesn't reflect individual Trainees' progress towards Fellowship.

The Australian Orthopaedic Association has not notified RACS of the regional or person type breakdown of applications received for the orthopaedic program in Australia. The totals listed in tables SET.1 to SET.4 have been included as Australian applicants only with no regional breakdown and included as Non IMG/Trainees. Also, it is unclear whether applicants to the orthopaedic program in Australia made applications to other specialties (table SET.3).

Active Trainees who started training, finished training or admitted to Fellowship in the middle of the year are counted as an active Trainee in all tables.

DATA SUMMARY

SET applications increased in 2017 by almost 6%, and Cardiothoracic Surgery had the largest increase in applications compared to 2016 (64%). The number of individual female SET applicants increased by 10%, and comprised almost one-third of all individual applicants (Table SET.3). There were 255 applicants who were offered a Trainee position in 2017. Just over 30% of successful applicants were female, a 6% increase from 2016 (Table SET.5).

TABLE SET.1 – SET applications by specialty and applicant type[a]

		SET	IMG	NON IMG/ Trainee[b]	Fellow	Total 2017	Total 2016	% Change 16/17
	Male	2	0	30	1	33	19	73.7
CAR	Female	2	0	11	0	13	9	44.4
	Total	**4**	**0**	**41**	**1**	**46**	**28**	**64.3**
	Male	0	0	180	0	180	163	10.4
GEN	Female	0	0	97	0	97	88	10.2
	Total	**0**	**0**	**277**	**0**	**277**	**251**	**10.4**
	Male	0	0	34	0	34	39	-12.8
NEU	Female	1	0	14	0	15	16	-6.3
	Total	**1**	**0**	**48**	**0**	**49**	**55**	**-10.9**
	Male	0	0	191	0	191	158	20.9
ORT[c]	Female	0	0	34	0	34	23	47.8
	Total	**0**	**0**	**225**	**0**	**225**	**181**	**24.3**
	Male	4	0	53	0	57	62	-8.1
OTO	Female	1	0	22	0	23	36	-36.1
	Total	**5**	**0**	**75**	**0**	**80**	**98**	**-18.4**
	Male	1	0	9	0	10	11	-9.1
PAE	Female	1	0	13	0	14	5	180.0
	Total	**2**	**0**	**22**	**0**	**24**	**16**	**50.0**
	Male	3	0	44	0	47	58	-19.0
PLA	Female	0	0	31	0	31	35	-11.4
	Total	**3**	**0**	**75**	**0**	**78**	**93**	**-16.1**
	Male	5	0	44	0	49	60	-18.3
URO	Female	1	0	12	0	13	18	-27.8
	Total	**6**	**0**	**56**	**0**	**62**	**78**	**-20.5**
	Male	5	0	26	0	31	31	0.0
VAS	Female	1	0	16	0	17	11	54.5
	Total	**6**	**0**	**42**	**0**	**48**	**42**	**14.3**
	Male	**20**	**0**	**611**	**1**	**632**	**601**	**5.2**
Total	**Female**	**7**	**0**	**250**	**0**	**257**	**241**	**6.6**
	Total	**27**	**0**	**861**	**1**	**889**	**842**	**5.6**

[a] Total number of SET applications may include more than one application from an individual.

[b] Non-IMG/Trainee refers to applications from those not currently Fellows, Trainees or IMGs.

TABLE SET.2 – SET applications by specialty and location of residence[a]

		ACT	NSW	NT	QLD	SA	TAS	VIC	WA	AUS Total	NZ	O/S	Total 2017	Total 2016	% Change 16/17
	Male	0	12	0	5	2	0	8	1	28	5	0	33	19	73.7
CAR	Female	0	6	0	2	0	0	4	0	12	1	0	13	9	44.4
	Total	**0**	**18**	**0**	**7**	**2**	**0**	**12**	**1**	**40**	**6**	**0**	**46**	**28**	**64.3**
	Male	5	51	3	44	10	0	37	14	164	15	1	180	163	10.4
GEN	Female	5	24	0	16	5	0	23	11	84	13	0	97	88	10.2
	Total	**10**	**75**	**3**	**60**	**15**	**0**	**60**	**25**	**248**	**28**	**1**	**277**	**251**	**10.4**
	Male	1	11	0	5	1	1	7	3	29	4	1	34	39	-12.8
NEU	Female	0	2	0	5	2	0	4	0	13	2	0	15	16	-6.3
	Total	**1**	**13**	**0**	**10**	**3**	**1**	**11**	**3**	**42**	**6**	**1**	**49**	**55**	**-10.9**
	Male	1	58	1	55	8	1	35	12	171	20	0	191	158	20.9
ORT[b]	Female	1	10	0	7	4	0	7	0	29	5	0	34	23	47.8
	Total	**2**	**68**	**1**	**62**	**12**	**1**	**42**	**12**	**200**	**25**	**0**	**225**	**181**	**24.3**
	Male	1	16	0	10	6	0	16	3	52	5	0	57	62	-8.1
OTO	Female	0	3	0	6	1	0	5	1	16	7	0	23	36	-36.1
	Total	**1**	**19**	**0**	**16**	**7**	**0**	**21**	**4**	**68**	**12**	**0**	**80**	**98**	**-18.4**
	Male	1	3	0	2	1	0	1	1	9	1	0	10	11	-9.1
PAE	Female	0	3	0	4	0	1	2	0	10	4	0	14	5	180.0
	Total	**1**	**6**	**0**	**6**	**1**	**1**	**3**	**1**	**19**	**5**	**0**	**24**	**16**	**50.0**
	Male	2	12	0	7	4	0	12	3	40	7	0	47	58	-19.0
PLA	Female	2	4	0	3	2	0	8	2	21	10	0	31	35	-11.4
	Total	**4**	**16**	**0**	**10**	**6**	**0**	**20**	**5**	**61**	**17**	**0**	**78**	**93**	**-16.1**
	Male	2	12	2	8	1	0	17	4	46	3	0	49	60	-18.3
URO	Female	0	1	0	6	1	0	4	0	12	1	0	13	18	-27.8
	Total	**2**	**13**	**2**	**14**	**2**	**0**	**21**	**4**	**58**	**4**	**0**	**62**	**78**	**-20.5**
	Male	1	8	0	5	3	0	7	2	26	5	0	31	31	0.0
VAS	Female	1	4	0	2	0	0	4	3	14	3	0	17	11	54.5
	Total	**2**	**12**	**0**	**7**	**3**	**0**	**11**	**5**	**40**	**8**	**0**	**48**	**42**	**14.3**
	Male	**13**	**125**	**5**	**86**	**28**	**1**	**105**	**31**	**565**	**65**	**2**	**632**	**601**	**5.2**
Total	**Female**	**8**	**47**	**0**	**44**	**11**	**1**	**54**	**17**	**211**	**46**	**0**	**257**	**241**	**6.6**
	Total	**21**	**172**	**5**	**130**	**39**	**2**	**159**	**48**	**776**	**111**	**2**	**889**	**842**	**5.6**

[a] Total number of SET applications may include more than one application from an individual.

TABLE SET.3 – Individual SET applicants by number of applications and applicant type[a]

No. of applications		SET	SET Deferred	IMG	NON IMG/ Trainee	Fellow	Total 2017	Total 2016	% Change 16/17
	Male	18	0	0	368	1	387	396	-2.3
1	Female	7	0	0	187	0	194	169	14.8
	Total	**25**	**0**	**0**	**555**	**1**	**581**	**565**	**2.8**
	Male	1	0	0	48	0	49	51	-3.9
2	Female	0	0	0	21	0	21	22	-4.5
	Total	**1**	**0**	**0**	**69**	**0**	**70**	**73**	**-4.1**
	Male	0	0	0	4	0	4	2	100.0
3	Female	0	0	0	0	0	0	4	-100.0
	Total	**0**	**0**	**0**	**4**	**0**	**4**	**6**	**-33.3**
	Male	0	0	0	0	0	0	0	–
≥4	Female	0	0	0	0	0	0	0	–
	Total	**0**	**0**	**0**	**0**	**0**	**0**	**0**	–
	Male	**19**	**0**	**0**	**420**	**1**	**440**	**449**	**-2.0**
Total	**Female**	**7**	**0**	**0**	**208**	**0**	**215**	**195**	**10.3**
	Total	**26**	**0**	**0**	**628**	**1**	**655**	**644**	**1.7**

[a] The total number of applicants to the Australian Orthopaedic SET program are included as single (1) applications only; it is unknown if these applicants also applied to other SET programs, therefore some applicants may be recorded more than once.

TABLE SET.4 – SET applications outcome by specialty and applicant type

	Offers[a]		Unsuccessful		Waiting List		Withdrawn		Ineligible		Declined		
Specialty	**No.**	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**	**Total 2017[b]**
CAR	8	17.4	38	82.6	0	0.0	0	0.0	0	0.0	0	0.0	46
GEN	105	37.9	165	59.6	0	0.0	0	0.0	0	0.0	7	2.5	277
NEU	8	16.3	41	83.7	0	0.0	0	0.0	0	0.0	0	0.0	49
ORT	56	24.8	170	75.2	0	0.0	0	0.0	0	0.0	0	0.0	226
OTO	25	31.3	55	68.8	0	0.0	0	0.0	0	0.0	0	0.0	80
PAE	4	16.7	19	79.2	0	0.0	0	0.0	0	0.0	1	4.2	24
PLA	20	25.6	58	74.4	0	0.0	0	0.0	0	0.0	0	0.0	78
URO	22	35.5	40	64.5	0	0.0	0	0.0	0	0.0	0	0.0	62
VAS	8	16.7	39	81.3	0	0.0	1	2.1	0	0.0	0	0.0	48
Total	**256**	**28.8**	**625**	**70.2**	**0**	**0.0**	**1**	**0.1**	**0**	**0.0**	**8**	**0.9**	**890**
Applicant type													
SET	9	33.3	12	44.4	0	0.0	0	0.0	0	0.0	6	22.2	27
Fellow	0	–	0	–	0	–		–	0	–	0	–	0
Non IMGTrainee	247	28.6	613	71.0	0	0.0	1	0.1	0	0.0	2	0.2	863
Total[b]	**256**	**28.8**	**625**	**70.2**	**0**	**0.0**	**1**	**0.1**	**0**	**0.0**	**8**	**0.9**	**890**

[a] Includes deferred applications

[b] Totals do not include declined applications as they were subsequently offered to other applicants and reflected in the Offers column.

TABLE SET.5 – Successful SET application by specialty and location of residence

		ACT	NSW	NT	QLD	SA	TAS	VIC	WA	AUS Total	NZ	O/S	Total 2017	Total 2016
	Male	0	3	0	0	0	0	1	0	4	1	0	5	5
CAR	Female	0	2	0	0	0	0	1	0	3	0	0	3	1
	Total	**0**	**5**	**0**	**0**	**0**	**0**	**2**	**0**	**7**	**1**	**0**	**8**	**6**
	Male	2	19	2	14	2	0	17	4	60	7	1	68	73
GEN	Female	1	8	0	8	2	0	8	2	29	8	0	37	33
	Total	**3**	**27**	**2**	**22**	**4**	**0**	**25**	**6**	**89**	**15**	**1**	**105**	**106**
	Male	0	0	0	1	0	0	1	1	3	0	0	3	11
NEU	Female	0	0	0	2	1	0	2	0	5	0	0	5	0
	Total	**0**	**0**	**0**	**3**	**1**	**0**	**3**	**1**	**8**	**0**	**0**	**8**	**11**
	Male	0	12	0	11	1	0	13	1	38	8	0	46	52
ORT	Female	0	3	0	0	2	0	3	0	8	2	0	10	3
	Total	**0**	**15**	**0**	**11**	**3**	**0**	**16**	**1**	**46**	**10**	**0**	**56**	**55**
	Male	0	6	0	5	4	0	1	1	17	2	0	19	11
OTO	Female	0	1	0	1	0	0	2	0	4	2	0	6	6
	Total	**0**	**7**	**0**	**6**	**4**	**0**	**3**	**1**	**21**	**4**	**0**	**25**	**17**
	Male	1	0	0	0	0	0	0	0	1	0	0	1	4
PAE	Female	0	2	0	1	0	0	0	0	3	0	0	3	3
	Total	**1**	**2**	**0**	**1**	**0**	**0**	**0**	**0**	**4**	**0**	**0**	**4**	**7**
	Male	0	3	0	3	3	0	1	2	12	1	0	13	15
PLA	Female	0	2	0	0	0	0	1	2	5	2	0	7	9
	Total	**0**	**5**	**0**	**3**	**3**	**0**	**2**	**4**	**17**	**3**	**0**	**20**	**24**
	Male	1	3	1	4	0	0	8	0	17	2	0	19	11
URO	Female	0	1	0	1	0	0	1	0	3	0	0	3	5
	Total	**1**	**4**	**1**	**5**	**0**	**0**	**9**	**0**	**20**	**2**	**0**	**22**	**16**
	Male	0	0	0	0	2	0	0	1	3	1	0	4	8
VAS	Female	0	1	0	1	0	0	1	0	3	1	0	4	2
	Total	**0**	**1**	**0**	**1**	**2**	**0**	**1**	**1**	**6**	**2**	**0**	**8**	**10**
	Male	**4**	**46**	**3**	**38**	**12**	**0**	**42**	**10**	**155**	**22**	**1**	**178**	**190**
Total	**Female**	**1**	**20**	**0**	**14**	**5**	**0**	**19**	**4**	**63**	**15**	**0**	**78**	**62**
	Total	**5**	**66**	**3**	**52**	**17**	**0**	**61**	**14**	**218**	**37**	**1**	**256**	**252**

TABLE SET.6 – Active SET Trainees by status and training location[a]

Trainee status		ACT	NSW	NT	QLD	SA	TAS	VIC	WA	AUS Total	NZ	O/S	Total 2017	Total 2016	% Change 16/17
	Male	11	252	7	127	51	13	180	67	708	126	1	835	800	4.4
Clinical	Female	6	87	3	46	19	6	73	19	259	41	0	300	309	-2.9
	Total	**17**	**339**	**10**	**173**	**70**	**19**	**253**	**86**	**967**	**167**	**1**	**1135**	**1109**	**2.3**
	Male	0	0	0	0	0	0	0	0	0	0	0	0	1	-100.0
Accredited Research	Female	0	0	0	0	0	0	0	1	1	0	0	1	0	–
	Total	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**1**	**1**	**0**	**0**	**1**	**1**	**0.0**
	Male	0	0	0	0	0	0	0	0	0	0	0	0	1	-100.0
Part Time	Female	0	0	0	4	1	0	0	0	5	0	0	5	3	66.7
	Total	**0**	**0**	**0**	**4**	**1**	**0**	**0**	**0**	**5**	**0**	**0**	**5**	**4**	**25.0**
	Male	0	1	0	1	0	0	4	0	6	0	0	6	12	-50.0
Probationary	Female	0	3	0	2	1	0	2	0	8	2	0	10	6	66.7
	Total	**0**	**4**	**0**	**3**	**1**	**0**	**6**	**0**	**14**	**2**	**0**	**16**	**18**	**-11.1**
	Male	0	3	0	0	2	0	2	1	8	3	0	11	23	-52.2
Exam Pending	Female	0	3	0	0	0	0	0	0	3	0	0	3	8	-62.5
	Total	**0**	**6**	**0**	**0**	**2**	**0**	**2**	**1**	**11**	**3**	**0**	**14**	**31**	**-54.8**
	Male	**11**	**256**	**7**	**128**	**53**	**13**	**186**	**68**	**722**	**129**	**1**	**852**	**837**	**1.8**
Total	**Female**	**6**	**93**	**3**	**52**	**21**	**6**	**75**	**20**	**276**	**43**	**0**	**319**	**326**	**-2.1**
	Total	**17**	**349**	**10**	**180**	**74**	**19**	**261**	**88**	**998**	**172**	**1**	**1171**	**1163**	**0.7**

[a] Total data cannot be verified as Australian Orthopaedic Association do not routinely report individual Australian Orthopaedic trainee data to RACS.

TABLE SET.7 – Inactive SET Trainees by status and training location[a]

Trainee status		ACT	NSW	NT	QLD	SA	TAS	VIC	WA	AUS Total	NZ	O/S	Total 2017	Total 2016	% Change 16/17
Approved interruption to training	Male	1	4	1	3	5	0	4	1	19	7	0	26	25	4.0
	Female	1	14	0	4	0	2	4	1	26	11	0	37	32	15.6
	Total	**2**	**18**	**1**	**7**	**5**	**2**	**8**	**2**	**45**	**18**	**0**	**63**	**57**	**10.5**
	Male	0	2	0	1	1	1	1	0	6	2	0	8	13	-38.5
Deferred	Female	0	1	0	1	1	0	0	0	3	1	0	4	2	100.0
	Total	**0**	**3**	**0**	**2**	**2**	**1**	**1**	**0**	**9**	**3**	**0**	**12**	**15**	**-20.0**
	Male	0	0	0	0	0	0	0	0	0	0	0	0	0	–
Suspended	Female	0	0	0	0	0	0	0	0	0	1	0	1	0	–
	Total	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**1**	**0**	**1**	**0**	**–**
	Male	**1**	**6**	**1**	**4**	**6**	**1**	**5**	**1**	**25**	**9**	**0**	**34**	**38**	**-10.5**
Total	**Female**	**1**	**15**	**0**	**5**	**1**	**2**	**4**	**1**	**29**	**13**	**0**	**42**	**34**	**23.5**
	Total	**2**	**21**	**1**	**9**	**7**	**3**	**9**	**2**	**54**	**22**	**0**	**76**	**72**	**5.6**

[a] Total data cannot be verified as Australian Orthopaedic Association do not routinely report individual Australian Orthopaedic trainee data to RACS.

TABLE SET.8 – Active SET Trainees by status and specialty[a]

Trainee status		CAR	GEN	NEU	ORT	OTO	PAE	PLA	URO	VAS	Total 2017	Total 2016	% Change 16/17
Clinical	Male	31	277	35	247	56	14	65	75	35	835	800	4.4
	Female	6	148	11	33	25	17	26	23	11	300	309	-2.9
	Total	**37**	**425**	**46**	**280**	**81**	**31**	**91**	**98**	**46**	**1135**	**1109**	**2.3**
Accredited Research	Male	0	0	0	0	0	0	0	0	0	0	1	-100.0
	Female	1	0	0	0	0	0	0	0	0	1	0	–
	Total	**1**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**1**	**1**	**0.0**
Part Time	Male	0	0	0	0	0	0	0	0	0	0	1	-100.0
	Female	0	5	0	0	0	0	0	0	0	5	3	66.7
	Total	**0**	**5**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**5**	**4**	**25.0**
Probationary	Male	0	0	1	0	2	0	1	2	0	6	12	-50.0
	Female	1	0	1	0	2	0	4	2	0	10	6	66.7
	Total	**1**	**0**	**2**	**0**	**4**	**0**	**5**	**4**	**0**	**16**	**18**	**-11.1**
Exam Pending	Male	2	2	0	3	0	0	3	0	1	11	23	-52.2
	Female	0	2	0	0	1	0	0	0	0	3	8	-62.5
	Total	**2**	**4**	**0**	**3**	**1**	**0**	**3**	**0**	**1**	**14**	**31**	**-54.8**
Total	**Male**	**33**	**279**	**36**	**250**	**58**	**14**	**69**	**77**	**36**	**852**	**837**	**1.8**
	Female	**8**	**155**	**12**	**33**	**28**	**17**	**30**	**25**	**11**	**319**	**326**	**-2.1**
	Total	**41**	**434**	**48**	**283**	**86**	**31**	**99**	**102**	**47**	**1171**	**1163**	**0.7**

[a] Total data cannot be verified as Australian Orthopaedic Association do not routinely report individual Australian Orthopaedic trainee data to RACS.

TABLE SET.9 – Inactive SET Trainees by status and specialty[a]

Trainee status		CAR	GEN	NEU	ORT	OTO	PAE	PLA	URO	VAS	Total 2017	Total 2016	% Change 16/17
Approved Interruption to training	Male	0	15	4	0	2	2	1	1	1	26	25	4.0
	Female	0	22	1	1	3	3	5	2	0	37	32	15.6
	Total	**0**	**37**	**5**	**1**	**5**	**5**	**6**	**3**	**1**	**63**	**57**	**10.5**
Deferred	Male	0	4	0	0	1	0	1	1	1	8	13	-38.5
	Female	0	0	0	0	1	0	2	1	0	4	2	100.0
	Total	**0**	**4**	**0**	**0**	**2**	**0**	**3**	**2**	**1**	**12**	**15**	**-20.0**
Suspended	Male	0	0	0	0	0	0	0	0	0	0	0	–
	Female	0	0	0	0	0	0	1	0	0	1	0	–
	Total	**0**	**0**	**0**	**0**	**0**	**0**	**1**	**0**	**0**	**1**	**0**	–
Total	**Male**	**0**	**19**	**4**	**0**	**3**	**2**	**2**	**2**	**2**	**34**	**38**	**-10.5**
	Female	**0**	**22**	**1**	**1**	**4**	**3**	**8**	**3**	**0**	**42**	**34**	23.5
	Total	**0**	**41**	**5**	**1**	**7**	**5**	**10**	**5**	**2**	**76**	**72**	**5.6**

[a] Total data cannot be verified as Australian Orthopaedic Association do not routinely report individual Australian Orthopaedic trainee data to RACS.

TABLE SET.10 – SET Trainees that exited the SET program, by specialty[a]

	Terminated from SET		Withdrawn from SET		Other		Total	
Specialty	**Male**	**Female**	**Male**	**Female**	**Male**	**Female**	**Male**	**Female**
CAR	0	1	0	0	0	0	0	1
GEN	3	0	4	4	0	0	7	4
NEU	0	0	0	0	0	0	0	0
ORT	3	0	0	1	0	0	3	1
OTO	1	0	1	2	1	0	3	2
PAE	0	0	0	0	0	0	0	0
PLA	0	1	0	0	0	0	0	1
URO	0	0	1	0	1	0	2	0
VAS	0	0	0	0	0	0	0	0
Total	**7**	**2**	**6**	**7**	**2**	**0**	**15**	**9**

[a] Trainees that exited SET have not been counted as active trainees in table SET.6 & 8.

TABLE SET.11 – SET Trainees that exited the SET program, by year of training[a]

	Terminated from SET		Withdrawn from SET		Other		Total	
Year	**Male**	**Female**	**Male**	**Female**	**Male**	**Female**	**Male**	**Female**
Year 1	0	0	2	3	0	0	2	3
Year 2	0	1	1	3	0	0	1	4
Year 3	3	1	0	0	1	0	4	1
Year 4	1	0	1	0	0	0	2	0
Year 5	2	0	1	0	0	0	3	0
Year 6+	1	0	1	1	1	0	3	1
Total	**7**	**2**	**6**	**7**	**2**	**0**	**15**	**9**

[a] Trainees that exited SET have not been counted as active trainees in table SET.6 & 8.

TABLE SET.12 – SET Trainees that exited the SET program, by region[a]

	Terminated from SET		Withdrawn from SET		Other		Total	
Region	**Male**	**Female**	**Male**	**Female**	**Male**	**Female**	**Male**	**Female**
ACT	0	0	0	0	0	0	0	0
NSW	4	1	1	2	1	0	6	3
NT	0	0	0	0	0	0	0	0
QLD	1	0	1	0	0	0	2	0
SA	1	0	0	0	0	0	1	0
TAS	0	0	0	0	0	0	0	0
VIC	1	1	2	1	0	0	3	2
WA	0	0	0	2	1	0	1	2
AUS	**7**	**2**	**4**	**5**	**2**	**0**	**13**	**7**
NZ	0	0	2	2	0	0	2	2
O/S	0	0	0	0	0	0	0	0
Total	**7**	**2**	**6**	**7**	**2**	**0**	**15**	**9**

[a] Trainees that exited SET have not been counted as active trainees in table SET.6 & 8.

TABLE SET.13 – Active SET Trainees by age and location of training post[a,b]

Age group		ACT	NSW	NT	QLD	SA	TAS	VIC	WA	AUS Total	NZ	O/S	Total 2017
	Male	6	124	6	63	34	7	105	30	375	79	1	455
<35	Female	3	44	2	21	8	4	41	18	141	27	0	168
	Total	**9**	**168**	**8**	**84**	**42**	**11**	**146**	**48**	**516**	**106**	**1**	**623**
	Male	5	95	1	49	14	5	61	26	256	37	0	293
35 – 39	Female	3	36	1	26	10	2	28	1	107	15	0	122
	Total	**8**	**131**	**2**	**75**	**24**	**7**	**89**	**27**	**363**	**52**	**0**	**415**
	Male	0	30	0	14	3	1	17	11	76	10	0	86
40 – 44	Female	0	9	0	5	3	0	5	1	23	1	0	24
	Total	**0**	**39**	**0**	**19**	**6**	**1**	**22**	**12**	**99**	**11**	**0**	**110**
	Male	0	5	0	2	1	0	2	1	11	2	0	13
45 – 49	Female	0	4	0	0	0	0	1	0	5	0	0	5
	Total	**0**	**9**	**0**	**2**	**1**	**0**	**3**	**1**	**16**	**2**	**0**	**18**
	Male	0	2	0	0	1	0	1	0	4	1	0	5
50 – 54	Female	0	0	0	0	0	0	0	0	0	0	0	0
	Total	**0**	**2**	**0**	**0**	**1**	**0**	**1**	**0**	**4**	**1**	**0**	**5**
	Male	0	0	0	0	0	0	0	0	0	0	0	0
55+	Female	0	0	0	0	0	0	0	0	0	0	0	0
	Total	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
	Male	**11**	**256**	**7**	**128**	**53**	**13**	**186**	**68**	**722**	**129**	**1**	**852**
Total	**Female**	**6**	**93**	**3**	**52**	**21**	**6**	**75**	**20**	**276**	**43**	**0**	**319**
	Total	**17**	**349**	**10**	**180**	**74**	**19**	**261**	**88**	**998**	**172**	**1**	**1171**

[a] Total data cannot be verified as Australian Orthopaedic Association do not routinely report individual Australian Orthopaedic trainee data to RACS.
Includes Trainees who started training /finished training/admitted to Fellowship in the middle of the year.

TABLE SET.14 – Active SET Trainees by age and specialty[a,b]

Age group		CAR	GEN	NEU	ORT	OTO	PAE	PLA	URO	VAS	Total 2017
	Male	22	145	24	127	29	10	29	46	23	455
<35	Female	5	75	6	21	13	9	16	16	7	168
	Total	**27**	**220**	**30**	**148**	**42**	**19**	**45**	**62**	**30**	**623**
	Male	6	95	10	91	26	3	28	24	10	293
35 – 39	Female	3	64	5	9	11	6	12	9	3	122
	Total	**9**	**159**	**15**	**100**	**37**	**9**	**40**	**33**	**13**	**415**
	Male	2	33	2	29	2	1	11	5	1	86
40 – 44	Female	0	12	1	3	4	1	2	0	1	24
	Total	**2**	**45**	**3**	**32**	**6**	**2**	**13**	**5**	**2**	**110**
	Male	1	4	0	3	1	0	1	2	1	13
45 – 49	Female	0	4	0	0	0	1	0	0	0	5
	Total	**1**	**8**	**0**	**3**	**1**	**1**	**1**	**2**	**1**	**18**
	Male	2	2	0	0	0	0	0	0	1	5
50 – 54	Female	0	0	0	0	0	0	0	0	0	0
	Total	**2**	**2**	**0**	**0**	**0**	**0**	**0**	**0**	**1**	**5**
	Male	0	0	0	0	0	0	0	0	0	0
55+	Female	0	0	0	0	0	0	0	0	0	0
	Total	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
	Male	**33**	**279**	**36**	**250**	**58**	**14**	**69**	**77**	**36**	**852**
Total	**Female**	**8**	**155**	**12**	**33**	**28**	**17**	**30**	**25**	**11**	**319**
	Total	**41**	**434**	**48**	**283**	**86**	**31**	**99**	**102**	**47**	**1171**

[a] Total data cannot be verified as Australian Orthopaedic Association do not routinely report individual Australian Orthopaedic trainee data to RACS.
[b] Includes Trainees who started training /finished training/admitted to Fellowship in the middle of the year.

TABLE SET.15 – Active SET Trainees by years in training and training post location[a,b]

		ACT	NSW	NT	QLD	SA	TAS	VIC	WA	AUS Total	NZ	O/S	Total 2017	Total 2016	% Change 16/17
	Male	4	57	3	29	17	4	32	13	159	36	0	195	159	
1 Year	Female	1	13	1	11	3	1	10	7	47	8	0	55	68	
	Total	**5**	**70**	**4**	**40**	**20**	**5**	**42**	**20**	**206**	**44**	**0**	**250**	**227**	**10.1**
	Male	2	41	2	24	11	3	36	13	132	22	0	154	141	
2 Years	Female	2	20	1	4	3	3	18	3	54	16	0	70	48	
	Total	**4**	**61**	**3**	**28**	**14**	**6**	**54**	**16**	**186**	**38**	**0**	**224**	**189**	**18.5**
	Male	1	40	1	17	6	3	29	14	111	24	0	135	162	
3 Years	Female	0	15	1	6	3	1	8	3	37	6	0	43	68	
	Total	**1**	**55**	**2**	**23**	**9**	**4**	**37**	**17**	**148**	**30**	**0**	**178**	**230**	**-22.6**
	Male	2	49	0	24	10	1	39	13	138	25	0	163	163	
4 Years	Female	0	15	0	16	3	1	19	4	58	5	0	63	53	
	Total	**2**	**64**	**0**	**40**	**13**	**2**	**58**	**17**	**196**	**30**	**0**	**226**	**216**	**4.6**
	Male	2	49	1	29	7	2	38	13	141	17	1	159	164	
5 Years	Female	3	15	0	7	5	0	12	2	44	6	0	50	66	
	Total	**5**	**64**	**1**	**36**	**12**	**2**	**50**	**15**	**185**	**23**	**1**	**209**	**230**	**-9.1**
	Male	0	20	0	5	2	0	12	2	41	5	0	46	48	
≥ 6 Years	Female	0	15	0	8	4	0	8	1	36	2	0	38	23	
	Total	**0**	**35**	**0**	**13**	**6**	**0**	**20**	**3**	**77**	**7**	**0**	**84**	**71**	**18.3**
	Male	**11**	**256**	**7**	**128**	**53**	**13**	**186**	**68**	**722**	**129**	**1**	**852**	**837**	
Total	**Female**	**6**	**93**	**3**	**52**	**21**	**6**	**75**	**20**	**276**	**43**	**0**	**319**	**326**	
	Total	**17**	**349**	**10**	**180**	**74**	**19**	**261**	**88**	**998**	**172**	**1**	**1171**	**1163**	**0.7**

[a] Total data cannot be verified as Australian Orthopaedic Association do not routinely report individual Australian Orthopaedic trainee data to RACS.
[b] Includes Trainees who started training /finished training/admitted to Fellowship in the middle of the year.

TABLE SET.16 – Active Cardiothoracic SET Trainees by years in training and training post location

		ACT	NSW	NT	QLD	SA	TAS	VIC	WA	AUS Total	NZ	O/S	Total 2017	Total 2016	% Change 16/17
	Male	0	2	0	0	1	0	2	0	5	1	0	6	6	
1 Year	Female	0	1	0	0	0	0	0	0	1	0	0	1	3	
	Total	**0**	**3**	**0**	**0**	**1**	**0**	**2**	**0**	**6**	**1**	**0**	**7**	**9**	**-22.2**
	Male	0	1	0	3	0	1	0	1	6	0	0	6	5	
2 Years	Female	0	0	0	0	0	0	1	1	2	0	0	2	2	
	Total	**0**	**1**	**0**	**3**	**0**	**1**	**1**	**2**	**8**	**0**	**0**	**8**	**7**	**14.3**
	Male	0	1	0	0	0	0	3	0	4	0	0	4	3	
3 Years	Female	0	0	0	0	1	0	0	0	1	1	0	2	2	
	Total	**0**	**1**	**0**	**0**	**1**	**0**	**3**	**0**	**5**	**1**	**0**	**6**	**5**	**20.0**
	Male	0	2	0	0	0	0	0	0	2	1	0	3	11	
4 Years	Female	0	0	0	0	0	0	1	0	1	1	0	2	1	
	Total	**0**	**2**	**0**	**0**	**0**	**0**	**1**	**0**	**3**	**2**	**0**	**5**	**12**	**-58.3**
	Male	0	2	0	2	0	0	4	0	8	1	1	10	3	
5 Years	Female	0	0	0	0	0	0	1	0	1	0	0	1	1	
	Total	**0**	**2**	**0**	**2**	**0**	**0**	**5**	**0**	**9**	**1**	**1**	**11**	**4**	**175.0**
	Male	0	2	0	0	1	0	0	0	3	1	0	4	2	
≥ 6 Years	Female	0	0	0	0	0	0	0	0	0	0	0	0	0	
	Total	**0**	**2**	**0**	**0**	**1**	**0**	**0**	**0**	**3**	**1**	**0**	**4**	**2**	**100.0**
	Male	**0**	**10**	**0**	**5**	**2**	**1**	**9**	**1**	**28**	**4**	**1**	**33**	**30**	
Total	**Female**	**0**	**1**	**0**	**0**	**1**	**0**	**3**	**1**	**6**	**2**	**0**	**8**	**9**	
	Total	**0**	**11**	**0**	**5**	**3**	**1**	**12**	**2**	**34**	**6**	**1**	**41**	**39**	**5.1**

TABLE SET.17 – Active General Surgery SET Trainees by years in training and training post location

		ACT	NSW	NT	QLD	SA	TAS	VIC	WA	AUS Total	NZ	O/S	Total 2017	Total 2016	% Change 16/17
	Male	1	20	3	8	7	3	8	5	55	12	0	67	43	
1 Year	Female	0	9	1	3	2	1	8	2	26	5	0	31	35	
	Total	**1**	**29**	**4**	**11**	**9**	**4**	**16**	**7**	**81**	**17**	**0**	**98**	**78**	**25.6**
	Male	1	9	1	7	0	1	15	2	36	4	0	40	42	
2 Years	Female	1	15	0	1	1	1	9	1	29	7	0	36	17	
	Total	**2**	**24**	**1**	**8**	**1**	**2**	**24**	**3**	**65**	**11**	**0**	**76**	**59**	**28.8**
	Male	1	10	1	7	1	2	7	6	35	7	0	42	72	
3 Years	Female	0	6	1	2	0	0	2	0	11	3	0	14	37	
	Total	**1**	**16**	**2**	**9**	**1**	**2**	**9**	**6**	**46**	**10**	**0**	**56**	**109**	**-48.6**
	Male	0	21	0	11	4	0	17	7	60	9	0	69	49	
4 Years	Female	0	9	0	10	3	0	12	2	36	2	0	38	29	
	Total	**0**	**30**	**0**	**21**	**7**	**0**	**29**	**9**	**96**	**11**	**0**	**107**	**78**	**37.2**
	Male	0	17	0	10	1	0	10	3	41	5	0	46	58	
5 Years	Female	2	10	0	3	2	0	6	0	23	2	0	25	26	
	Total	**2**	**27**	**0**	**13**	**3**	**0**	**16**	**3**	**64**	**7**	**0**	**71**	**84**	**-15.5**
	Male	0	8	0	1	1	0	3	2	15	0	0	15	14	
≥ 6 Years	Female	0	4	0	3	1	0	3	0	11	0	0	11	11	
	Total	**0**	**12**	**0**	**4**	**2**	**0**	**6**	**2**	**26**	**0**	**0**	**26**	**25**	**4.0**
	Male	**3**	**85**	**5**	**44**	**14**	**6**	**60**	**25**	**242**	**37**	**0**	**279**	**278**	
Total	**Female**	**3**	**53**	**2**	**22**	**9**	**2**	**40**	**5**	**136**	**19**	**0**	**155**	**155**	
	Total	**6**	**138**	**7**	**66**	**23**	**8**	**100**	**30**	**378**	**56**	**0**	**434**	**433**	**0.2**

TABLE SET.18 – Active Neurosurgery SET Trainees by years in training and training post location

		ACT	NSW	NT	QLD	SA	TAS	VIC	WA	AUS Total	NZ	O/S	Total 2017	Total 2016	% Change 16/17
	Male	1	5	0	1	0	0	1	1	9	1	0	10	10	
1 Year	Female	0	0	0	0	0	0	0	0	0	0	0	0	1	
	Total	**1**	**5**	**0**	**1**	**0**	**0**	**1**	**1**	**9**	**1**	**0**	**10**	**11**	**-9.1**
	Male	1	2	0	0	1	0	3	1	8	2	0	10	5	
2 Years	Female	0	0	0	0	0	0	0	0	0	1	0	1	3	
	Total	**1**	**2**	**0**	**0**	**1**	**0**	**3**	**1**	**8**	**3**	**0**	**11**	**8**	**37.5**
	Male	0	1	0	1	0	0	2	0	4	1	0	5	4	
3 Years	Female	0	1	0	1	0	0	1	0	3	0	0	3	2	
	Total	**0**	**2**	**0**	**2**	**0**	**0**	**3**	**0**	**7**	**1**	**0**	**8**	**6**	**33.3**
	Male	0	1	0	2	1	0	2	0	6	0	0	6	2	
4 Years	Female	0	1	0	0	0	1	0	0	2	0	0	2	2	
	Total	**0**	**2**	**0**	**2**	**1**	**1**	**2**	**0**	**8**	**0**	**0**	**8**	**4**	**100.0**
	Male	0	1	0	0	0	0	2	0	3	0	0	3	3	
5 Years	Female	0	1	0	1	0	0	0	0	2	0	0	2	4	
	Total	**0**	**2**	**0**	**1**	**0**	**0**	**2**	**0**	**5**	**0**	**0**	**5**	**7**	**-28.6**
	Male	0	2	0	0	0	0	0	0	2	0	0	2	9	
≥ 6 Years	Female	0	3	0	1	0	0	0	0	4	0	0	4	1	
	Total	**0**	**5**	**0**	**1**	**0**	**0**	**0**	**0**	**6**	**0**	**0**	**6**	**10**	**-40.0**
	Male	**2**	**12**	**0**	**4**	**2**	**0**	**10**	**2**	**32**	**4**	**0**	**36**	**33**	
Total	**Female**	**0**	**6**	**0**	**3**	**0**	**1**	**1**	**0**	**11**	**1**	**0**	**12**	**13**	
	Total	**2**	**18**	**0**	**7**	**2**	**1**	**11**	**2**	**43**	**5**	**0**	**48**	**46**	**4.3**

TABLE SET.19 – Active Orthopaedic SET Trainees by years in training and training post location[a]

		ACT	NSW	NT	QLD	SA	TAS	VIC	WA	AUS Total	NZ	O/S	Total 2017	Total 2016	% Change 16/17
	Male	1	13	0	12	3	0	12	4	45	10	0	55	48	
1 Year	Female	0	1	0	0	1	0	0	1	3	0	0	3	11	
	Total	**1**	**14**	**0**	**12**	**4**	**0**	**12**	**5**	**48**	**10**	**0**	**58**	**59**	**-1.7**
	Male	0	14	0	8	4	0	8	6	40	7	0	47	60	
2 Years	Female	0	1	0	1	1	1	5	0	9	3	0	12	7	
	Total	**0**	**15**	**0**	**9**	**5**	**1**	**13**	**6**	**49**	**10**	**0**	**59**	**67**	**-11.9**
	Male	0	23	0	7	3	1	11	6	51	7	0	58	37	
3 Years	Female	0	3	0	0	1	1	2	0	7	0	0	7	6	
	Total	**0**	**26**	**0**	**7**	**4**	**2**	**13**	**6**	**58**	**7**	**0**	**65**	**43**	**51.2**
	Male	2	8	0	5	3	1	9	2	30	9	0	39	47	
4 Years	Female	0	0	0	2	0	0	1	0	3	1	0	4	4	
	Total	**2**	**8**	**0**	**7**	**3**	**1**	**10**	**2**	**33**	**10**	**0**	**43**	**51**	**-15.7**
	Male	2	15	1	8	2	2	6	5	41	8	0	49	50	
5 Years	Female	1	0	0	0	1	0	1	0	3	2	0	5	7	
	Total	**3**	**15**	**1**	**8**	**3**	**2**	**7**	**5**	**44**	**10**	**0**	**54**	**57**	**-5.3**
	Male	0	1	0	0	0	0	0	0	1	1	0	2	3	
≥ 6 Years	Female	0	0	0	1	0	0	1	0	2	0	0	2	0	
	Total	**0**	**1**	**0**	**1**	**0**	**0**	**1**	**0**	**3**	**1**	**0**	**4**	**3**	**33.3**
	Male	**5**	**74**	**1**	**40**	**15**	**4**	**46**	**23**	**208**	**42**	**0**	**250**	**245**	
Total	**Female**	**1**	**5**	**0**	**4**	**4**	**2**	**10**	**1**	**27**	**6**	**0**	**33**	**35**	
	Total	**6**	**79**	**1**	**44**	**19**	**6**	**56**	**24**	**235**	**48**	**0**	**283**	**280**	**1.1**

[a] Total data cannot be verified as Australian Orthopaedic Association do not routinely report individual Australian Orthopaedic trainee data to RACS.

TABLE SET.20 – Active Otolaryngology SET Trainees by years in training and training post location

		ACT	NSW	NT	QLD	SA	TAS	VIC	WA	AUS Total	NZ	O/S	Total 2017	Total 2016	% Change 16/17
	Male	1	5	0	3	2	0	0	1	12	3	0	15	8	
1 Year	Female	1	0	0	2	0	0	0	0	3	0	0	3	3	
	Total	**2**	**5**	**0**	**5**	**2**	**0**	**0**	**1**	**15**	**3**	**0**	**18**	**11**	**63.6**
	Male	0	1	0	0	1	0	3	1	6	2	0	8	9	
2 Years	Female	1	0	1	0	1	0	0	0	3	0	0	3	7	
	Total	**1**	**1**	**1**	**0**	**2**	**0**	**3**	**1**	**9**	**2**	**0**	**11**	**16**	**-31.3**
	Male	0	2	0	1	1	0	1	0	5	3	0	8	14	
3 Years	Female	0	3	0	1	0	0	0	2	6	1	0	7	8	
	Total	**0**	**5**	**0**	**2**	**1**	**0**	**1**	**2**	**11**	**4**	**0**	**15**	**22**	**-31.8**
	Male	0	7	0	3	0	0	2	1	13	1	0	14	11	
4 Years	Female	0	1	0	2	0	0	2	1	6	0	0	6	4	
	Total	**0**	**8**	**0**	**5**	**0**	**0**	**4**	**2**	**19**	**1**	**0**	**20**	**15**	**33.3**
	Male	0	2	0	3	0	0	5	0	10	1	0	11	11	
5 Years	Female	0	0	0	0	0	0	2	1	3	1	0	4	8	
	Total	**0**	**2**	**0**	**3**	**0**	**0**	**7**	**1**	**13**	**2**	**0**	**15**	**19**	**-21.1**
	Male	0	0	0	0	0	0	0	0	0	2	0	2	2	
≥ 6 Years	Female	0	1	0	1	2	0	1	0	5	0	0	5	3	
	Total	**0**	**1**	**0**	**1**	**2**	**0**	**1**	**0**	**5**	**2**	**0**	**7**	**5**	**40.0**
	Male	**1**	**17**	**0**	**10**	**4**	**0**	**11**	**3**	**46**	**12**	**0**	**58**	**55**	
Total	**Female**	**2**	**5**	**1**	**6**	**3**	**0**	**5**	**4**	**26**	**2**	**0**	**28**	**33**	
	Total	**3**	**22**	**1**	**16**	**7**	**0**	**16**	**7**	**72**	**14**	**0**	**86**	**88**	**-2.3**

TABLE SET.21 – Active Paediatric SET Trainees by years in training and training post location

		ACT	NSW	NT	QLD	SA	TAS	VIC	WA	AUS Total	NZ	O/S	Total 2017	Total 2016	% Change 16/17
	Male	0	0	0	1	1	1	0	0	3	2	0	5	2	
1 Year	Female	0	0	0	2	0	0	0	0	2	1	0	3	4	
	Total	**0**	**0**	**0**	**3**	**1**	**1**	**0**	**0**	**5**	**3**	**0**	**8**	**6**	**33.3**
	Male	0	1	1	0	0	0	0	0	2	0	0	2	4	
2 Years	Female	0	2	0	0	0	0	1	0	3	2	0	5	2	
	Total	**0**	**3**	**1**	**0**	**0**	**0**	**1**	**0**	**5**	**2**	**0**	**7**	**6**	**16.7**
	Male	0	0	0	0	1	0	0	0	1	2	0	3	1	
3 Years	Female	0	0	0	1	0	0	0	1	2	0	0	2	2	
	Total	**0**	**0**	**0**	**1**	**1**	**0**	**0**	**1**	**3**	**2**	**0**	**5**	**3**	**66.7**
	Male	0	0	0	0	0	0	1	0	1	0	0	1	4	
4 Years	Female	0	0	0	0	0	0	1	0	1	0	0	1	2	
	Total	**0**	**0**	**0**	**0**	**0**	**0**	**2**	**0**	**2**	**0**	**0**	**2**	**6**	**-66.7**
	Male	0	0	0	0	0	0	2	0	2	1	0	3	0	
5 Years	Female	0	0	0	1	0	0	0	0	1	0	0	1	4	
	Total	**0**	**0**	**0**	**1**	**0**	**0**	**2**	**0**	**3**	**1**	**0**	**4**	**4**	**0.0**
	Male	0	0	0	0	0	0	0	0	0	0	0	0	2	
≥ 6 Years	Female	0	4	0	0	0	0	1	0	5	0	0	5	4	
	Total	**0**	**4**	**0**	**0**	**0**	**0**	**1**	**0**	**5**	**0**	**0**	**5**	**6**	**-16.7**
	Male	**0**	**1**	**1**	**1**	**2**	**1**	**3**	**0**	**9**	**5**	**0**	**14**	**13**	
Total	**Female**	**0**	**6**	**0**	**4**	**0**	**0**	**3**	**1**	**14**	**3**	**0**	**17**	**18**	
	Total	**0**	**7**	**1**	**5**	**2**	**1**	**6**	**1**	**23**	**8**	**0**	**31**	**31**	**0.0**

TABLE SET.22 – Active Plastic and Reconstructive SET Trainees by years in training and training post location

		ACT	NSW	NT	QLD	SA	TAS	VIC	WA	AUS Total	NZ	O/S	Total 2017	Total 2016	% Change 16/17
	Male	0	3	0	1	2	0	4	1	11	4	0	15	15	
1 Year	Female	0	1	0	2	0	0	1	3	7	0	0	7	7	
	Total	**0**	**4**	**0**	**3**	**2**	**0**	**5**	**4**	**18**	**4**	**0**	**22**	**22**	**0.0**
	Male	0	5	0	2	3	0	3	1	14	1	0	15	11	
2 Years	Female	0	0	0	1	0	1	2	0	4	2	0	6	4	
	Total	**0**	**5**	**0**	**3**	**3**	**1**	**5**	**1**	**18**	**3**	**0**	**21**	**15**	**40.0**
	Male	0	1	0	0	0	0	5	2	8	2	0	10	8	
3 Years	Female	0	1	0	1	0	0	0	0	2	1	0	3	6	
	Total	**0**	**2**	**0**	**1**	**0**	**0**	**5**	**2**	**10**	**3**	**0**	**13**	**14**	**-7.1**
	Male	0	3	0	1	0	0	2	1	7	1	0	8	14	
4 Years	Female	0	3	0	2	0	0	0	0	5	0	0	5	5	
	Total	**0**	**6**	**0**	**3**	**0**	**0**	**2**	**1**	**12**	**1**	**0**	**13**	**19**	**-31.6**
	Male	0	5	0	1	2	0	4	5	17	1	0	18	16	
5 Years	Female	0	2	0	0	1	0	2	0	5	1	0	6	9	
	Total	**0**	**7**	**0**	**1**	**3**	**0**	**6**	**5**	**22**	**2**	**0**	**24**	**25**	**-4.0**
	Male	0	2	0	0	0	0	1	0	3	0	0	3	1	
≥ 6 Years	Female	0	0	0	0	1	0	1	1	3	0	0	3	0	
	Total	**0**	**2**	**0**	**0**	**1**	**0**	**2**	**1**	**6**	**0**	**0**	**6**	**1**	**500.0**
	Male	**0**	**19**	**0**	**5**	**7**	**0**	**19**	**10**	**60**	**9**	**0**	**69**	**65**	
Total	**Female**	**0**	**7**	**0**	**6**	**2**	**1**	**6**	**4**	**26**	**4**	**0**	**30**	**31**	
	Total	**0**	**26**	**0**	**11**	**9**	**1**	**25**	**14**	**86**	**13**	**0**	**99**	**96**	**3.1**

TABLE SET.23 – Active Urology SET Trainees by years in training and training post location

		ACT	NSW	NT	QLD	SA	TAS	VIC	WA	AUS Total	NZ	O/S	Total 2017	Total 2016	% Change 16/17
	Male	0	5	0	2	1	0	3	1	12	3	0	15	20	
1 Year	Female	0	1	0	2	0	0	1	0	4	1	0	5	3	
	Total	**0**	**6**	**0**	**4**	**1**	**0**	**4**	**1**	**16**	**4**	**0**	**20**	**23**	**-13.0**
	Male	0	7	0	4	1	1	1	1	15	4	0	19	1	
2 Years	Female	0	1	0	0	0	0	0	1	2	0	0	2	2	
	Total	**0**	**8**	**0**	**4**	**1**	**1**	**1**	**2**	**17**	**4**	**0**	**21**	**3**	**600.0**
	Male	0	0	0	1	0	0	0	0	1	0	0	1	11	
3 Years	Female	0	0	0	0	0	0	2	0	2	0	0	2	4	
	Total	**0**	**0**	**0**	**1**	**0**	**0**	**2**	**0**	**3**	**0**	**0**	**3**	**15**	**-80.0**
	Male	0	2	0	2	1	0	3	1	9	2	0	11	15	
4 Years	Female	0	1	0	0	0	0	1	1	3	1	0	4	5	
	Total	**0**	**3**	**0**	**2**	**1**	**0**	**4**	**2**	**12**	**3**	**0**	**15**	**20**	**-25.0**
	Male	0	5	0	4	1	0	5	0	15	0	0	15	20	
5 Years	Female	0	2	0	1	1	0	0	1	5	0	0	5	7	
	Total	**0**	**7**	**0**	**5**	**2**	**0**	**5**	**1**	**20**	**0**	**0**	**20**	**27**	**-25.9**
	Male	0	5	0	4	0	0	7	0	16	0	0	16	13	
≥ 6 Years	Female	0	2	0	2	0	0	1	0	5	2	0	7	3	
	Total	**0**	**7**	**0**	**6**	**0**	**0**	**8**	**0**	**21**	**2**	**0**	**23**	**16**	**43.8**
	Male	**0**	**24**	**0**	**17**	**4**	**1**	**19**	**3**	**68**	**9**	**0**	**77**	**80**	
Total	**Female**	**0**	**7**	**0**	**5**	**1**	**0**	**5**	**3**	**21**	**4**	**0**	**25**	**24**	
	Total	**0**	**31**	**0**	**22**	**5**	**1**	**24**	**6**	**89**	**13**	**0**	**102**	**104**	**-1.9**

TABLE SET.24 – Active Vascular Surgery SET Trainees by years in training and training post location

		ACT	NSW	NT	QLD	SA	TAS	VIC	WA	AUS Total	NZ	O/S	Total 2017	Total 2016	% Change 16/17
	Male	0	4	0	1	0	0	2	0	7	0	0	7	7	
1 Year	Female	0	0	0	0	0	0	0	1	1	1	0	2	1	
	Total	**0**	**4**	**0**	**1**	**0**	**0**	**2**	**1**	**8**	**1**	**0**	**9**	**8**	**12.5**
	Male	0	1	0	0	1	0	3	0	5	2	0	7	4	
2 Years	Female	0	1	0	1	0	0	0	0	2	1	0	3	4	
	Total	**0**	**2**	**0**	**1**	**1**	**0**	**3**	**0**	**7**	**3**	**0**	**10**	**8**	**25.0**
	Male	0	2	0	0	0	0	0	0	2	2	0	4	12	
3 Years	Female	0	1	0	0	1	0	1	0	3	0	0	3	1	
	Total	**0**	**3**	**0**	**0**	**1**	**0**	**1**	**0**	**5**	**2**	**0**	**7**	**13**	**-46.2**
	Male	0	5	0	0	1	0	3	1	10	2	0	12	10	
4 Years	Female	0	0	0	0	0	0	1	0	1	0	0	1	1	
	Total	**0**	**5**	**0**	**0**	**1**	**0**	**4**	**1**	**11**	**2**	**0**	**13**	**11**	**18.2**
	Male	0	2	0	1	1	0	0	0	4	0	0	4	3	
5 Years	Female	0	0	0	1	0	0	0	0	1	0	0	1	0	
	Total	**0**	**2**	**0**	**2**	**1**	**0**	**0**	**0**	**5**	**0**	**0**	**5**	**3**	**66.7**
	Male	0	0	0	0	0	0	1	0	1	1	0	2	2	
≥ 6 Years	Female	0	1	0	0	0	0	0	0	1	0	0	1	1	
	Total	**0**	**1**	**0**	**0**	**0**	**0**	**1**	**0**	**2**	**1**	**0**	**3**	**3**	**0.0**
	Male	**0**	**14**	**0**	**2**	**3**	**0**	**9**	**1**	**29**	**7**	**0**	**36**	**38**	
Total	**Female**	**0**	**3**	**0**	**2**	**1**	**0**	**2**	**1**	**9**	**2**	**0**	**11**	**8**	
	Total	**0**	**17**	**0**	**4**	**4**	**0**	**11**	**2**	**38**	**9**	**0**	**47**	**46**	**2.2**

EXPLANATORY NOTES

Location – State and/or Country reflected in these reports refer to the candidate's mailing address. This is not necessarily the location where the candidate has undertaken all of their training, oversight and/or or examinations.

Surgical Science Examinations – Generic and Speciality Specific

The Generic Surgical Science Examination (GSSE) comprises two components and is mandatory for all specialities. Numbers reflected in these reports are representative of all examination sittings held in Australia and New Zealand in 2017 (including all attempts). As passing the GSSE is now a requirement prior to applying to the SET program for all specialties, the number of new SET Trainees that have already passed the GSSE prior to commencing SET training is increasing. Conversely, the number of existing SET Trainees who will sit for the GSSE will decrease. The name change to Table EXAM.1 to include the term 'SET Trainees' highlights this change. The GSSE was conducted three times in 2017 for prevocational doctors and twice for SET Trainees.

All specialty specific examinations are presented in the one table and indicate all sittings and all attempts (Table EXAM.2). Held concurrently with the GSSE, the Specialty Specific Examination is conducted for Otolaryngology Head and Neck Surgery, Urology and Vascular Surgery. For Trainees commencing from 2014, the Board in General Surgery replaced the Specialty Specific Examination in General Surgery with Surgical Education and Assessment Modules (SEAM); SEAM is not reported by RACS. For Trainees commencing from 2016, the Board of Neurosurgery removed the specialty specific examination as a training requirement. The remaining speciality specific examinations are the Cardiothoracic Surgical Science and Principles (CSSP), Orthopaedic Principles and Basic Sciences (OPBS), Plastic and Reconstructive Surgical Sciences and Principles (PRSSP) and the Paediatric Anatomy and Embryology (PAE) and Paediatric Pathology and Pathophysiology (PPE) Examinations.

Clinical Examination

TThe Clinical Examination consists of 16 Objective Structured Clinical Examinations (OSCE) stations. Numbers reflected in the Clinical Examination report are representative of the exams held in Australia and New Zealand for all sittings and all attempts. For Trainees commencing from 2016, the Board of Neurosurgery removed the Clinical Examination as a requirement.

Fellowship Examinations (FEX)

Numbers reflected in the Fellowship Examination reports are representative of the exams held in Australia and New Zealand in May and September 2017 and reported with respect to:

- Individual sitting and annual pass rate
- Eventual pass rate by specialty (compares the number of candidates successfully completing the Fellowship Examinations within a 5 year period since first attempt; includes SET Trainees and IMGs
- Annual Fellowship Examination pass rate by state and specialty – SET Trainees
- Annual Fellowship Examination pass rate by state and specialty – International Medical Graduates
- Cumulative attempts to pass the Fellowship Examination (all candidates presenting in 2017 and the number of attempts). Note that previous reporting of this table has always included cumulative attempts for both SET and IMGs, and we have changed the title of this table to reflect this.

Data reporting in Tables EXAM.6 and EXAM.7

Tables EXAM.6 and EXAM.7 report annual pass rates. The annual pass rate reports on the overall success of the candidate passing Fellowship Exam within the calendar year. Previous years Activities Reports have reported the individual pass rate attempts.

Table EXAM.8 reports the number of female and male candidates who present for the Fellowship Examinations. The numbers represented include SET Trainees and IMGs who sat and passed the FEX within the calendar year by specialty. Activities Reports from earlier years did not report this information.

DATA SUMMARY

Generic and Specialty Specific Surgical Science Examinations

The number of SET Trainees sitting the GSSE has decreased sharply from 2016, reflecting the policy change that requires prevocational doctors to pass the exam prior to applying to the SET program. The cumulative pass rate for the prevocational doctor cohort decreased from 70.9% in 2016 to 61.2% in 2017 (Table EXAM.10).

The 84.8% pass rate in the Specialty Specific Surgical Science Examination this year was an increase from the 75.3% pass rate in 2016.

Clinical Examination

The pass rate for the Clinical Examination was 79.3%, a decrease of 4.4%. Neurosurgery SET Trainees are not required to present for the Clinical Examination.

Fellowship Examination

The overall pass rate for the Fellowship Examination has decreased by 7.3% in 2017 compared to 2016 (Table EXAM.4). There was also a decrease in the total numbers both SET Trainees and IMGs sitting for the exam compared to 2016. The overall pass rate for SET Trainees continues to vary between specialties (Table EXAM.6).

The eventual Fellowship Examination pass rate for SET Trainees and IMGs continues to be consistent across the last four Trainee cohorts, with the last two cohorts reporting an eventual pass rate of more than 98% (Table EXAM.5). The eventual pass rate of the IMG cohort remains at a comparable level compared to the SET cohort.

The number of female candidates sitting for the Fellowship Examination increased from 77 candidates in 2016 to 93 candidates in 2017. By gender, the pass rate for female candidates increased by 2% but decreased for male candidates by 8% (Table EXAM.8).

Compared to 2016, the annual pass rate has decreased for first attempt and second attempts. The numbers take into consideration both SET Trainees and IMGs. The pass rate for General surgery at the first attempt decreased from 73% in 2016 to 67% in 2017, while for Orthopaedic Surgery the pass rate increased from 78% in 2016 to 88% in 2017 (Table EXAM.9).

RACS continues to monitor examination pass rates and identify areas for ongoing improvement.

TABLE EXAM.1 – SET Trainee pass rate of individual attempts (total sittings) at Generic Surgical Science Examination by specialty and location

		ACT	NSW	NT	QLD	SA	TAS	VIC	WA	AUS Total	NZ	O/S	Total 2017	% Pass
CAR	Sat	0	1	0	0	0	0	0	0	1	0	0	1	100.0
	Pass	0	1	0	0	0	0	0	0	1	0	0	1	
GEN	Sat	2	1	0	2	0	0	4	0	9	0	0	9	77.8
	Pass	1	0	0	2	0	0	4	0	7	0	0	7	
NEU	Sat	0	0	0	0	0	0	0	0	0	0	0	0	–
	Pass	0	0	0	0	0	0	0	0	0	0	0	0	
ORT	Sat	0	0	0	0	0	0	4	0	4	2	0	6	16.7
	Pass	0	0	0	0	0	0	1	0	1	0	0	1	
OTO	Sat	0	3	0	1	0	0	0	0	4	3	0	7	71.4
	Pass	0	1	0	1	0	0	0	0	2	3	0	5	
PAE	Sat	0	0	0	0	0	0	0	0	0	0	0	0	–
	Pass	0	0	0	0	0	0	0	0	0	0	0	0	
PLA	Sat	0	0	0	1	0	0	0	4	5	2	0	7	14.3
	Pass	0	0	0	0	0	0	0	0	0	1	0	1	
URO	Sat	0	0	0	0	0	0	0	0	0	0	0	0	–
	Pass	0	0	0	0	0	0	0	0	0	0	0	0	
VAS	Sat	0	0	0	0	0	0	1	0	1	0	0	1	100.0
	Pass	0	0	0	0	0	0	1	0	1	0	0	1	
Total	**Sat**	**2**	**5**	**0**	**4**	**0**	**0**	**9**	**4**	**24**	**7**	**0**	**31**	
	Pass	**1**	**2**	**0**	**3**	**0**	**0**	**6**	**0**	**12**	**4**	**0**	**16**	**51.6**
	% Pass	**50.0**	**40.0**	**–**	**75.0**	**–**	**–**	**66.7**	**0.0**	**50.0**	**57.1**	**–**	**51.6**	

Note: Sat numbers are based on unique candidates; that is, candidates who sat multiple times for examinations are only counted once.

FIGURE EXAM.1 – Overall annual pass rate of individual attempts (total sittings) at Generic Surgical Science Examination (2010-2017)

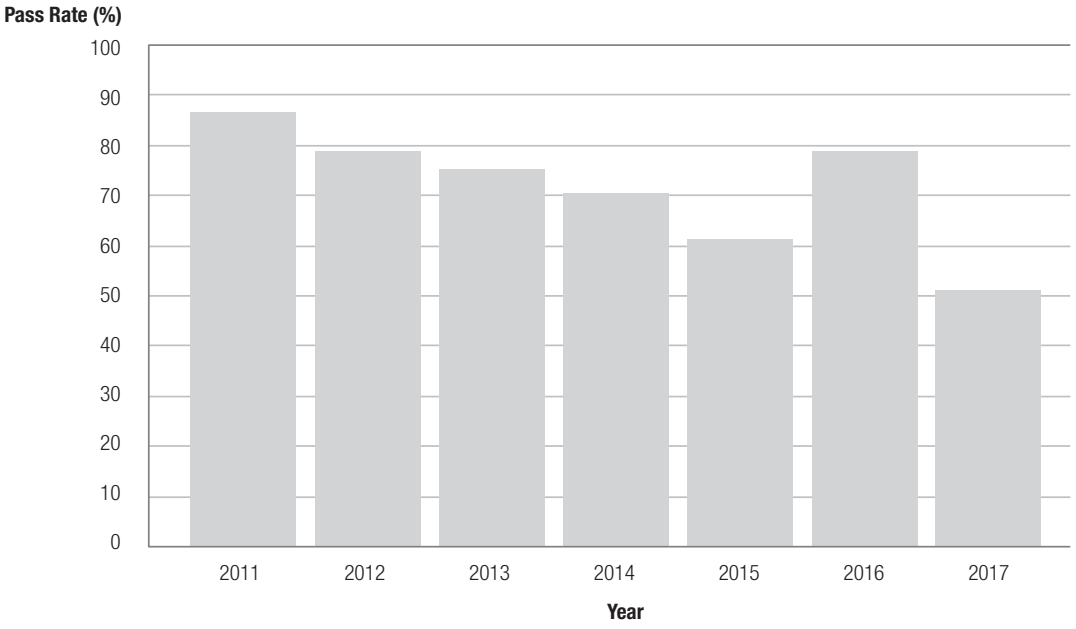


TABLE EXAM.2 – Pass rate of individual attempts (total sittings) at Specialty Specific Surgical Science Examination by specialty and location

		ACT	NSW	NT	QLD	SA	TAS	VIC	WA	AUS Total	NZ	O/S	Total 2017	% Pass
CAR (CSSP)	Sat	0	1	0	1	0	1	4	1	8	1	0	9	66.7
	Pass	0	0	0	1	0	0	3	1	5	1	0	6	
GEN	Sat	0	0	0	0	0	0	0	0	0	0	0	0	–
	Pass	0	0	0	0	0	0	0	0	0	0	0	0	
NEU	Sat	0	0	0	0	0	0	0	0	0	0	0	0	–
	Pass	0	0	0	0	0	0	0	0	0	0	0	0	
ORT (OPBS)	Sat	1	35	0	16	4	1	20	6	83	11	0	94	80.9
	Pass	1	26	0	15	4	0	16	3	65	11	0	76	
OTO	Sat	0	8	0	6	2	0	1	0	17	3	0	20	85.0
	Pass	0	7	0	4	2	0	1	0	14	3	0	17	
PAE (PAEE)	Sat	1	0	1	3	2	0	0	0	7	2	0	9	66.7
	Pass	0	0	1	2	2	0	0	0	5	1	0	6	
PAE (PPPE)	Sat	0	2	0	1	1	0	0	0	4	2	0	6	100.0
	Pass	0	2	0	1	1	0	0	0	4	2	0	6	
PLA (PRSSP)	Sat	0	3	0	4	3	0	10	0	20	5	0	25	92.0
	Pass	0	1	0	4	3	0	10	0	18	5	0	23	
URO	Sat	0	4	0	2	1	1	6	1	15	5	0	20	100.0
	Pass	0	4	0	2	1	1	6	1	15	5	0	20	
VAS	Sat	0	3	0	0	1	0	3	0	7	1	0	8	100.0
	Pass	0	3	0	0	1	0	3	0	7	1	0	8	
	Sat	**2**	**56**	**1**	**33**	**14**	**3**	**44**	**8**	**161**	**30**	**0**	**191**	
Total	**Pass**	**1**	**43**	**1**	**29**	**14**	**1**	**39**	**5**	**133**	**29**	**0**	**162**	**84.8**
	% Pass	**50.0**	**76.8**	**100.0**	**87.9**	**100.0**	**33.3**	**88.6**	**62.5**	**82.6**	**96.7**	**–**	**84.8**	

Note: Sat numbers are based on unique candidates; that is, candidates who sat multiple times for examinations are only counted once

FIGURE EXAM.2 – Overall annual pass rate of individual attempts (total sittings) at Specialty Specific Surgical Science Examination (2010-2017)

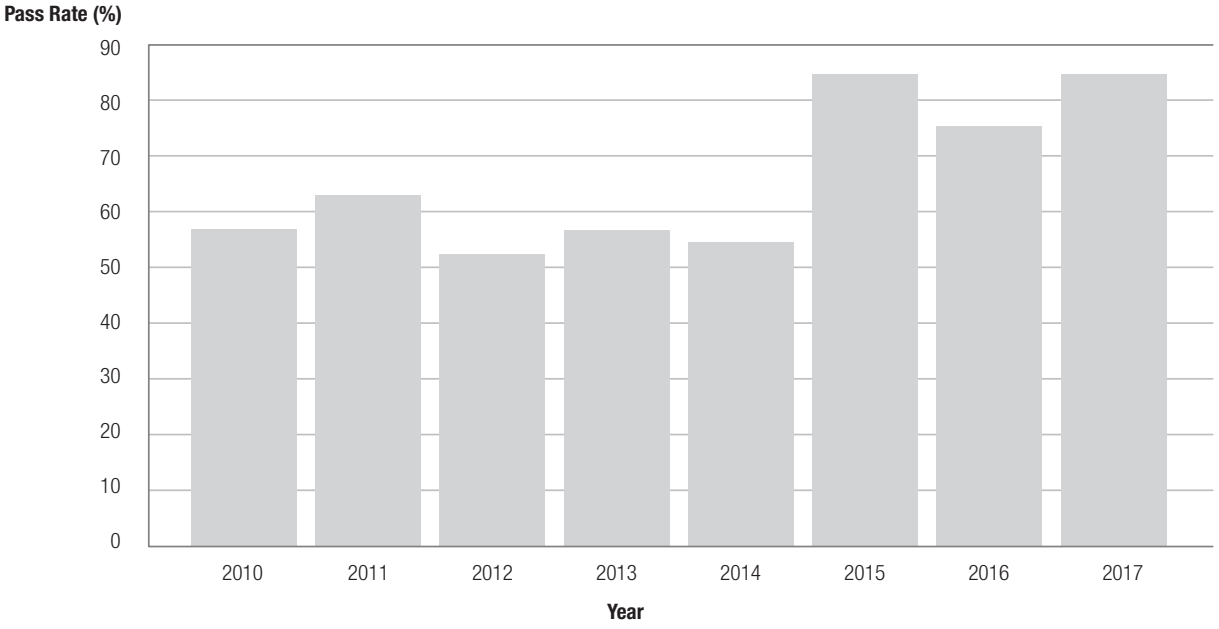


TABLE EXAM.3 – Pass rate of individual attempts (total sittings) at Clinical Examination by specialty and location

		ACT	NSW	NT	QLD	SA	TAS	VIC	WA	AUS Total	NZ	O/S	Total 2017	% Pass
CAR	Sat	0	2	0	0	0	0	1	1	4	1	0	5	60.0
	Pass	0	2	0	0	0	0	0	0	2	1	0	3	
GEN	Sat	4	26	1	16	11	2	27	9	96	19	0	115	79.1
	Pass	2	22	1	15	9	1	20	6	76	15	0	91	
NEU	Sat	0	0	0	0	0	0	0	0	0	0	0	0	–
	Pass	0	0	0	0	0	0	0	0	0	0	0	0	
ORT	Sat	2	20	0	14	5	0	18	7	66	9	0	75	84.0
	Pass	1	16	0	13	4	0	16	6	56	7	0	63	
OTO	Sat	0	6	0	4	0	0	2	0	12	4	0	16	62.5
	Pass	0	5	0	2	0	0	1	0	8	2	0	10	
PAE	Sat	0	1	0	0	0	1	0	0	2	5	0	7	42.9
	Pass	0	0	0	0	0	0	0	0	0	3	0	3	
PLA	Sat	0	7	0	4	2	0	5	3	21	6	0	27	85.2
	Pass	0	6	0	3	1	0	5	2	17	6	0	23	
URO	Sat	1	7	0	3	0	1	4	0	16	5	0	21	85.7
	Pass	1	4	0	3	0	1	4	0	13	5	0	18	
VAS	Sat	0	1	0	1	2	1	3	0	8	1	0	9	77.8
	Pass	0	0	0	0	2	1	3	0	6	1	0	7	
	Sat	**7**	**70**	**1**	**42**	**20**	**5**	**60**	**20**	**225**	**50**	**0**	**275**	
Total	**Pass**	**4**	**55**	**1**	**36**	**16**	**3**	**49**	**14**	**178**	**40**	**0**	**218**	**79.3**
	% Pass	**57.1**	**78.6**	**100.0**	**85.7**	**80.0**	**60.0**	**81.7**	**70.0**	**79.1**	**80.0**	**–**	**79.3**	

FIGURE EXAM. 3 – Overall annual pass rate of individual attempts (total sittings) at Clinical Examination (2010-2017)

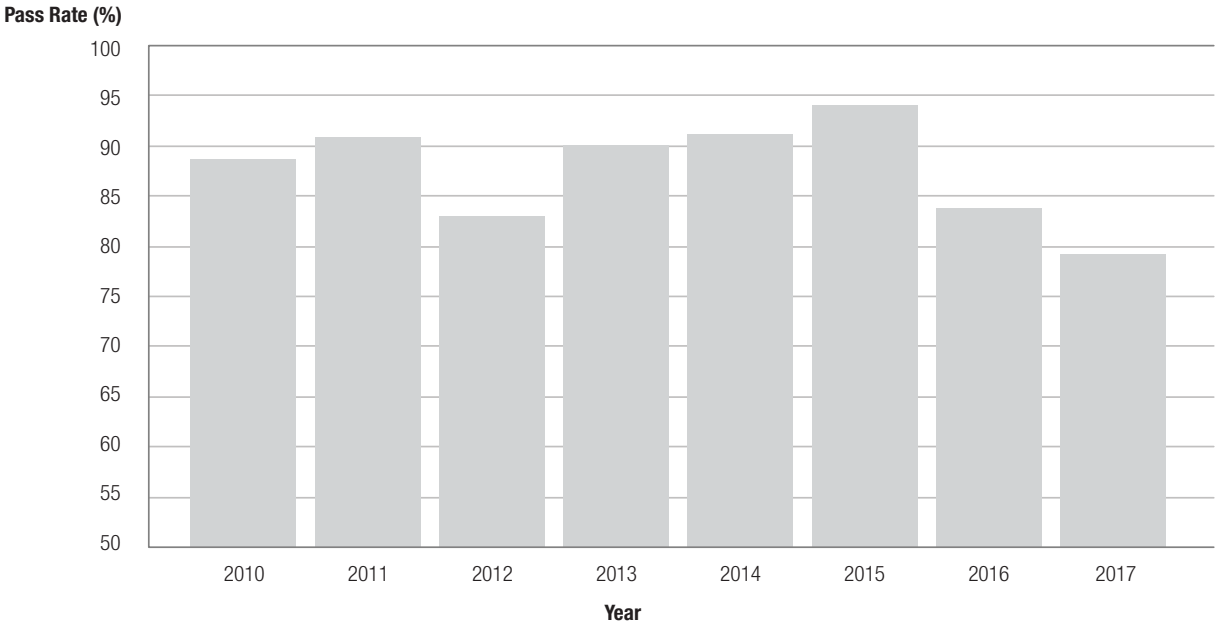


TABLE EXAM.4 – SET and IMG individual attempts and annual pass rate of Fellowship Examinations by specialty

	May (Total sittings)			September (Total sittings)			Pass rate (Total sittings)[a]			Annual Pass Rate[b]		
	Sat	Pass	%	Sat	Pass	%	Sat	Pass	%	Sat	Pass	%
CAR	6	3	50.0	5	2	40.0	11	5	45.5	8	5	62.5
GEN	79	53	67.1	39	23	59.0	118	76	64.4	95	76	80.0
NEU	4	4	100.0	3	3	100.0	7	7	100.0	7	7	100.0
ORT	62	47	75.8	22	10	45.5	84	57	67.9	70	57	81.4
OTO	18	11	61.1	7	3	42.9	25	14	56.0	21	14	66.7
PAE	2	1	50.0	2	0	0.0	4	1	25.0	3	1	33.3
PLA	22	14	63.6	12	6	50.0	34	20	58.8	26	20	76.9
URO	14	12	85.7	17	8	47.1	31	20	64.5	29	20	69.0
VAS	7	5	71.4	6	2	33.3	13	7	53.8	12	7	58.3
Total	**214**	**150**	**70.1**	**113**	**57**	**50.4**	**327**	**207**	**63.3**	**271**	**207**	**76.4**

[a] Total sittings: records numbers of candidates; some candidates sit twice during a year.

[b] Annual pass rate reports on the success rate of the individual candidates (over 1 or 2 sittings) passing Fellowship Exam in 2017.

TABLE EXAM.5 – Eventual Fellowship Examination pass rate by specialty

This table compares the number of Trainees successfully completing the Fellowship Examination within a 5 year period since first attempt (including IMGs).

		2009	2014		2010	2015		2011	2016		2012	2017	
		Initially Sat	Eventual Pass	% Fellows 09/14	Initially Sat	Eventual Pass	% Fellows 10/15	Initially Sat	Eventual Pass	% Fellows 11/16	Initially Sat	Eventual Pass	% Fellows 12/17
CAR	Trainee	2	2	100.0	15	14	93.3	2	2	100.0	7	7	100.0
	IMG	2	2	100.0	2	2	100.0	0	0	–	2	2	100.0
GEN	Trainee	65	62	95.4	60	58	96.7	85	85	100.0	85	83	97.6
	IMG	16	16	100.0	8	6	75.0	7	5	71.4	7	6	85.7
NEU	Trainee	8	8	100.0	9	8	88.9	4	4	100.0	10	10	100.0
	IMG	3	3	100.0	2	2	100.0	3	3	100.0	1	1	100.0
ORT	Trainee	57	57	100.0	61	61	100.0	56	55	98.2	56	54	96.4
	IMG	6	5	83.3	8	7	87.5	5	5	100.0	6	6	100.0
OTO	Trainee	18	17	94.4	23	22	95.7	16	16	100.0	20	20	100.0
	IMG	3	3	100.0	4	3	75.0	1	1	100.0	2	1	50.0
PAE	Trainee	3	3	100.0	4	4	100.0	4	4	100.0	3	3	100.0
	IMG	1	1	100.0	1	1	100.0	2	1	50.0	0	0	–
PLA	Trainee	15	15	100.0	21	19	90.5	26	26	100.0	13	13	100.0
	IMG	2	1	50.0	1	1	100.0	1	1	100.0	3	2	66.7
URO	Trainee	19	19	100.0	20	19	95.0	19	19	100.0	22	22	100.0
	IMG	0	0	0.0	6	6	100.0	2	2	100.0	2	2	100.0
VAS	Trainee	11	11	100.0	9	9	100.0	8	8	100.0	7	7	100.0
	IMG	1	1	100.0	1	1	100.0	0	0	–	0	0	–
Total	**Trainee**	**198**	**194**	**98.0**	**222**	**214**	**96.4**	**220**	**219**	**99.5**	**223**	**219**	**98.2**
	IMG	**34**	**32**	**94.1**	**33**	**29**	**87.9**	**21**	**18**	**85.7**	**23**	**20**	**87.0**

TABLE EXAM.6 – Fellowship Examinations pass rate (per sitting) of SET Trainees by location and specialty

		ACT	NSW	NT	QLD	SA	TAS	VIC	WA	AUS Total	NZ	O/S	Total 2017	% Pass
CAR	Sat	0	5	0	1	0	0	2	0	8	1	0	9	44.4
	Pass	0	2	0	1	0	0	0	0	3	1	0	4	
GEN	Sat	0	41	0	21	6	0	23	6	97	12	0	109	67.9
	Pass	0	25	0	14	3	0	18	5	65	9	0	74	
NEU	Sat	1	4	0	1	0	0	0	0	6	0	0	6	100.0
	Pass	1	4	0	1	0	0	0	0	6	0	0	6	
ORT	Sat	3	13	0	9	5	0	13	6	49	15	0	64	79.7
	Pass	1	12	0	9	3	0	11	5	41	10	0	51	
OTO	Sat	1	2	0	5	0	0	7	1	16	7	0	23	60.9
	Pass	1	1	0	4	0	0	5	1	12	2	0	14	
PAE	Sat	0	3	0	0	0	0	1	0	4	0	0	4	25.0
	Pass	0	0	0	0	0	0	1	0	1	0	0	1	
PLA	Sat	0	12	0	1	4	0	7	3	27	3	1	31	64.5
	Pass	0	6	0	1	3	0	5	1	16	3	1	20	
URO	Sat	0	10	0	4	1	0	8	1	24	2	0	26	65.4
	Pass	0	7	0	2	1	0	5	1	16	1	0	17	
VAS	Sat	1	3	0	1	1	0	1	0	7	3	0	10	50.0
	Pass	0	1	0	1	1	0	1	0	4	1	0	5	
	Sat	**6**	**93**	**0**	**43**	**17**	**0**	**62**	**17**	**238**	**43**	**1**	**282**	
Total	**Pass**	**3**	**58**	**0**	**33**	**11**	**0**	**46**	**13**	**164**	**27**	**1**	**192**	**68.1**
	% Pass	**50.0**	**62.4**	**–**	**76.7**	**64.7**	**–**	**74.2**	**76.5**	**68.9**	**62.8**	**–**	**68.1**	

TABLE EXAM.7 – Fellowship Examinations pass rate (per sitting) of International Medical Graduates by location and specialty

		ACT	NSW	NT	QLD	SA	TAS	VIC	WA	AUS Total	NZ	O/S	Total 2017	% Pass
CAR	Sat	0	0	0	2	0	0	0	0	2	0	0	2	50.0
	Pass	0	0	0	1	0	0	0	0	1	0	0	1	
GEN	Sat	0	2	2	2	1	0	1	1	9	0	0	9	–
	Pass	0	0	0	1	0	0	1	0	2	0	0	2	
NEU	Sat	0	1	0	0	0	0	0	0	1	0	0	1	–
	Pass	0	1	0	0	0	0	0	0	1	0	0	1	
ORT	Sat	0	4	0	6	1	0	6	3	20	0	0	20	30.0
	Pass	0	0	0	2	0	0	3	1	6	0	0	6	
OTO	Sat	0	0	0	0	0	0	2	0	2	0	0	2	0.0
	Pass	0	0	0	0	0	0	0	0	0	0	0	0	
PAE	Sat	0	0	0	0	0	0	0	0	0	0	0	0	–
	Pass	0	0	0	0	0	0	0	0	0	0	0	0	
PLA	Sat	0	2	0	0	0	0	0	1	3	0	0	3	0.0
	Pass	0	0	0	0	0	0	0	0	0	0	0	0	
URO	Sat	0	0	0	1	0	1	3	0	5	0	0	5	60.0
	Pass	0	0	0	1	0	1	1	0	3	0	0	3	
VAS	Sat	0	0	0	2	0	0	0	1	3	0	0	3	66.7
	Pass	0	0	0	1	0	0	0	1	2	0	0	2	
	Sat	**0**	**9**	**2**	**13**	**2**	**1**	**12**	**6**	**45**	**0**	**0**	**45**	
Total	**Pass**	**0**	**1**	**0**	**6**	**0**	**1**	**5**	**2**	**15**	**0**	**0**	**15**	**33.3**
	% Pass	**–**	**11.1**	**0.0**	**46.2**	**0.0**	**100.0**	**41.7**	**33.3**	**33.3**	**–**	**–**	**33.3**	

TABLE EXAM.8 – Fellowship Examinations pass rate (per sitting) of SET and IMG by gender and specialty

		CAR	GEN	NEU	ORT	OTO	PAE	PLA	URO	VAS	Total 2017	% Pass
Female	Sat	0	45	4	6	11	4	13	8	2	93	65.6
	Pass	0	29	4	6	6	1	9	6	0	61	
Male	Sat	11	73	3	78	14	0	21	23	11	234	62.4
	Pass	5	47	3	51	8	0	11	14	7	146	
	Sat	**11**	**118**	**7**	**84**	**25**	**4**	**34**	**31**	**13**	**327**	**63.3**
Total	**Pass**	**5**	**76**	**7**	**57**	**14**	**1**	**20**	**20**	**7**	**207**	
	% Pass	**45.5**	**64.4**	**100.0**	**67.9**	**56.0**	**25.0**	**58.8**	**64.5**	**53.8**	**63.3**	**65.6**

TABLE EXAM.9 – SET Trainees and IMGs cumulative attempts to pass Fellowship Examination by specialty for candidates presenting in 2017

Attempt Number		CAR	GEN	NEU	ORT	OTO	PAE	PLA	URO	VAS	Total 2017	Total 2016
	Sat	7	85	4	57	16	3	20	23	11	226	253
1	Pass	3	57	4	50	10	1	13	13	7	158	189
	% pass	43	67	100	88	63	33	65	57	64	70	75
	Sat	4	28	1	7	4	1	8	5	1	59	70
2	Pass	2	18	1	3	2	0	4	4	0	34	49
	% pass	50	64	100	43	50	0	50	80	0	58	70
	Sat	0	2	1	7	2	0	4	2	1	19	28
3	Pass	0	1	1	0	1	0	2	2	0	7	15
	% pass	–	50	100	0	50	–	50	100	0	37	54
	Sat	0	1	0	8	1	0	1	1	0	12	15
4	Pass	0	0	0	2	1	0	0	1	0	4	8
	% pass	–	0	–	25	100	–	0	100	–	33	53
	Sat	0	1	0	4	0	0	1	0	0	6	7
5	Pass	0	0	0	1	0	0	1	0	0	2	0
	% pass	–	0	–	25	–	–	100	–	–	33	0
	Sat	0	1	1	0	1	0	0	0	0	3	2
6	Pass	0	0	1	0	0	0	0	0	0	1	0
	% pass	–	0	100	–	0	–	–	–	–	33	0
	Sat	0	0	0	1	0	0	0	0	0	1	1
7	Pass	0	0	0	1	0	0	0	0	0	1	0
	% pass	–	–	–	100	–	–	–	–	–	100	0
	Sat	0	0	0	0	1	0	0	0	0	1	1
8	Pass	0	0	0	0	0	0	0	0	0	0	0
	% pass	–	–	–	–	0	–	–	–	–	0	0
	Sat	**11**	**118**	**7**	**84**	**25**	**4**	**34**	**31**	**13**	**327**	**378**
Total	**Pass**	**5**	**76**	**7**	**57**	**14**	**1**	**20**	**20**	**7**	**207**	**261**
	% pass	**45.5**	**64.4**	**100.0**	**67.9**	**56.0**	**25.0**	**58.8**	**64.5**	**53.8**	**63.3**	**69.0**

FIGURE EXAM.4 –Overall Fellowship Examination pass rate of SET Trainees and IMGs (2010-2017)

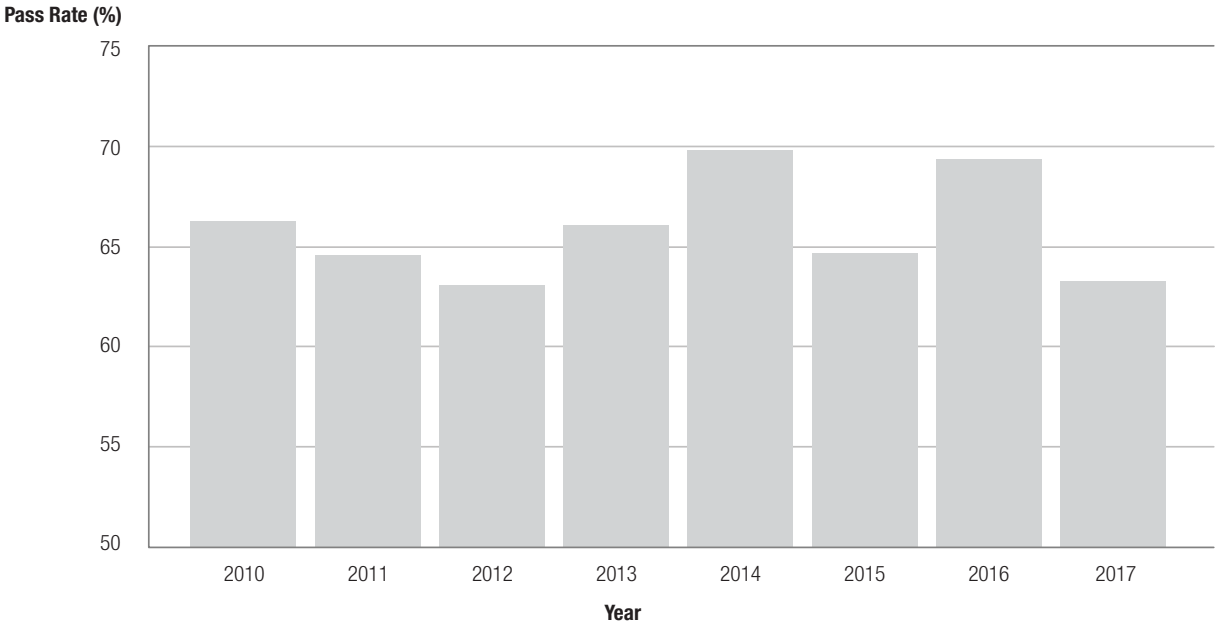


TABLE EXAM.10 – Non-SET cumulative attempts to pass Generic Surgical Science Examination by location

Attempt Number		ACT	NSW	NT	QLD	SA	TAS	VIC	WA	AUS TOTAL	NZ	O/S	Total 2017
	Sat	12	198	2	126	38	7	145	65	593	103	3	699
1	Pass	11	142	2	94	23	4	96	37	409	89	2	500
	% pass	91.7	71.7	100.0	74.6	60.5	57.1	66.2	56.9	69.0	86.4	0.0	71.5
	Sat	2	53	2	34	8	2	45	27	173	12	0	185
2	Pass	1	23	1	19	3	1	17	11	76	6	0	82
	% pass	50.0	43.4	50.0	55.9	37.5	50.0	37.8	40.7	43.9	50.0	–	44.3
	Sat	2	31	1	13	6	0	17	8	78	9	1	88
3	Pass	0	11	0	9	4	0	6	3	33	2	0	35
	% pass	0.0	35.5	0.0	69.2	66.7	–	35.3	37.5	42.3	22.2	0.0	39.8
	Sat	2	16	1	9	1	0	11	1	41	5	0	46
4	Pass	0	1	1	1	1	0	4	0	8	2	0	10
	% pass	0.0	6.3	100.0	11.1	100.0	0.0	36.4	0.0	19.5	40.0	–	21.7
	Sat	0	5	0	5	0	0	2	1	13	0	0	13
5	Pass	0	0	0	4	0	0	1	1	6	0	0	6
	% pass	–	0.0	–	80.0	–	–	50.0	100.0	46.2	–	–	46.2
	Sat	1	3	0	1	0	0	1	0	6	0	0	6
6	Pass	1	2	0	0	0	0	0	0	3	0	0	3
	% pass	100.0	66.7	–	0.0	–	–	0.0	–	50.0	–	–	50.0
	Sat	0	1	0	2	0	0	0	0	3	0	0	3
7	Pass	0	0	0	1	0	0	0	0	1	0	0	1
	% pass	–	0.0	–	50.0	–	–	–	–	33.3	–	–	33.3
	Sat	0	0	0	1	0	0	0	0	1	0	0	1
8	Pass	0	0	0	0	0	0	0	0	0	0	0	0
	% pass	–	–	–	0.0	–	–	–	–	0.0	–	–	0
	Sat	**19**	**307**	**6**	**191**	**53**	**9**	**221**	**102**	**908**	**129**	**4**	**1041**
Total	**Pass**	**13**	**179**	**4**	**128**	**31**	**5**	**124**	**52**	**536**	**99**	**2**	**637**
	% pass	**68.4**	**58.3**	**66.7**	**67.0**	**58.5**	**55.6**	**59.3**	**51.0**	**59.0**	**76.7**	**50.0**	**61.2**

EXPLANATORY NOTES

In all tables the last known address is used when the current address is unknown. Region is based on mailing postcode and country. An active Fellow is involved in medicine, surgery, medico-legal work or other specialist non-procedural and non-clinical work such as surgical administration and academia.

DATA SUMMARY

In 2017, there were 7429 Fellows across Australia, New Zealand and overseas (Table WFD.1). Of these 5179 were active Fellows in Australia and 820 were active Fellows in New Zealand.

The number of admissions to RACS Fellowship was slightly lower in 2017 compared to the previous year, with 241 SET Trainees and International Medical Graduates obtaining Fellowship (Table WFD.11). Almost 22% of surgeons who achieved Fellowship through the SET pathway were female (Table WFD.9), while almost 21% of IMGs who obtained Fellowship were female (Table WFD.10). Female surgeons make up 12% of the active surgical workforce, with the number of female surgeons in active practice increasing by 7% in the last year (Table WFD.3).

The proportion of surgeons located in rural or regional areas remains steady. The specialties of General surgery (20%), Orthopaedic surgery (16%), and Urology (16%) have the largest proportion of Fellows working in rural and remote areas of Australia (Table WFD.6).

TABLE WFD.1 – Active and retired RACS Fellows by location and specialty

		ACT	NSW	NT	QLD	SA	TAS	VIC	WA	AUS Total	NZ	O/S	Total 2017	Total 2016	% Change 16/17
	Male	6	65	0	42	15	4	60	18	210	34	32	276	276	0.0
CAR	Female	0	5	0	2	0	0	7	1	15	3	0	18	17	5.9
	Total	**6**	**70**	**0**	**44**	**15**	**4**	**67**	**19**	**225**	**37**	**32**	**294**	**293**	**0.3**
	Male	24	637	18	344	162	31	489	157	1862	279	172	2313	2273	1.8
GEN	Female	4	96	3	51	26	6	87	24	297	43	21	361	335	7.8
	Total	**28**	**733**	**21**	**395**	**188**	**37**	**576**	**181**	**2159**	**322**	**193**	**2674**	**2608**	**2.5**
	Male	7	79	0	47	18	8	62	21	242	23	32	297	289	2.8
NEU	Female	1	8	0	8	5	1	8	1	32	1	1	34	33	3.0
	Total	**8**	**87**	**0**	**55**	**23**	**9**	**70**	**22**	**274**	**24**	**33**	**331**	**322**	**2.8**
	Male	21	459	4	306	127	22	320	142	1401	278	65	1744	1714	1.8
ORT	Female	3	16	0	11	5	0	17	3	55	16	2	73	66	10.6
	Total	**24**	**475**	**4**	**317**	**132**	**22**	**337**	**145**	**1456**	**294**	**67**	**1817**	**1780**	**2.1**
	Male	12	154	2	97	46	6	113	45	475	84	28	587	579	1.4
OTO	Female	1	24	0	10	5	2	22	3	67	18	4	89	82	8.5
	Total	**13**	**178**	**2**	**107**	**51**	**8**	**135**	**48**	**542**	**102**	**32**	**676**	**661**	**2.3**
	Male	3	32	0	15	5	2	27	7	91	16	28	135	134	0.7
PAE	Female	1	10	0	4	3	1	8	4	31	3	7	41	40	2.5
	Total	**4**	**42**	**0**	**19**	**8**	**3**	**35**	**11**	**122**	**19**	**35**	**176**	**174**	**1.1**
	Male	4	128	2	62	44	11	134	49	434	60	18	512	503	1.8
PLA	Female	0	15	0	14	8	1	26	6	70	13	8	91	83	9.6
	Total	**4**	**143**	**2**	**76**	**52**	**12**	**160**	**55**	**504**	**73**	**26**	**603**	**586**	**2.9**
	Male	7	143	1	96	34	12	121	39	453	66	28	547	531	3.0
URO	Female	0	12	0	7	3	0	17	7	46	7	2	55	52	5.8
	Total	**7**	**155**	**1**	**103**	**37**	**12**	**138**	**46**	**499**	**73**	**30**	**602**	**583**	**3.3**
	Male	4	66	0	38	19	5	59	18	209	19	4	232	223	4.0
VAS	Female	0	8	0	6	2	0	6	1	23	1	0	24	24	0.0
	Total	**4**	**74**	**0**	**44**	**21**	**5**	**65**	**19**	**232**	**20**	**4**	**256**	**247**	**3.6**
	Male	**88**	**1763**	**27**	**1047**	**470**	**101**	**1385**	**496**	**5377**	**859**	**407**	**6643**	**6522**	**1.9**
Sub Total	**Female**	**10**	**194**	**3**	**113**	**57**	**11**	**198**	**50**	**636**	**105**	**45**	**786**	**732**	**7.4**
	Total	**98**	**1957**	**30**	**1160**	**527**	**112**	**1583**	**546**	**6013**	**964**	**452**	**7429**	**7254**	**2.4**
	Male	0	6	0	1	0	0	14	0	21	0	1	22	23	-4.3
OB & GYN	Female	0	0	0	0	0	0	0	0	0	0	0	0	0	–
	Total	**0**	**6**	**0**	**1**	**0**	**0**	**14**	**0**	**21**	**0**	**1**	**22**	**23**	**-4.3**
	Male	4	82	0	47	13	5	64	18	233	12	8	253	266	-4.9
OPH	Female	0	14	1	2	2	0	13	1	33	2	0	35	36	-2.8
	Total	**4**	**96**	**1**	**49**	**15**	**5**	**77**	**19**	**266**	**14**	**8**	**288**	**302**	**-4.6**
	Male	**92**	**1851**	**27**	**1095**	**483**	**106**	**1463**	**514**	**5631**	**871**	**416**	**6918**	**6811**	**1.6**
Total	**Female**	**10**	**208**	**4**	**115**	**59**	**11**	**211**	**51**	**669**	**107**	**45**	**821**	**768**	**6.9**
	Total	**102**	**2059**	**31**	**1210**	**542**	**117**	**1674**	**565**	**6300**	**978**	**461**	**7739**	**7579**	**2.1**

TABLE WFD.2 – Active RACS Fellows by location and specialty

		ACT	NSW	NT	QLD	SA	TAS	VIC	WA	AUS Total	NZ	O/S	Total 2017	Total 2016	% Change 16/17
	Male	5	54	0	37	11	3	52	14	176	28	22	226	224	0.9
CAR	Female	0	5	0	2	0	0	6	1	14	3	0	17	16	6.3
	Total	**5**	**59**	**0**	**39**	**11**	**3**	**58**	**15**	**190**	**31**	**22**	**243**	**240**	**1.3**
	Male	20	492	17	266	122	22	388	120	1447	208	128	1783	1745	2.2
GEN	Female	4	94	3	50	25	6	86	24	292	41	20	353	327	8.0
	Total	**24**	**586**	**20**	**316**	**147**	**28**	**474**	**144**	**1739**	**249**	**148**	**2136**	**2072**	**3.1**
	Male	7	70	0	43	11	6	61	19	217	20	25	262	257	1.9
NEU	Female	1	8	0	8	5	1	8	1	32	1	1	34	33	3.0
	Total	**8**	**78**	**0**	**51**	**16**	**7**	**69**	**20**	**249**	**21**	**26**	**296**	**290**	**2.1**
	Male	20	424	3	288	114	21	296	127	1293	252	49	1594	1561	2.1
ORT	Female	3	16	0	11	5	0	17	3	55	15	2	72	65	10.8
	Total	**23**	**440**	**3**	**299**	**119**	**21**	**313**	**130**	**1348**	**267**	**51**	**1666**	**1626**	**2.5**
	Male	8	129	2	83	40	6	97	38	403	76	22	501	492	1.8
OTO	Female	1	24	0	10	5	2	22	3	67	18	4	89	82	8.5
	Total	**9**	**153**	**2**	**93**	**45**	**8**	**119**	**41**	**470**	**94**	**26**	**590**	**574**	**2.8**
	Male	2	25	0	11	4	2	16	5	65	13	19	97	96	1.0
PAE	Female	1	10	0	3	3	0	7	4	28	3	5	36	36	0.0
	Total	**3**	**35**	**0**	**14**	**7**	**2**	**23**	**9**	**93**	**16**	**24**	**133**	**132**	**0.8**
	Male	3	113	2	52	37	9	124	40	380	51	16	447	443	0.9
PLA	Female	0	14	0	13	7	1	26	6	67	13	8	88	82	7.3
	Total	**3**	**127**	**2**	**65**	**44**	**10**	**150**	**46**	**447**	**64**	**24**	**535**	**525**	**1.9**
	Male	6	123	1	82	28	12	107	33	392	53	22	467	454	2.9
URO	Female	0	12	0	7	3	0	17	7	46	7	2	55	52	5.8
	Total	**6**	**135**	**1**	**89**	**31**	**12**	**124**	**40**	**438**	**60**	**24**	**522**	**506**	**3.2**
	Male	4	61	0	33	16	4	50	14	182	17	3	202	192	5.2
VAS	Female	0	8	0	6	2	0	6	1	23	1	0	24	24	0.0
	Total	**4**	**69**	**0**	**39**	**18**	**4**	**56**	**15**	**205**	**18**	**3**	**226**	**216**	**4.6**
	Male	**75**	**1491**	**25**	**895**	**383**	**85**	**1191**	**410**	**4555**	**718**	**306**	**5579**	**5464**	**2.1**
Sub Total	**Female**	**10**	**191**	**3**	**110**	**55**	**10**	**195**	**50**	**624**	**102**	**42**	**768**	**717**	**7.1**
	Total	**85**	**1682**	**28**	**1005**	**438**	**95**	**1386**	**460**	**5179**	**820**	**348**	**6347**	**6181**	**2.7**
	Male	0	1	0	0	0	0	0	0	1	0	0	1	2	-50.0
OB & GYN	Female	0	0	0	0	0	0	0	0	0	0	0	0	0	–
	Total	**0**	**1**	**0**	**0**	**0**	**0**	**0**	**0**	**1**	**0**	**0**	**1**	**2**	**-50.0**
	Male	2	67	0	32	10	3	53	11	178	6	5	189	201	-6.0
OPH	Female	0	13	1	1	2	0	13	1	31	2	0	33	34	-2.9
	Total	**2**	**80**	**1**	**33**	**12**	**3**	**66**	**12**	**209**	**8**	**5**	**222**	**235**	**-5.5**
	Male	**77**	**1559**	**25**	**927**	**393**	**88**	**1244**	**421**	**4734**	**724**	**311**	**5769**	**5667**	**1.8**
Total	**Female**	**10**	**204**	**4**	**111**	**57**	**10**	**208**	**51**	**655**	**104**	**42**	**801**	**751**	**6.7**
	Total	**87**	**1763**	**29**	**1038**	**450**	**98**	**1452**	**472**	**5389**	**828**	**353**	**6570**	**6418**	**2.4**

TABLE WFD.3 – Active RACS Fellows by location and age

Age group (years)		ACT	NSW	NT	QLD	SA	TAS	VIC	WA	AUS Total	NZ	O/S	Total 2017	Total 2016	% Change 16/17
	Male	2	50	1	20	11	2	51	7	144	32	12	188	190	-1.1
<35	Female	1	19	1	10	2	2	25	1	61	5	6	72	80	-10.0
	Total	**3**	**69**	**2**	**30**	**13**	**4**	**76**	**8**	**205**	**37**	**18**	**260**	**270**	**-3.7**
	Male	6	114	1	76	33	5	116	35	386	59	27	472	488	-3.3
35-39	Female	0	39	0	25	11	0	40	13	128	22	6	156	144	8.3
	Total	**6**	**153**	**1**	**101**	**44**	**5**	**156**	**48**	**514**	**81**	**33**	**628**	**632**	**-0.6**
	Male	9	243	3	163	58	9	201	73	759	83	40	882	886	-0.5
40-44	Female	3	55	1	30	12	1	39	11	152	28	13	193	180	7.2
	Total	**12**	**298**	**4**	**193**	**70**	**10**	**240**	**84**	**911**	**111**	**53**	**1075**	**1066**	**0.8**
	Male	19	234	5	169	64	16	179	87	773	115	34	922	869	6.1
45-49	Female	4	31	1	20	13	4	35	12	120	17	6	143	125	14.4
	Total	**23**	**265**	**6**	**189**	**77**	**20**	**214**	**99**	**893**	**132**	**40**	**1065**	**994**	**7.1**
	Male	10	206	6	130	49	8	150	50	609	110	29	748	745	0.4
50-54	Female	1	22	0	13	7	1	23	8	75	13	2	90	82	9.8
	Total	**11**	**228**	**6**	**143**	**56**	**9**	**173**	**58**	**684**	**123**	**31**	**838**	**827**	**1.3**
	Male	10	150	2	126	42	13	119	51	513	108	43	664	647	2.6
55-59	Female	1	14	0	8	6	0	20	4	53	12	7	72	72	0.0
	Total	**11**	**164**	**2**	**134**	**48**	**13**	**139**	**55**	**566**	**120**	**50**	**736**	**719**	**2.4**
	Male	10	139	3	77	38	13	101	56	437	95	39	571	537	6.3
60-64	Female	0	8	0	3	3	2	9	1	26	3	1	30	21	42.9
	Total	**10**	**147**	**3**	**80**	**41**	**15**	**110**	**57**	**463**	**98**	**40**	**601**	**558**	**7.7**
	Male	5	113	2	59	31	9	100	17	336	57	35	428	456	-6.1
65-69	Female	0	0	0	0	1	0	2	0	3	2	0	5	4	25.0
	Total	**5**	**113**	**2**	**59**	**32**	**9**	**102**	**17**	**339**	**59**	**35**	**433**	**460**	**-5.9**
	Male	4	242	2	75	57	10	174	34	598	59	47	704	646	9.0
70+	Female	0	3	0	1	0	0	2	0	6	0	1	7	9	-22.2
	Total	**4**	**245**	**2**	**76**	**57**	**10**	**176**	**34**	**604**	**59**	**48**	**711**	**655**	**8.5**
	Male	**75**	**1491**	**25**	**895**	**383**	**85**	**1191**	**410**	**4555**	**718**	**306**	**5579**	**5464**	**2.1**
Total	**Female**	**10**	**191**	**3**	**110**	**55**	**10**	**195**	**50**	**624**	**102**	**42**	**768**	**717**	**7.1**
	Total	**85**	**1682**	**28**	**1005**	**438**	**95**	**1386**	**460**	**5179**	**820**	**348**	**6347**	**6181**	**2.7**
								% of active Fellows under 55 years							
	Male	61.3	56.8	64.0	62.3	56.1	47.1	58.5	61.5	58.6	55.6	46.4	57.6	58.2	-1.0
%	Female	90.0	86.9	100.0	89.1	81.8	80.0	83.1	90.0	85.9	83.3	78.6	85.2	85.2	-0.1
	Total	**64.7**	**60.2**	**67.9**	**65.3**	**59.4**	**50.5**	**62.0**	**64.6**	**61.9**	**59.0**	**50.3**	**60.9**	**61.3**	**-0.6**

Note: Data excludes OB & GYN and OPH.

TABLE WFD.4 – Active Australian RACS Fellows by specialty and age

Age group (years)		CAR	GEN	NEU	ORT	OTO	PAE	PLA	URO	VAS	Total 2017	Total 2016	% Change 16/17
	Male	2	60	4	39	8	1	10	10	10	144	148	-2.7
<35	Female	0	33	0	4	7	3	3	8	3	61	62	-1.6
	Total	**2**	**93**	**4**	**43**	**15**	**4**	**13**	**18**	**13**	**205**	**210**	**-2.4**
	Male	10	121	12	121	32	2	26	46	16	386	410	-5.9
35-39	Female	3	67	4	9	19	3	10	9	4	128	120	6.7
	Total	**13**	**188**	**16**	**130**	**51**	**5**	**36**	**55**	**20**	**514**	**530**	**-3.0**
	Male	17	243	39	227	68	9	67	62	27	759	753	0.8
40-44	Female	2	70	6	15	17	4	18	13	7	152	146	4.1
	Total	**19**	**313**	**45**	**242**	**85**	**13**	**85**	**75**	**34**	**911**	**899**	**1.3**
	Male	33	204	48	230	72	10	67	77	32	773	729	6.0
45-49	Female	4	59	11	8	10	3	13	9	3	120	106	13.2
	Total	**37**	**263**	**59**	**238**	**82**	**13**	**80**	**86**	**35**	**893**	**835**	**6.9**
	Male	35	184	34	148	51	13	57	58	29	609	601	1.3
50-54	Female	1	27	8	10	8	4	9	6	2	75	67	11.9
	Total	**36**	**211**	**42**	**158**	**59**	**17**	**66**	**64**	**31**	**684**	**668**	**2.4**
	Male	25	141	24	175	33	7	49	45	14	513	491	4.5
55-59	Female	3	22	1	5	5	8	6	1	2	53	54	-1.9
	Total	**28**	**163**	**25**	**180**	**38**	**15**	**55**	**46**	**16**	**566**	**545**	**3.9**
	Male	22	138	19	122	42	11	30	37	16	437	416	5.0
60-64	Female	0	11	1	4	1	2	5	0	2	26	17	52.9
	Total	**22**	**149**	**20**	**126**	**43**	**13**	**35**	**37**	**18**	**463**	**433**	**6.9**
	Male	15	127	13	96	29	6	17	20	13	336	353	-4.8
65-69	Female	1	1	0	0	0	0	1	0	0	3	3	0.0
	Total	**16**	**128**	**13**	**96**	**29**	**6**	**18**	**20**	**13**	**339**	**356**	**-4.8**
	Male	17	229	24	135	68	6	57	37	25	598	557	7.4
70+	Female	0	2	1	0	0	1	2	0	0	6	8	-25.0
	Total	**17**	**231**	**25**	**135**	**68**	**7**	**59**	**37**	**25**	**604**	**565**	**6.9**
	Male	**176**	**1447**	**217**	**1293**	**403**	**65**	**380**	**392**	**182**	**4555**	**4458**	**2.2**
Total	**Female**	**14**	**292**	**32**	**55**	**67**	**28**	**67**	**46**	**23**	**624**	**583**	**7.0**
	Total	**190**	**1739**	**249**	**1348**	**470**	**93**	**447**	**438**	**205**	**5179**	**5041**	**2.7**
						% of active Fellows under 55 years							
	Male	55.1	56.1	63.1	59.2	57.3	53.8	59.7	64.5	62.6	58.6	59.2	-1.0
%	Female	71.4	87.7	90.6	83.6	91.0	60.7	79.1	97.8	82.6	85.9	85.9	0.0
	Total	**56.3**	**61.4**	**66.7**	**60.2**	**62.1**	**55.9**	**62.6**	**68.0**	**64.9**	**61.9**	**62.3**	**-0.7**

Note: Data excludes OB & GYN and OPH.

TABLE WFD.5 – Active New Zealand RACS Fellows by specialty and age

Age group (years)		CAR	GEN	NEU	ORT	OTO	PAE	PLA	URO	VAS	Total 2017	Total 2016	% Change 16/17
	Male	2	17	0	9	0	0	0	3	1	32	36	-11.1
<35	Female	0	3	0	1	1	0	0	0	0	5	11	-54.5
	Total	**2**	**20**	**0**	**10**	**1**	**0**	**0**	**3**	**1**	**37**	**47**	**-21.3**
	Male	2	22	0	20	5	0	2	7	1	59	53	11.3
35-39	Female	1	9	0	2	4	0	4	1	1	22	16	37.5
	Total	**3**	**31**	**0**	**22**	**9**	**0**	**6**	**8**	**2**	**81**	**69**	**17.4**
	Male	2	16	3	39	6	2	6	7	2	83	89	-6.7
40-44	Female	0	10	0	3	7	0	5	3	0	28	27	3.7
	Total	**2**	**26**	**3**	**42**	**13**	**2**	**11**	**10**	**2**	**111**	**116**	**-4.3**
	Male	4	34	4	43	9	1	12	6	2	115	112	2.7
45-49	Female	0	8	0	4	2	0	2	1	0	17	12	41.7
	Total	**4**	**42**	**4**	**47**	**11**	**1**	**14**	**7**	**2**	**132**	**124**	**6.5**
	Male	3	30	5	35	14	2	9	10	2	110	109	0.9
50-54	Female	1	7	0	1	1	0	1	2	0	13	12	8.3
	Total	**4**	**37**	**5**	**36**	**15**	**2**	**10**	**12**	**2**	**123**	**121**	**1.7**
	Male	4	29	2	39	10	5	8	7	4	108	111	-2.7
55-59	Female	1	4	1	3	1	2	0	0	0	12	12	0.0
	Total	**5**	**33**	**3**	**42**	**11**	**7**	**8**	**7**	**4**	**120**	**123**	**-2.4**
	Male	8	23	1	27	20	2	5	5	4	95	84	13.1
60-64	Female	0	0	0	1	1	0	1	0	0	3	3	0.0
	Total	**8**	**23**	**1**	**28**	**21**	**2**	**6**	**5**	**4**	**98**	**87**	**12.6**
	Male	3	22	3	18	4	0	3	4	0	57	61	-6.6
65-69	Female	0	0	0	0	1	1	0	0	0	2	1	100.0
	Total	**3**	**22**	**3**	**18**	**5**	**1**	**3**	**4**	**0**	**59**	**62**	**-4.8**
	Male	0	15	2	22	8	1	6	4	1	59	48	22.9
70+	Female	0	0	0	0	0	0	0	0	0	0	0	–
	Total	**0**	**15**	**2**	**22**	**8**	**1**	**6**	**4**	**1**	**59**	**48**	**22.9**
	Male	**28**	**208**	**20**	**252**	**76**	**13**	**51**	**53**	**17**	**718**	**703**	**2.1**
Total	**Female**	**3**	**41**	**1**	**15**	**18**	**3**	**13**	**7**	**1**	**102**	**94**	**8.5**
	Total	**31**	**249**	**21**	**267**	**94**	**16**	**64**	**60**	**18**	**820**	**797**	**2.9**
							% of active Fellows under 55 years						
	Male	46.4	57.2	60.0	57.9	44.7	38.5	56.9	62.3	47.1	55.6	56.8	-2.1
%	Female	66.7	90.2	0.0	73.3	83.3	0.0	92.3	100.0	100.0	83.3	83.0	0.4
	Total	**48.4**	**62.7**	**57.1**	**58.8**	**52.1**	**31.3**	**64.1**	**66.7**	**50.0**	**59.0**	**59.8**	**-1.4**

TABLE WFD.6 – Active Australian RACS Fellows by RRMA code and specialty

Speciality	M1	M2	R1	R2	R3	Rem1	Rem2	Total 2017	% In M1/M2 2017	Total 2016	% In M1/M2 2016	% Change in M1/M2 16/17
CAR	170	18	0	2	0	0	0	190	98.9	189	98.9	0.0
GEN	1225	164	171	137	37	4	1	1739	79.9	1684	80.0	-0.2
NEU	222	24	1	2	0	0	0	249	98.8	242	99.2	-0.4
ORT	998	130	125	82	12	1	0	1348	83.7	1313	83.7	0.0
OTO	362	45	44	15	4	0	0	470	86.6	460	86.1	0.6
PAE	79	12	2	0	0	0	0	93	97.8	95	97.9	-0.1
PLA	389	31	15	6	5	0	1	447	94.0	440	94.5	-0.6
URO	327	41	53	15	2	0	0	438	84.0	423	84.6	-0.7
VAS	161	25	15	4	0	0	0	205	90.7	195	90.8	-0.1
Total	**3933**	**490**	**426**	**263**	**60**	**5**	**2**	**5179**	**85.4**	**5041**	**85.6**	**-0.2**

Note: Data Excludes OB & GYN and OPH

TABLE WFD.7 – Active Australian RACS Fellows by RRMA and location

Region	M1	M2	R1	R2	R3	Rem1	Rem2	Total 2017	% In M1/M2 2017	Total 2016	% In M1/M2 2016	% Change in M1/M2 16/17
ACT	84	0	1	0	0	0	0	85	98.8	84	97.6	1.2
NSW	1205	199	134	109	33	0	2	1682	83.5	1652	84.0	-0.7
NT	4	24	0	0	0	0	0	28	100.0	27	96.2	4.0
QLD	564	199	182	54	3	3	0	1005	75.9	965	76.4	-0.6
SA	422	1	3	9	3	0	0	438	96.6	424	96.5	0.1
TAS	57	1	29	7	1	0	0	95	61.1	94	61.7	-1.0
VIC	1170	66	77	58	15	0	0	1386	89.2	1343	89.1	0.1
WA	427	0	0	26	5	2	0	460	92.8	452	92.3	0.6
Total	**3933**	**490**	**426**	**263**	**60**	**5**	**2**	**5179**	**85.4**	**5041**	**85.6**	**-0.2**

Note: Data Excludes OB & GYN and OPH

TABLE WFD.8 – Active Australian RACS Fellows by RRMA and age group

Age Group (years)	M1	M2	R1	R2	R3	Rem1	Rem2	Total 2017	% In M1/M2 2017	Total 2016	% In M1/M2 2016	% Change in M1/M2 16/17
<35	166	21	12	5	1	0	0	205	91.2	210	91.0	0.2
35-39	414	43	28	24	5	0	0	514	88.9	530	90.4	-1.6
40-44	713	88	75	30	5	0	0	911	87.9	899	89.2	-1.4
45-49	685	102	62	37	6	1	0	893	88.1	835	87.1	1.2
50-54	494	71	71	37	10	1	0	684	82.6	668	80.4	2.7
55-59	403	49	72	36	4	2	0	566	79.9	545	82.4	-3.1
60-64	348	40	37	31	5	1	1	463	83.8	433	81.3	3.1
65-69	235	29	37	32	6	0	0	339	77.9	356	79.5	-2.0
70+	475	47	32	31	18	0	1	604	86.4	565	87.3	-1.0
Total	**3933**	**490**	**426**	**263**	**60**	**5**	**2**	**5179**	**85.4**	**5041**	**85.6**	**-0.2**

Note: Data Excludes OB & GYN and OPH

TABLE WFD.9 – Active RACS SET Trainees obtaining RACS Fellowship in 2017 by location of residence and specialty

		ACT	NSW	NT	QLD	SA	TAS	VIC	WA	AUS Total	NZ	O/S	Total 2017
	Male	0	2	0	0	0	0	0	0	2	1	0	3
CAR	Female	0	0	0	0	0	0	0	0	0	0	0	0
	Total	**0**	**2**	**0**	**0**	**0**	**0**	**0**	**0**	**2**	**1**	**0**	**3**
	Male	1	16	1	5	4	0	15	2	44	9	1	54
GEN	Female	0	5	1	2	3	1	6	1	19	2	0	21
	Total	**1**	**21**	**2**	**7**	**7**	**1**	**21**	**3**	**63**	**11**	**1**	**75**
	Male	0	1	0	2	0	1	3	0	7	0	3	10
NEU	Female	0	1	0	0	0	0	0	0	1	0	0	1
	Total	**0**	**2**	**0**	**2**	**0**	**1**	**3**	**0**	**8**	**0**	**3**	**11**
	Male	0	15	0	7	3	1	10	4	40	6	2	48
ORT	Female	0	2	0	2	1	0	0	0	5	1	0	6
	Total	**0**	**17**	**0**	**9**	**4**	**1**	**10**	**4**	**45**	**7**	**2**	**54**
	Male	0	3	0	2	2	0	2	0	9	2	0	11
OTO	Female	0	1	0	2	0	0	2	0	5	1	0	6
	Total	**0**	**4**	**0**	**4**	**2**	**0**	**4**	**0**	**14**	**3**	**0**	**17**
	Male	0	0	0	0	0	0	0	0	0	0	1	1
PAE	Female	0	0	0	0	0	0	1	0	1	0	0	1
	Total	**0**	**0**	**0**	**0**	**0**	**0**	**1**	**0**	**1**	**0**	**1**	**2**
	Male	0	1	0	2	1	0	5	0	9	1	0	10
PLA	Female	0	1	0	0	1	0	1	0	3	1	2	6
	Total	**0**	**2**	**0**	**2**	**2**	**0**	**6**	**0**	**12**	**2**	**2**	**16**
	Male	0	2	0	5	0	1	3	0	11	2	2	15
URO	Female	0	1	0	0	0	0	2	0	3	0	0	3
	Total	**0**	**3**	**0**	**5**	**0**	**1**	**5**	**0**	**14**	**2**	**2**	**18**
	Male	0	2	0	1	1	0	1	0	5	0	1	6
VAS	Female	0	0	0	0	0	0	0	0	0	0	0	0
	Total	**0**	**2**	**0**	**1**	**1**	**0**	**1**	**0**	**5**	**0**	**1**	**6**
	Male	**1**	**42**	**1**	**24**	**11**	**3**	**39**	**6**	**127**	**21**	**10**	**158**
Total	**Female**	**0**	**11**	**1**	**6**	**5**	**1**	**12**	**1**	**37**	**5**	**2**	**44**
	Total	**1**	**53**	**2**	**30**	**16**	**4**	**51**	**7**	**164**	**26**	**12**	**202**

TABLE WFD.10 – Active International Medical Graduates obtaining RACS Fellowship in 2017 by location of residence and specialty

		ACT	NSW	NT	QLD	SA	TAS	VIC	WA	AUS Total	NZ	O/S	Total 2017
	Male	0	0	0	1	0	0	0	0	1	0	0	1
CAR	Female	0	0	0	0	0	0	0	0	0	0	0	0
	Total	**0**	**0**	**0**	**1**	**0**	**0**	**0**	**0**	**1**	**0**	**0**	**1**
	Male	0	1	1	4	2	0	3	1	12	1	1	14
GEN	Female	0	0	0	4	0	0	1	0	5	0	0	5
	Total	**0**	**1**	**1**	**8**	**2**	**0**	**4**	**1**	**17**	**1**	**1**	**19**
	Male	0	1	0	0	0	0	0	0	1	0	0	1
NEU	Female	0	0	0	0	0	0	0	0	0	0	0	0
	Total	**0**	**1**	**0**	**0**	**0**	**0**	**0**	**0**	**1**	**0**	**0**	**1**
	Male	0	1	0	3	0	0	2	0	6	0	0	6
ORT	Female	0	0	0	0	0	0	1	0	1	0	0	1
	Total	**0**	**1**	**0**	**3**	**0**	**0**	**3**	**0**	**7**	**0**	**0**	**7**
	Male	0	0	0	1	0	0	0	0	1	0	0	1
OTO	Female	0	0	0	0	1	0	0	0	1	0	0	1
	Total	**0**	**0**	**0**	**1**	**1**	**0**	**0**	**0**	**2**	**0**	**0**	**2**
	Male	0	0	0	1	0	0	1	0	2	0	1	3
PAE	Female	0	0	0	0	0	0	0	0	0	0	0	0
	Total	**0**	**0**	**0**	**1**	**0**	**0**	**1**	**0**	**2**	**0**	**1**	**3**
	Male	0	1	0	0	0	0	0	0	1	0	0	1
PLA	Female	0	0	0	0	1	0	0	0	1	0	0	1
	Total	**0**	**1**	**0**	**0**	**1**	**0**	**0**	**0**	**2**	**0**	**0**	**2**
	Male	0	0	0	0	0	1	1	0	2	0	0	2
URO	Female	0	0	0	0	0	0	0	0	0	0	0	0
	Total	**0**	**0**	**0**	**0**	**0**	**1**	**1**	**0**	**2**	**0**	**0**	**2**
	Male	0	0	0	1	1	0	0	0	2	0	0	2
VAS	Female	0	0	0	0	0	0	0	0	0	0	0	0
	Total	**0**	**0**	**0**	**1**	**1**	**0**	**0**	**0**	**2**	**0**	**0**	**2**
	Male	**0**	**4**	**1**	**11**	**3**	**1**	**7**	**1**	**28**	**1**	**2**	**31**
Total	**Female**	**0**	**0**	**0**	**4**	**2**	**0**	**2**	**0**	**8**	**0**	**0**	**8**
	Total	**0**	**4**	**1**	**15**	**5**	**1**	**9**	**1**	**36**	**1**	**2**	**39**

TABLE WFD.11 – Total number of SET Trainees and International Medical Graduates obtaining RACS Fellowship by specialty (2008 – 2017)

		2008	2009	2010	2011	2012	2013	2014	2015	2016	2017
	Male	10	6	5	11	5	15	4	7	10	4
CAR	Female	0	0	0	1	1	0	0	2	2	0
	Total	**10**	**6**	**5**	**12**	**6**	**15**	**4**	**9**	**12**	**4**
	Male	62	47	63	54	64	57	55	65	74	68
GEN	Female	14	23	13	12	30	17	20	25	33	26
	Total	**76**	**70**	**76**	**66**	**94**	**74**	**75**	**90**	**107**	**94**
	Male	14	7	12	6	9	5	6	18	9	11
NEU	Female	4	2	0	0	0	3	6	0	1	1
	Total	**18**	**9**	**12**	**6**	**9**	**8**	**12**	**18**	**10**	**12**
	Male	41	67	49	60	59	61	38	60	66	54
ORT	Female	2	3	2	8	2	4	3	4	3	7
	Total	**43**	**70**	**51**	**68**	**61**	**65**	**41**	**64**	**69**	**61**
	Male	9	12	16	21	12	15	14	14	13	12
OTO	Female	4	5	6	5	7	6	11	4	2	7
	Total	**13**	**17**	**22**	**26**	**19**	**21**	**25**	**18**	**15**	**19**
	Male	3	2	3	2	4	2	4	5	1	4
PAE	Female	0	1	1	3	2	1	4	1	3	1
	Total	**3**	**3**	**4**	**5**	**6**	**3**	**8**	**6**	**4**	**5**
	Male	19	7	7	18	22	14	13	11	15	11
PLA	Female	4	3	8	4	1	5	5	8	7	7
	Total	**23**	**10**	**15**	**22**	**23**	**19**	**18**	**19**	**22**	**18**
	Male	15	12	15	22	19	22	21	14	17	17
URO	Female	3	3	3	3	3	5	6	1	6	3
	Total	**18**	**15**	**18**	**25**	**22**	**27**	**27**	**15**	**23**	**20**
	Male	4	11	5	10	5	4	11	9	5	8
VAS	Female	1	1	0	2	2	2	4	1	2	0
	Total	**5**	**12**	**5**	**12**	**7**	**6**	**15**	**10**	**7**	**8**
	Male	**177**	**171**	**175**	**204**	**199**	**195**	**166**	**203**	**210**	**189**
Total	**Female**	**32**	**41**	**33**	**38**	**48**	**43**	**59**	**46**	**59**	**52**
	Total	**209**	**212**	**208**	**242**	**247**	**238**	**225**	**249**	**269**	**241**

FIGURE WFD.1 – Total annual number of SET Trainees and International Medical Graduates obtaining RACS Fellowship (2008–2017)

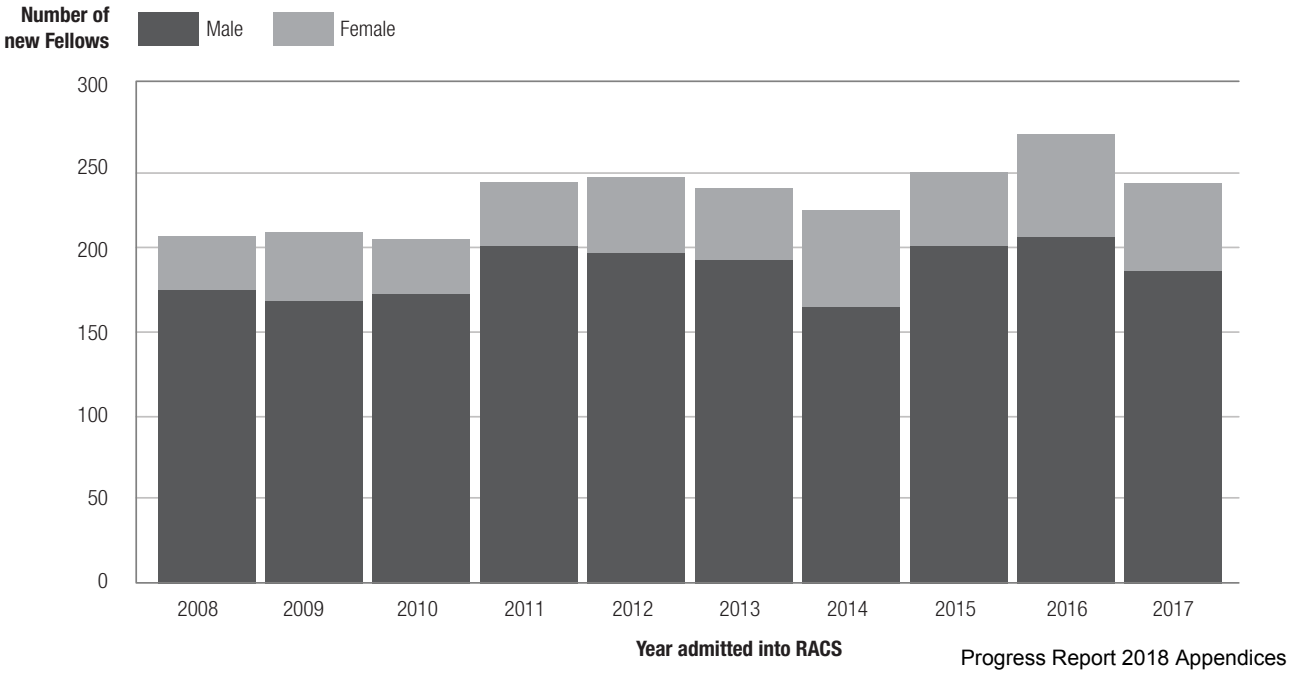


TABLE WFD.12 – Ratio of active Australian and New Zealand RACS Fellows per population by location

	No. of surgeons	Ratio of surgeons per 10,000 population	Population
ACT	85	2.1	410,301
NSW	1682	2.1	7,861,068
NT	28	1.1	246,105
QLD	1005	2.0	4,928,457
SA	438	2.5	1,723,548
TAS	95	1.8	520,877
VIC	1386	2.2	6,323,606
WA	460	1.8	2,580,354
AUS	**5179**	**2.1**	**24,598,900**
NZ	**820**	**1.7**	**4,785,100**

Data excludes Obstetrics & Gynaecology and Ophthalmology Fellows.

Population Source: Australian Bureau of Statistics website www.abs.gov.au and Statistics New Zealand website www.stats.govt.nz and is accurate as at December 2017.

TABLE WFD.13 – Ratio of active Australian and New Zealand RACS Fellows per population aged 65 years or older by location

	No. of surgeons	Ratio of surgeons per 1,000 population ≥ 65 years	Population over ≥ 65 years
ACT	82	1.6	51,183
NSW	1647	1.3	1,252,461
NT	28	1.6	17,807
QLD	991	1.3	741,868
SA	432	1.4	311,424
TAS	93	0.9	100,346
VIC	1363	1.4	959,072
WA	451	1.3	359,901
AUS	**5087**	**1.3**	**3,794,800**
NZ	**804**	**1.1**	**723,000**

Data excludes the surgical specialties of Paediatric surgery, Obstetrics & Gynaecology and Ophthalmology.

Population Source: Australian Bureau of Statistics website www.abs.gov.au and Statistics New Zealand website www.stats.govt.nz and is accurate as at December 2017.

EXPLANATORY NOTES

All active Fellows have a requirement to participate in either the College Continuing Professional Development (CPD) program or in another CPD program that is approved by the College as meeting its standards for CPD. CPD program data is submitted to RACS in the year following participation, therefore the latest available 2016 CPD participation data are reported in Tables CPD.1 to CPD.5. Ophthalmologists and obstetricians and gynaecologists who held RACS Fellowship have been included.

DATA SUMMARY

In 2016 there were 6,321 Fellows participating in the College CPD or other CPD approved program including Ophthalmologists and Obstetricians and Gynaecologists who hold a RACS Fellowship.

In 2016 99.6% of Fellows complied with the RACS CPD Program, representing a -0.3% reduction in compliance from 2015. Failure to comply constitutes a breach of the College's Code of Conduct and is managed via the RACS Sanctions Policy.

To facilitate the maintenance of surgical competence of Fellows, RACS provides professional development activities that are tailored to the specific needs of Fellows. These activities address the skills and knowledge required in each of the College's nine surgical competencies.

During 2017, the Professional Development Department delivered activities to a total of 3725 participants (3365 Fellows, 85 Trainees, 40 IMGs and 235 medical practitioners and health professionals), more than double compared to 2016. The increase is largely due to the delivery of 109 Foundation Skills for Surgical Educators (FSSE) courses as part of the RACS Building Respect, Improving Patient Safety Action Plan.

TABLE CPD.1 – Participation in RACS CPD program 2014 – 2016 by specialty

	2014			2015			2016		
Specialty	**Total required to participate**	**Total compliant**	**% compliant**	**Total required to participate**	**Total compliant**	**% compliant**	**Total required to participate**	**Total compliant**	**% compliant**
CAR	218	218	100.0	229	229	100.0	236	234	99.2
GEN	1903	1903	100.0	1943	1942	99.9	2019	2014	99.8
NEU	267	267	100.0	281	281	100.0	286	285	99.7
ORT	505	505	100.0	525	525	100.0	544	544	100.0
OTO	546	546	100.0	561	561	100.0	571	568	99.5
PAE	129	129	100.0	129	129	100.0	128	128	100.0
PLA	488	488	100.0	503	503	100.0	515	511	99.2
URO	475	475	100.0	483	483	100.0	498	497	99.8
VAS	207	207	100.0	214	214	100.0	222	219	98.6
Sub Total	**4738**	**4738**	**100.0**	**4868**	**4867**	**99.9**	**5019**	**5000**	**99.6**
OB & GYN and OPH	8	8	100.0	7	7	100.0	6	6	100.0
Total	**4746**	**4746**	**100.0**	**4875**	**4874**	**99.9**	**5025**	**5006**	**99.6**

TABLE CPD.2 – Participation in RACS CPD program 2014 – 2016 by region

	2014			2015			2016		
Specialty	**Total required to participate**	**Total compliant**	**% compliant**	**Total required to participate**	**Total compliant**	**% compliant**	**Total required to participate**	**Total compliant**	**% compliant**
ACT	62	62	100.0	62	62	100.0	67	67	100.0
NSW	1246	1246	100.0	1283	1283	100.0	1323	1316	99.5
NT	26	26	100.0	25	25	100.0	24	24	100.0
SA	330	330	100.0	343	343	100.0	350	349	99.7
QLD	748	748	100.0	768	768	100.0	801	799	99.8
TAS	76	76	100.0	77	77	100.0	76	76	100.0
VIC	1050	1050	100.0	1085	1084	99.9	1122	1115	99.4
WA	365	365	100.0	377	377	100.0	384	383	99.7
AUS Total	**3903**	**3903**	**100.0**	**4020**	**4019**	**99.9**	**4147**	**4129**	**99.6**
NZ	529	529	100.0	535	535	100.0	555	554	99.8
O/S	314	314	100.0	320	320	100.0	323	323	100.0
Total	**4746**	**4746**	**100.0**	**4875**	**4874**	**99.9**	**5025**	**5006**	**99.6**

All active Fellows have a requirement to participate in either the College CPD program or in another CPD program approved by the College as meeting its standards for CPD. In 2016 there were 6321 Fellows participating in the College CPD or other CPD approved program. Ophthalmologists and Obstetricians and Gynaecologists who held RACS Fellowship have been included.

TABLE CPD.3 – Fellow participation in RACS and other CPD programs in 2016

College CPD Programs	**Number of participating Fellows**	**% of participating Fellows**
Royal Australasian College of Surgeons	5025	79.5
Australian Orthopaedic Association	830	13.1
New Zealand Orthopaedic Association	235	3.7
Royal Australian College of General Practitioners	12	0.2
Royal Australian and New Zealand College of Ophthalmologists	213	3.4
Royal Australian and New Zealand College of Obstetricians and Gynaecologists	1	0.0
Other College CPD program	5	0.1
Total	**6321**	**100.0**

TABLE CPD.4 – Participation in RACS CPD program in 2016 by program category and specialty

	Fellows' specialty											
CPD category	**CAR**	**GEN**	**NEU**	**OPH**	**ORT**	**OTO**	**PAE**	**PLA**	**URO**	**VAS**	**Total**	**% Total**
Operative practice in hospitals or day surgery units	201	1790	252	5	507	511	121	477	471	206	4541	90.4
Operative procedures in rooms only	0	8	0	1	0	3	0	2	2	0	16	0.3
Operative Practice as a locum only	0	25	0	0	5	8	0	1	3	0	42	0.8
Clinical consulting practice only	5	52	22	0	20	36	1	15	6	5	162	3.2
Other practice type	30	144	11	0	12	13	6	20	17	11	264	5.3
Total	**236**	**2019**	**285**	**6**	**544**	**571**	**128**	**515**	**499**	**222**	**5025**	**100.0**

TABLE CPD.5 – Registrations in RACS MOPS program in 2016

	AUS	NZ	O/S	Total registrations
Persons	9	10	0	19
IMGs	2	65	1	68
Total	**11**	**75**	**1**	**87**

Note: The category 'Persons' are surgeons who do not have a FRACS and are not on a pathway to Fellowship

TABLE CPD.6 – Professional Development participation by location and status

Location	Fellow	SET Trainee	IMG	Medical practitioners and health workers	Total 2017	Total 2016	% Change 16/17
ACT	28	5	0	2	35	31	12.9
NSW	888	24	1	43	956	255	274.9
NT	19	1	0	0	20	24	-16.7
QLD	447	15	8	58	528	260	103.1
SA	208	5	1	12	226	98	130.6
TAS	70	0	0	3	73	20	265.0
VIC	887	20	2	82	991	316	213.6
WA	225	1	0	6	232	115	101.7
AUS	**2772**	**71**	**12**	**206**	**3061**	**1119**	**173.5**
NZ	577	14	28	20	639	187	241.7
O/S	16	0	0	9	25	23	8.7
Total	**3365**	**85**	**40**	**235**	**3725**	**1329**	**180.3**

TABLE CPD.7 – Professional Development participation by specialty and status

Specialty	Total 2017	Total 2016	% Change 16/17
CAR	99	58	70.7
GEN	1278	413	209.4
NEU	155	67	131.3
ORT	552	156	253.8
OTO	359	116	209.5
PAE	114	31	267.7
PLA	283	0*	–
URO	364	83	338.6
VAS	154	53	190.6
Sub Total	**3358**	**977**	**243.7**
OPH	7	4	75.0
SET	85	49	73.5
IMG	40	24	66.7
Medical practitioners and health workers	235	275	-14.5
Total	**3725**	**1329**	**180.3**

*Data unavailable at time of publication

EXPLANATORY NOTES

RACS Global Health programs encapsulate the College's on-going commitment in:

- partnering with Southeast Asia and Pacific neighbours to provide access to much needed health services and assist in the development of medical and surgical capacity; and
- advocating for access to safe surgery and anaesthesia within the global health agenda.

PACIFIC ISLANDS PROGRAM (PIP)

The Australian Government support to this initiative started in 1995 under a series of funding contracts with RACS as the managing contractor. The current iteration of PIP has activities contributing to a new overarching Pacific Regional Clinical Services and Workforce Improvement Program. The PIP is one of three components implemented under this regional program, and was the first to be contracted, with funding & activity implementation from 2016 to 2021. Other components will be managed by Fiji National University and the Secretariat of the Pacific Community. The new program design will continue the provision of specialist clinical services while also providing the platform for supporting continuing professional development of health workforce and improving clinical systems. The PIP activities are delivered by volunteer medical practitioners as well as nurses and allied health professionals.

The activities implemented throughout 2017 were at the specific request and/or in consultation with the recipient countries, including: Cook Islands, Fiji, Kiribati, Federated States of Micronesia, Nauru, Samoa, Solomon Islands, Tonga, Tuvalu, and Vanuatu.

AUSTRALIA TIMOR-LESTE PROGRAM OF ASSISTANCE FOR SECONDARY SERVICES PHASE II (ATLASS II)

The ATLASS II Program is designed to contribute to the Government of Timor-Leste's overall aim of producing a comprehensive, high quality health service for the benefit of the Timorese population. The program's main component is dedicated to building the capacity of the Timorese health workforce through a range of formal and informal training, mentoring and support activities. In 2014, the program commenced the delivery of a bridging/foundation program for East Timorese who completed their medical undergraduate qualification in Cuba. Upon completion of the Foundation Year, the trainees would either continue to pursue specialist post graduate training or mobilised for delivery of health services in the districts.

By the end of 2017, 60 Timorese doctors have completed the Foundation Year, of which 27 Timorese candidates have completed their Post Graduate Diploma program in Family Medicine, Paediatrics, Anaesthetics, Surgery or Ophthalmology, and 32 currently enrolled in the diploma program. Thirty new trainees are currently undertaking the Foundation Year training program. The Masters of Medicine in Paediatrics also continued in 2017 with 10 trainees enrolled, completing their final assessments in June or December 2017.

EAST TIMOR EYE PROGRAM (ETEP)

The East Timor Eye Program (ETEP), established in July 2000, is a program targeted at delivering eye-care services to Timor-Leste. The key objectives are to help Timor-Leste achieve self-sufficiency in the provision of eye care by 2020 and to work towards completely eradicating preventable blindness by 2025. The program will achieve this goal through training local surgeons and health practitioners and strengthening infrastructure, thereby considerably increasing the availability of eye health services in Timor-Leste.

The national eye care services are now delivered under the Department of Ophthalmology of Hospital Nasional Guido Valadares. In 2017, the ETEP continued to support the delivery of the Post Graduate Diploma of Ophthalmology in Timor Leste. Three candidates completed the diploma program, of which two have proceeded to commence in a Masters of Medicine in Ophthalmology program.

HEALTH SERVICES DEVELOPMENT PROGRAM IN PAPUA AND WEST PAPUA, INDONESIA

The Health Services Development Program aims to improve health services and workforce development through provision of medical education in Papua and West Papua. Health education priorities identified by in-country partners include appropriate trauma, burns and pain management, nurse training and clinical, anaesthesia and pathology services.

In 2017, the program supported the delivery of the Essential Pain Management and Emergency Management of Severe Burns courses. In collaboration with the College of Surgeons Indonesia, Basic Surgical Skills, nurse training and trauma training was also provided to health care practitioners, including many from the remote areas of the Papua and West Papua provinces.

SUMBA EYE PROGRAM (SEP), NUSA TENGARA TIMUR (NTT)

The Sumba Eye Program (SEP) was established in 2008 to provide eye care for the people of Sumba island, Nusa Tenggara Timur, Indonesia. Services comprise screening for eye diseases, eye operations as well as optometry. The SEP team has been concentrating on expanding the program's training and capacity building component to promote sustainability.

In 2017, the Australian team delivered two clinical and training visits in collaboration with Sumba Foundation and regional ophthalmologists. The team worked alongside and mentored two Sumbanese eye care nurses to create a self-sustainable local medical team for the Sumbanese and the greater area of Nusa Tenggara Timur. The nurses undertook a training visit to Melbourne in March 2017.

MYANMAR PROGRAMS

In partnership with the Myanmar Medical Association, Ministry of Health, and University of Medicine 1, RACS continues to support emergency medicine and primary trauma care (PTC) training in Myanmar. Building upon the success of the PTC program, the College worked closely with the Myanmar medical institutions, Australian College of Emergency Medicine and individual specialists from Hong Kong to develop and deliver a Post-Graduate Diploma in Emergency Medicine Course in Myanmar. In 2017, a team of four volunteer RACS instructors delivered 3 Surgical Skills training courses in Yangon and Mandalay in February and August. This was the fifth Surgical Skills Program delivered in Myanmar.

KIRIBATI EYE CLINIC SUPPORT PROJECT

The Kiribati Eye Clinic Support Project is an initiative jointly funded by the Australian Government through the Australian NGO Cooperation Program, and the RACS Foundation for Surgery. At the request of the i-Kiribati Ministry of Health and Medical Services, this short term project is designed to assist the i-Kiribati Ophthalmologist to establish a functional eye clinic at the main hospital in Kiribati, Tungaru Central Hospital.

The project was completed in 2017, with final equipment purchased and delivered to the clinic, and an Australian volunteer equipment technician mobilised to Kiribati to train local bio-med technicians on the service and maintenance of optic equipment. The project is designed to assist Kiribati realise the full potential of their trained Ophthalmologist and eye care nurses, to deliver eye care services independently, including reducing the incidence of vision impairment in the country.

ASIA PAEDIATRIC SURGERY EDUCATION PROGRAM (APSEP)

The APSEP is an initiative jointly funded by the Australian Government through the Australian NGO Cooperation Program, the Monash Children's Hospital International and the RACS Foundation for Surgery. The APSEP aims to support the education and development of Vietnamese, Cambodian and Myanmar surgeons through in-country teaching clinics delivered by volunteer visiting specialist teams and training attachments and attendance to courses in Australia or other appropriate locations. In 2017, one visit was undertaken by the APSEP team to Myanmar, focusing on paediatric burns and trauma training.

ANAESTHESIA TRAINING CENTRE SUPPORT PROJECT

The Anaesthesia Training Centre project is an initiative jointly funded by the Australian Government through the Australian NGO Cooperation Program, and the RACS Foundation for Surgery. This project seeks to enhance the quality and safety of anaesthesia training and hospital services by supporting the Solomon Islands Ministry of Health and Medical Services to enhance infrastructure and anaesthetic equipment in the National Referral Hospital in Honiara. The project will support the procurement of a laryngoscope and bronchoscope; alongside supporting the training and use of these pieces of equipment within Solomon Islands to strengthen in-country anaesthesia training.

ROWAN NICKS FELLOWSHIPS AND SCHOLARSHIPS

The Rowan Nicks fellowships and scholarships are offered annually to young surgeons who have been identified as surgical or medical leaders of the future. These opportunities are tenable in an institution where recipients will learn the craft of surgery and also become involved in teaching, research and administration.

WEARY DUNLOP BOONPONG EXCHANGE FELLOWSHIP

The Weary Dunlop Boonpong Fellowship Program is a collaboration between RACS and the Royal College of Surgeons of Thailand. The exchange program provides opportunities for Thai surgeons to undertake clinical attachments in Australian hospitals in their nominated field of interest.

SURGEONS INTERNATIONAL AWARD

The Surgeons International Award provides for doctors, nurses or other health professionals from underprivileged backgrounds to undertake short term visits to one or more Australian hospitals to acquire the knowledge, skills and contacts needed for the promotion of improved health services in the recipient's own country.

TABLE GH.1 – RACS Global Health clinical visits

Projects	No. of clinical visits	Surgeons	RACS Fellows	Anaesthetists, nurses & other health care workers	Consultations	Operations/ Procedures
PNG – Neurosurgery Visit	**1**	**1**	**1**	**–**	**18**	**2**
Timor Leste						
ATLASS II *	7	3	2	8	3,583	886
East Timor Eye Program (ETEP)*	25	23	5	12	10,486	945
SUB TOTAL (EAST TIMOR)	**32**	**26**	**7**	**20**	**14069**	**1831**
Indonesia						
Health Service Development – Papua & West Papua	1	2	2	4	8	5
Sumba Eye Program – Nusa Tengara Timur	2	3	2	7	1,920	126
SUB TOTAL (INDONESIA)	**3**	**5**	**4**	**11**	**1928**	**131**
Pacific Islands Projects (PIP)						
Cook Islands	1	–	–	1	70	14
Fiji	5	6	3	6	144	69
Kiribati	2	3	3	5	424	27
Federated States of Micronesia	2	2	2	4	170	23
Nauru	1	–	–	2	76	–
Samoa	3	5	5	9	184	89
Solomon Islands	6	5	5	14	349	118
Tonga	3	3	3	4	97	47
Tuvalu	1	–	–	2	242	–
Vanuatu	5	8	8	17	309	108
SUB TOTAL (PIP)	29	32	29	64	2065	495
TOTAL 2017	**65**	**64**	**41**	**95**	**18080**	**2459**

*ATLASS/ETEP consultations and operations/procedures statistics include output of East Timor-based long term advisers (General Surgeon, Anaesthetist, Paediatrician, Obstetrician/ Gynaecologist, Internal Medicine and Ophthalmologist). ETEP figures include outputs of Timorese clinicians supported under ETEP

TABLE GH.2 – RACS Global Health non-clinical visits

Country	Surgical workshops	Medical & allied health workshops	Nursing workshops	Other assisting programs	Total
ATLASS II	–	1	–	–	1
East Timor	1			1	2
Papua – Indonesia	1	7	3	5	16
Myanmar	8	–	–	–	8
Indonesia	–	–	–	2	2
Fiji	1	–	–	–	1
Nauru	1	–	–	–	1
Solomon Islands	–	1	–	–	1
Total 2017	**12**	**9**	**3**	**8**	**32**

TABLE GH.3 – International scholarships awarded to surgeons with hospital attachments in Australia, New Zealand or South East Asia

International Scholarships Programs	Country Location of Recipients:	No. of Surgeons Supported	No. Anaesthetists, nurses & other health care workers supported	No. Conferences/Courses Attended by Recipients
Rowan Nicks	UK	2	–	1
Surgeons International	Myanmar	1	–	–
	Vietnam	3	–	–
Weary Dunlop Boon Pong	Thailand	4	–	1
Myanmar Scholarship	Myanmar	1	–	1
TOTAL 2017		**11**	**–**	**3**

TABLE GH.4 – International travel and educational grants – support for conference attendance

Country Location of Recipients:	No. grants awarded
Tonga	1
Timor Leste	1
Nepal	1
Thailand	2
Bangladesh	1
China	2
Malaysia	1
Indonesia	3
TOTAL 2017	**12**

EXPLANATORY NOTES

The Conferences and Events Department is based in the External Affairs Division of the Royal Australasian College of Surgeons.

The Department manages surgical events on behalf of Fellows and medical professionals with a major annual event being the RACS Annual Scientific Congress. The 2017 Annual Scientific Congress (ASC) was held in Adelaide.

The Department strives to deliver conferences of high professional value, with strong perceptions of educative worth demonstrated through the positive feedback of RACS Fellows.

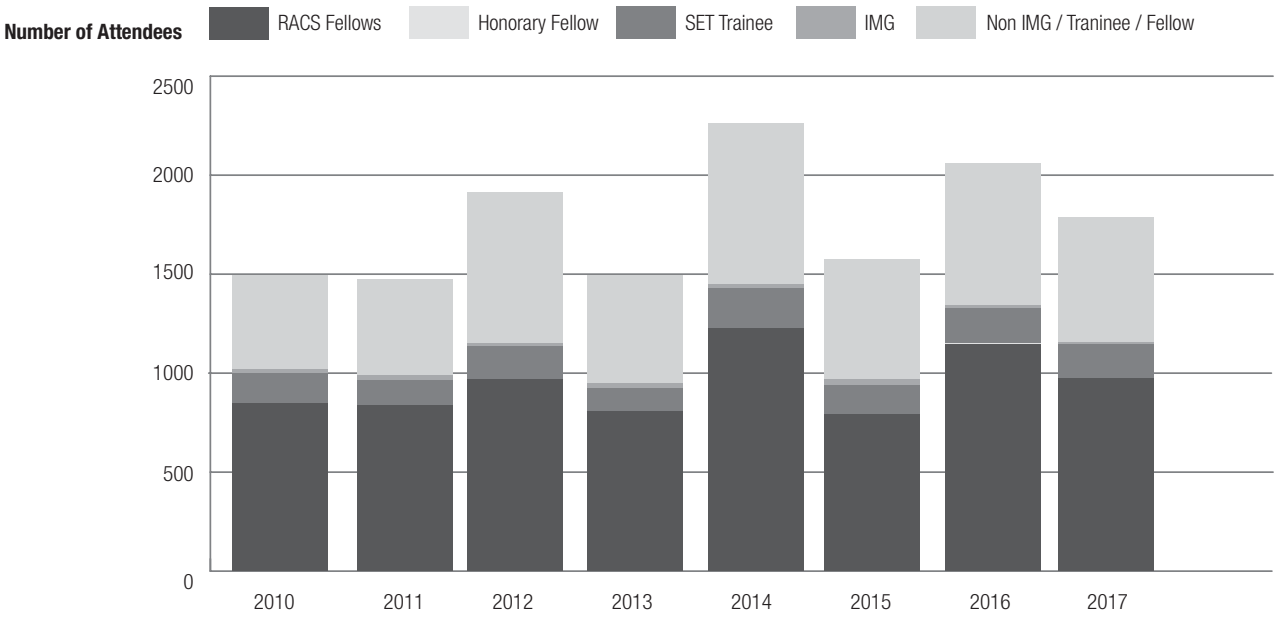
The Department tenders for several external events each year and also supports the RACS annual meetings held in New Zealand and Australian states and territories. In addition to the ASC, the Department successfully co-ordinated the following conferences and meetings in 2017:

- ASOHNS Annual Scientific Meeting
- Developing a Career in Academic Surgery (DCAS) Course
- New Zealand Surgery 2017 Meeting
- Queensland Annual State Meeting
- WA/SA/NT Annual Scientific Meeting
- NSA Annual Scientific Meeting
- ANZHNCS Annual Scientific Meeting
- ANZSVS Conference
- Victorian Annual Surgical Meeting
- WA Surgeons Ball – Registrations Only
- The Alfred General Surgery Meeting
- ACT Annual Scientific Meeting
- SA HoodSweeney 2017 Royal Colleges Golf Day – Registrations Only
- SA Annual Dinner and Anstey Giles Lecture – Registrations Only
- ANZSCTS Annual Scientific Meeting
- Combined Sydney Colorectal Meeting
- ICOSET

TABLE C&E.1 – RACS Annual Scientific Congress attendance 2017

Attendee classification	CAR	GEN	NEU	ORT	OTO	PAE	PLA	URO	VAS	Total 2017	Total 2016	% Change 16/17
RACS Fellow	32	685	20	70	29	51	28	17	41	973	1146	-15.1
Honorary Fellow	–	–	–	–	–	–	–	–	–	4	3	33.3
SET Trainee	27	116	1	1	5	13	2	2	1	168	178	-5.6
IMG	–	–	–	–	–	–	–	–	–	10	15	-33.3
NON IMG/Trainee/Fellow	–	–	–	–	–	–	–	–	–	631	717	-12.0
Total	**59**	**801**	**21**	**71**	**34**	**64**	**30**	**19**	**42**	**1786**	**2059**	**-13.3**

FIGURE C&E.1 – Total number of attendees at RACS Annual Scientific Congress (2010–2017)



EXPLANATORY NOTES

The RACS Skills & Education Centre's major function is to ensure that surgeons and other health professionals have access to the facilities and technical support required for training in modern surgical skills and related areas. The Centre provides a well-equipped and flexible skills laboratory and multi-purpose training and conference areas in which regular surgical educational courses are conducted for Trainees and Fellows of the College.

The Centre's key components are the Skills Laboratory, the Level 1 Lecture Room, the Level 2 Training Area, and the Hughes Room. The Skills Laboratory is a 'wet' workshop area, while the other rooms are meeting/conference areas.

The facilities are available for use on a seven day per week basis for RACS (internal) and outside organisations (external). The aim is to maximise use of the rooms by external hirers when not booked by RACS users. The Skills Centre facilities accommodated a total of 2,050 room bookings including 1,475 bookings for RACS staff, Fellows, and Trainees along with 575 room bookings for External events attended by over 20,000 people. College-wide, the Skills Centre and Event Services team dealt with 4,274 individual room bookings in 2017.

DATA SUMMARY

Skills Laboratory Workshops

Table SEC.1 shows the number of workshops and training events conducted in the Skills Laboratory in 2017. Workshops are separated into two categories: RACS workshops include those for Fellows and Trainees including mandatory courses such as ASSET, specialty training programs, and optional skills courses. External events include workshops conducted on behalf of other medical specialty Colleges and a range of other groups.

Workshops by Surgical Specialty

Figure SEC.1 provides a breakdown by specialty of the surgical educational workshops conducted for Fellows and Trainees. Note that a number of these fall into the External Workshops category shown in Table SEC.1. 'Not specialty specific' indicates that the workshop covered skills relevant to multiple surgical specialties, for example the ASSET fundamental skills workshop.

Skills Laboratory Usage

Figure SEC.2 shows the percentage of available days of the week when the Skills Laboratory is in use for internal and external workshops. This includes time when workshops are being conducted along with preparation, set-up, pack-down, cleaning and decontamination directly associated with those workshops.

Workshop Participants

Table SEC.2 shows the cumulative number of participants (including faculty) in Skills Laboratory workshops throughout 2017.

Surgical Workshop Participants by Specialty

Figure SEC.3 shows the cumulative number of participants from each surgical specialty who took part in Skills Laboratory workshops in 2017.

Total Workshop Participants by Profession

Figure SEC.4 provides a breakdown by profession of participants in all of the Skills Laboratory workshops in 2017. 'Other' covers a wide range of workshop attendees including simulation educators, medical postgraduates, intensivists, ophthalmologists, haematologists, anatomists, veterinarians, product specialists, etc.

TABLE SEC.1 – Number of workshops held in the Skills Laboratory in 2017

Attendee classification	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	Total 2017	Total 2016	% Change 16/17
RACS workshops	1	2	5	2	4	3	6	3	4	7	4	3	44	41	7
External workshops	0	2	14	3	2	4	1	3	8	5	5	2	49	49	0
Total	**1**	**4**	**19**	**5**	**6**	**7**	**7**	**6**	**12**	**12**	**9**	**5**	**93**	**90**	**3**

FIGURE SEC.1 – Surgical workshops held in the Skills Laboratory by specialty (either RACS or external workshop)

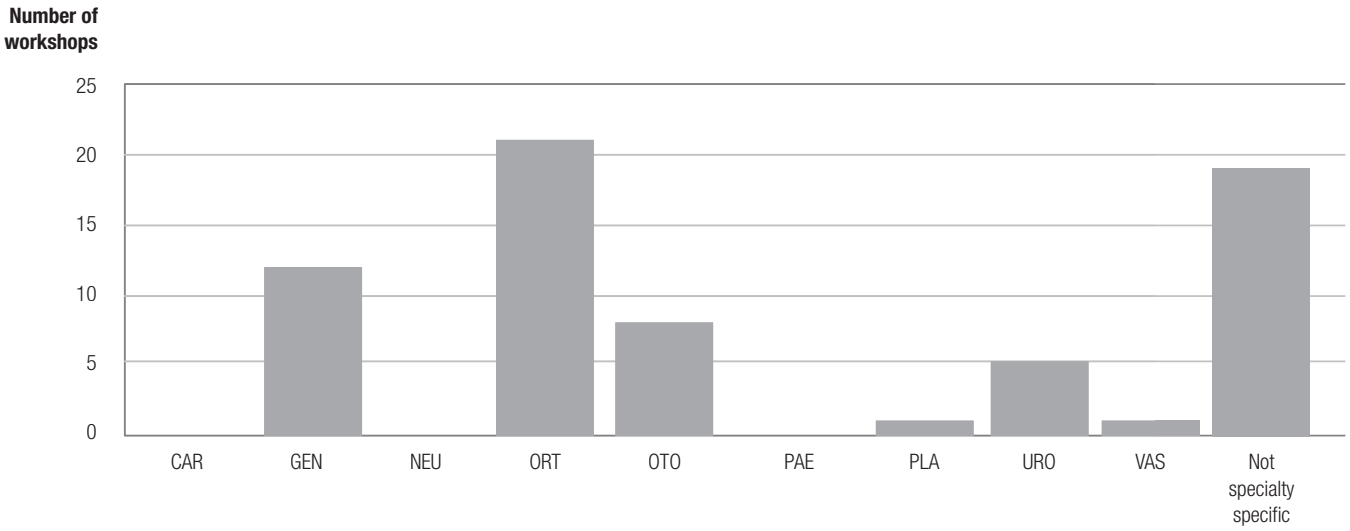
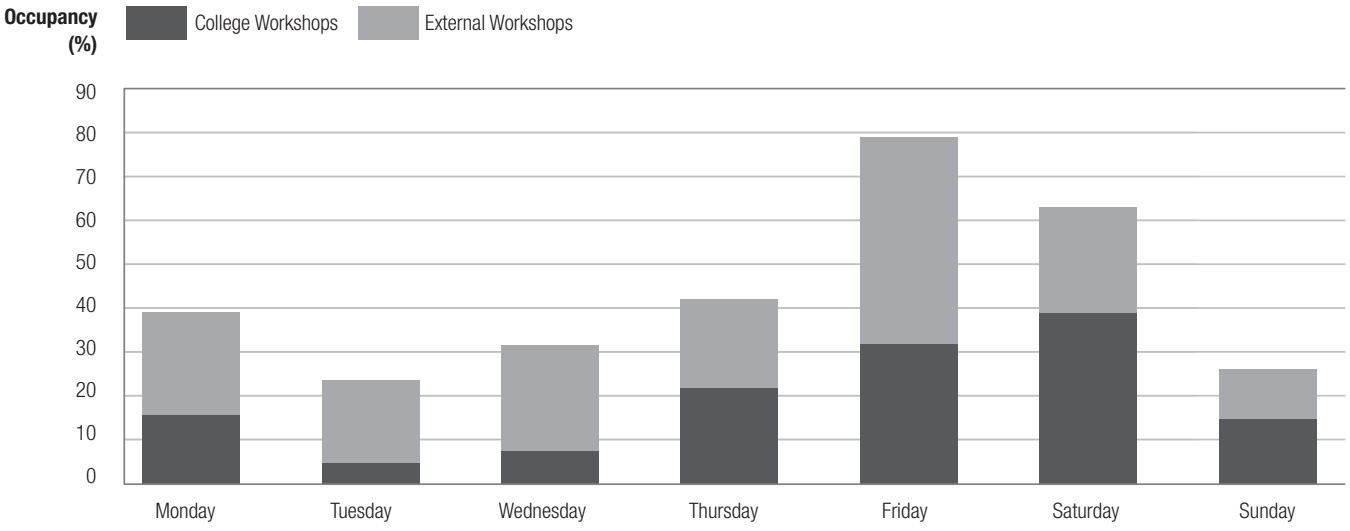


FIGURE SEC.2 – Occupancy of the Skills Laboratory on a seven-day basis in 2017



Note: Occupancy is measured by half-day blocks as a percentage of all available blocks for the year.

TABLE SEC.2 – Number of Skills Laboratory workshop participants in 2017

Attendee classification	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	Total 2017	Total 2016	% Change 16/17
RACS participants	22	70	83	87	140	85	171	126	106	181	58	48	1177	1153	2
External participants	0	62	222	75	38	69	44	28	93	117	164	22	934	1020	-8
Total	**22**	**132**	**305**	**162**	**178**	**154**	**215**	**154**	**199**	**298**	**222**	**70**	**2111**	**2173**	**-3**

FIGURE SEC.3 – Total number of Skills Laboratory surgical workshop participants in 2017 by specialty

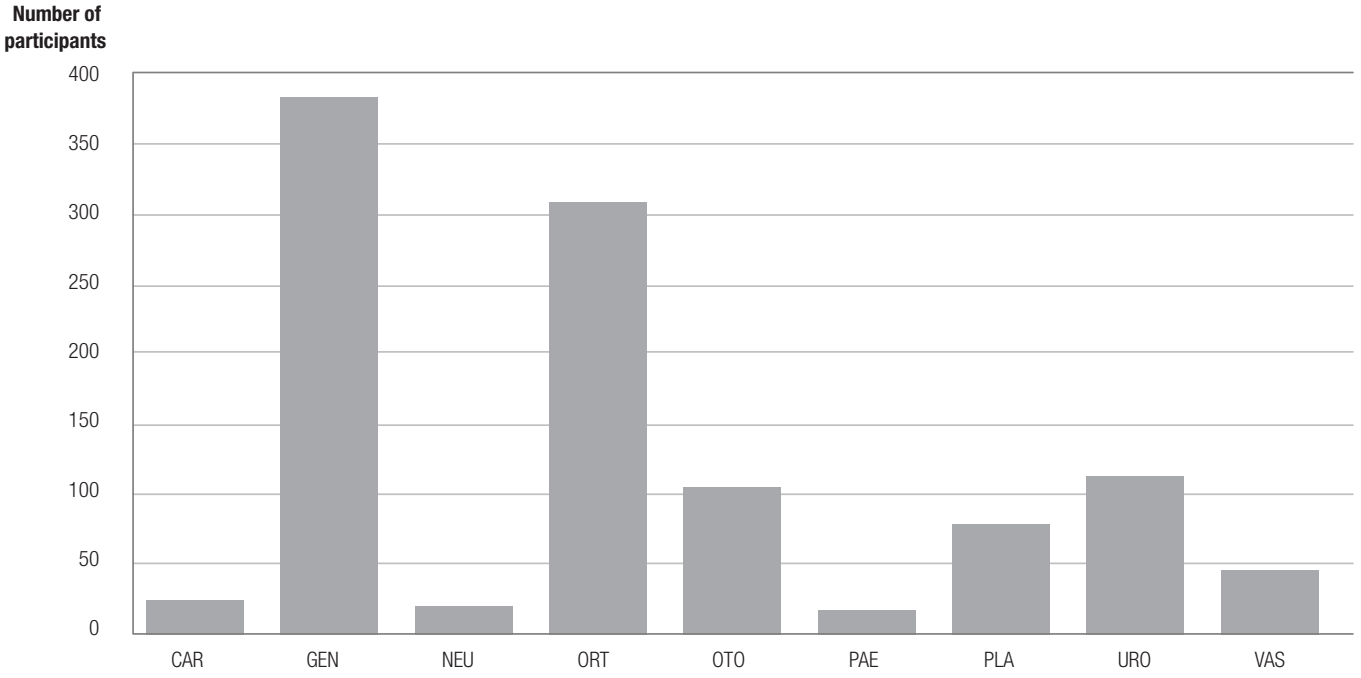
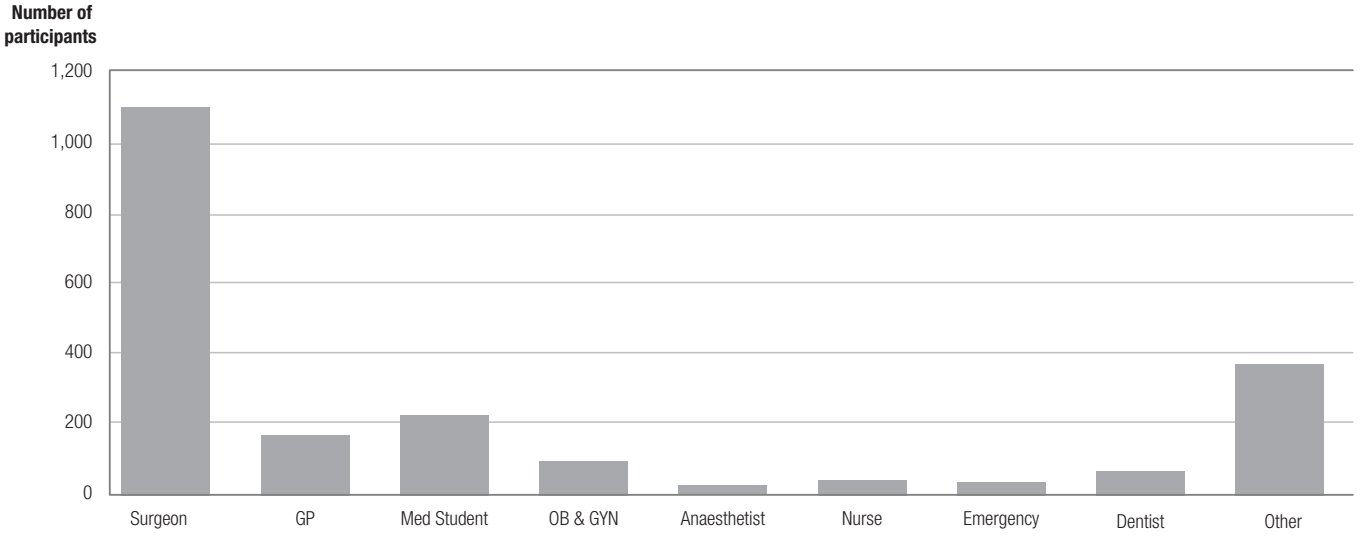


FIGURE SEC.4 – Total number of Skills Laboratory workshop participants in 2017 by profession



APPENDIX A:

DEFINITIONS FOR REGIONAL, RURAL AND RRMA DATA

RRMA Codes

The Rural, Remote and Metropolitan Area code (RRMA) is used to help classify healthcare facilities across Australia according to the types of communities they serve. The RRMA code divides Australia into areas according to city status, population, rurality and remoteness.

Use of Postcode to Determine Region

The allocation of Fellows to regions and RRMA classification is determined by the postcode from each Fellow's preferred mailing address as of December 2017. The last known mailing address was used if the current address was unknown.

Rural Remote and Metropolitan Areas Classification & Population Size

RRMA CODE	DEFINITION	POPULATION SIZE	EXAMPLES
M1	Capital cities	> 500,000	Sydney, Melbourne, Brisbane, Perth, Adelaide, Hobart, Darwin and Canberra
M2	Other metropolitan centres	100,000 – 499,999	Newcastle, Wollongong, Queanbeyan (part of Canberra-Queanbeyan), Geelong, Gold Coast-Tweed Heads, Townsville
R1	Large rural cities	25,000 – 99,999	Albury-Wodonga, Dubbo, Lismore, Orange, Port Macquarie, Tamworth, Wagga Wagga, (NSW); Ballarat, Bendigo, Shepparton-Mooroopna (VIC); Bundaberg, Cairns, Mackay, Maroochydore-Mooloolaba, Rockhampton, Toowoomba (QLD), Whyalla (SA); and Launceston (TAS)
R2	Small rural centres	10,000 – 24,999	Armidale, Mildura, Hervey Bay, Mount Gambier, Bunbury, Devonport
R3	Other rural centres	< 10,000	Cowra Shire, Temora Shire, Guyra Shire (NSW); Ararat Shire, Cobram Shire (Vic); Cardwell Shire, Whitsunday Shire (Qld); Barossa, Pinnaroo (SA); Moora Shire, York Shire (WA); George Town, Ross (TAS); Coomalie, Litchfield (NT)
Rem 1	Remote centres	25,000 – 99,999	Broome, Kalgoorlie/Boulder, Alice Springs
Rem 2	Other remote centres	10,000 – 24,999	Bourke, Orbost, Quilpie, Coober Pedy, Shark Bay, King Island, Gove

Source: Rural, Remote and Metropolitan Area (RRMA) classification developed by the Commonwealth Departments of Primary Industries and Energy and Health and Family Services (DPIE & DHFS 1994).).

APPENDIX 9

Standards for Supervision

Standards for Supervision

ROYAL AUSTRALASIAN
COLLEGE OF SURGEONS

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The SET program and supervision

The Royal Australasian College of Surgeons (RACS), is responsible for the delivery of the RACS Surgical Education and Training (SET) program, through its Specialty Training Boards (STBs) and in collaboration with Specialty Society partners. The STBs are responsible for the selection, assessment, supervision and management of surgical trainees in accredited hospital-based training posts, under the direction of appointed supervisors.

The SET program relies on the significant *pro bono* commitment of Fellows who undertake the supervisor role. Supervisors, who are RACS Fellows in the relevant specialty, offer their time and expertise to train the independent surgical consultants of the future and to ensure that the Australian and New Zealand communities receive healthcare at continuing world class standards.

RACS recognises the multiple responsibilities of surgeons as they provide patient care and manage clinical risks, in addition to delivering comprehensive training and supervision. Sharing knowledge and expertise with the next generation of surgeons is one of the most significant contributions an individual Fellow can make to the community and to the collegiality of RACS.

Supervisor, as a nomenclature, means the designated supervisor for the specialty for an accredited training post at the hospital. Other terms are sometimes used by STBs and are defined in individual STB training regulations.

Standards for supervisors

To assist supervisors in their roles in educating and assessing trainees for the relevant STBs, RACS has developed a set of standards. The standards outline the attributes, roles and responsibilities and effective teaching methods for supervisors, who model the integration of the RACS competencies into daily practice. Defined standards of educational practice for supervisors are necessary to improve and maintain high-quality surgical education and training.

The standards for supervisors are consistent with the accreditation standards of the Australian Medical Council (AMC) and the Medical Council of New Zealand (MCNZ) that govern specialist medical colleges.

The RACS Building Respect, Improving Patient Safety Action Plan[1] identifies the need for supervisors to be equipped with appropriate teaching, interpersonal and leadership skills in order to educate trainees. The standards provide a framework to clarify the expectations of the supervisory role and can be referenced as a guide to improve the quality of clinical teaching and learning[2].

The standards encompass the nine RACS competencies that are incorporated into the SET program. The 'Becoming a Competent and Proficient Surgeon: Training Standards for the Nine RACS Competencies'[3] provides guidance for supervisors, trainers and trainees to stage training in each of the competencies.

Supervisors as teachers and assessors

Supervisors of training are key personnel in guiding and supporting trainees in their workplace learning and in the assessment of that learning. The workplace is the richest environment for trainees to gain the knowledge, skills and behaviours required for practising clinicians[4]. Real life activities engage the trainee on a higher cognitive level and are the foundation of the SET program. Situated learning encourages the learning and consolidation of new skills, knowledge and behaviours. Interacting with role models and responding to feedback assists trainees to attain professional behaviours.

Work-based learning and assessment, as outlined in the RACS Work-based Assessment: A practical guide[5], facilitates the integration of multiple competencies. Relating the learning to different contexts encourages the trainee to review and reconnect their knowledge and skills. This strengthens long-term memory, information retention, retrieval and the transfer of learning.[6]

Supervisor responsibilities aligned to RACS competencies

The responsibilities at the core of clinical supervision and trainee support can be mapped to the RACS competencies.

Principal Responsibility	Collaboration and Teamwork	Communication	Health Advocacy	Judgement-Clinical decision Making	Management & Leadership	Medical Expertise	Professionalism & Ethics	Scholarship & Teaching	Technical Expertise
1. Demonstrates all RACS competencies with patients and all work healthcare workers	X	X	X	X	X	X	X	X	X
2. Undertakes trainee orientation	X	X			X		X	X	
3. Ensures trainees receive appropriate training, observation, assessment and feedback		X			X			X	
4. Leads in-training assessment	X	X		X	X	X	X	X	
5. Guides trainees' personal and professional development	X	X	X		X		X	X	
6. Liaises with the training board and/or regional subcommittee regarding their trainees' performance and wellbeing		X	X		X		X	X	
7. Provides feedback at scheduled performance reviews and when underperformance has been identified		X	X		X	X	X	X	
8. Coordinates, in liaison with the boards, the remediation process for a trainee with identified underperformance in rotations and/or assessment tasks, including the early and Fellowship examinations	X	X		X	X	X	X	X	

Supervisor role

Supervisors are crucial to meeting the community's need for safe and effective clinical care. Supervisors ensure safe medical practice while facilitating the learning of future surgeons.

The aim of supervision is to facilitate trainees to become competent surgeons who provide consistently safe and effective surgical care of the highest standard to the Australian and New Zealand communities.

Effective supervision enables trainees to develop their practice safely and in supportive environments that expedite the acquisition of knowledge, skills and professionalism. Supervision promotes a culture of continuous learning and professional development[7].

The RACS Surgical Supervisors[8] policy, in conjunction with the relevant specialty training program Training Regulations, details the full role and responsibilities of supervisors.

Supervisor attributes

The attributes of an effective supervisor include:

- Competent practitioner
- Reflective and emotionally intelligent
- Motivated to develop educational practice
- Consistently models high standards of professional behaviour
- Well organised
- Develops rapport with trainees
- Manages conflicts of interests
- Available and responsive
- Communicates and collaborates effectively
- Enthusiastic educator

Supervisor support

RACS and the STBs support supervisors by ensuring that supervisors develop the knowledge, skills and behaviours necessary for the role. This is achieved by ensuring that supervisors:

- are appropriately orientated and inducted to their role and responsibilities
- are informed of and are able to access relevant professional development activities; and
- have opportunities for feedback on their performance and opportunities to further develop their supervisory skills

Principal responsibilities of a surgical supervisor

Surgical supervisors, irrespective of specialty, will perform tasks aligned to eight principal responsibilities that are the core of clinical supervision and trainee support. The following table lists those responsibilities and related tasks that are reflective of an effective supervisor. Each responsibility can also be mapped to the RACS competencies.

Principal Responsibility	Related Tasks
1. Demonstrates all RACS competencies with patients and all healthcare workers	▪ Role models professional behaviour at all times ▪ Ensures patient safety ▪ Leads positive cultural change ▪ Ensures compliance with training accreditation standards
2. Undertakes trainee orientation	▪ Conducts or coordinates post/workplace induction (e.g. systems, protocols, OHS, HR) ▪ In conjunction with the trainee, develops learning goals and plans aligned to curriculum and trainee's level of performance ▪ Identifies and undertakes learning opportunities ▪ Empowers trainees to undertake self-directed learning
3. Ensures trainees receive appropriate training, observation, assessment and feedback	▪ Ensures that training and assessments are aligned to curricula and trainees' knowledge and skills ▪ Liaises with trainers regarding trainee learning goals and plans ▪ Directs trainees to learning opportunities and resources ▪ Observes trainees and provides regular, specific feedback to guide trainee performance
4. Leads in-training assessment	▪ Liaises with trainers to provide comprehensive mid-term formative assessments and end-of-term summative assessments. ▪ Modifies trainees' learning goals and plans where indicated. ▪ Complies with STB and RACS assessment and reporting requirements
5. Guides trainees' personal and professional development	▪ Is available for and provides confidential advice on trainees' concerns including career advice, wellbeing ▪ Encourages open communication with trainees ▪ Encourages trainees to establish work-life balance, e.g. by providing advice regarding flexible training options, career trajectories and leave. ▪ Facilitates trainees to reflect on decision-making and performance ▪ Advocates (with Board and employers) for trainee education and career opportunities

Principal Responsibility	Related Tasks
6. Liaises with the training board and/or regional subcommittee regarding their trainees' performance and wellbeing	▪ Informs board/regional committee regarding trainee performance ▪ Advocates for trainee wellbeing ▪ Alerts training board regarding trainee underperformance ▪ Identifies trainee stress, fatigue and underperformance, and acts to address these
7. Provides feedback at scheduled perfromance reviews and when underperformance has been identified	▪ Adopts effective methods for providing timely, constructive and respectful feedback to guide learning and performance ▪ Identifies trainee underperformance and communicates this appropriately ▪ Regularly documents examples of trainee performance ▪ Highlights and reinforces satisfactory performance
8. Coordinates, in liaision with the boards, the remediation process for a trainee with identified underperformance in rotations and/or assessment tasks, including the early and Fellowship examinations	▪ Helps trainee to identify areas for improvement ▪ Works with trainee to clarify agreed standards of performance ▪ Assists in developing specific strategies for supporting improvement in performance ▪ Regularly monitors trainee performance and wellbeing ▪ Complies with reporting requirements

RACS resources for supervisors

Publications

- RACS Becoming a Competent and Proficient Surgeon: Training standards for the Nine RACS Competencies, outlines the nine competencies and describes the stages of progress from a pre-vocational doctor to a competent clinician(3).
- RACS Surgical Competence and Performance: A guide to aid the assessment and development of surgeons. The framework provides a structured conceptual map of the learning outcomes of the SET program(s): description s of surgical performance as behaviours(9).
- RACS Work-based Assessment: A practical guide for building an assessment system around work(5).

Courses

- Foundation Skills for Surgical Educators – mandatory
- Operate with Respect - mandatory
- Surgical Teacher's Course - desirable
- Supervisors and Trainers for Surgical Education and Training (SATSET) (or module)
- Keeping Trainees on Track (KTOT) (or module)
- Clinical Decision Making
- Critical Literature Evaluation and Research (CLEAR)

Forums

- Academy of Surgical Educators Forum
- Academy Educator Studio Sessions - webinar

eLearning modules

- Let's Operate with Respect - mandatory
- Keeping Trainees on Track (KTOT)
- Supervisors and Trainers for Surgical Education and Training (SATSET)
- Trainees in Difficulty
- Standards of Performance
- Goal Setting
- Self-Assessment

RACS co-badged programs with the University of Melbourne

- Graduate Certificate in Surgical Education
- Graduate Diploma in Surgical Education
- Masters in Surgical Education

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References

1. Australasian College of Surgeons. Building Respect , Improving Patient Safety Action Plan [Internet]. 2015. Available from: http://www.surgeons.org/media/22260415/RACS-Action-Plan_Bullying-Harassment_F-Low-Res_FINAL.pdf
2. Standards Australia. Standards Development [Internet]. 2017. Available from: http://www.standards.org.au/StandardsDevelopment/What_is_a_Standard/Pages/default.aspx
3. Australasian College of Surgeons. Becoming a Competent and Proficient Surgeon : Training Standards for the Nine RACS Competencies [Internet]. Melbourne; 2012. Available from: http://www.surgeons.org/media/18726523/mnl_2012-02-24_training_standards_final_1.pdf
4. Health Education and Training Institute. The Learning Guide: A handbook for allied health professionals facilitating learning in the workplace [Internet]. Sydney; 2012. Available from: http://www.heti.nsw.gov.au/Global/HETI-Resources/allied-health/allied-health-learning-guide.pdf
5. Tri-Partite Alliance Royal College of Physicians and Surgeons of Canada Royal Australasian College of Physicians and the Royal Australasian College of Surgeons. Work-based Assessment: A practical guide. [Internet]. 2014 [cited 2017 Jan 23]. Available from: http://www.surgeons.org/media/20786937/bkt_tripartite_wba__march_7__2_.pdf
6. Gooding HC, Mann K, Armstrong E. Twelve tips for applying the science of learning to health professions education. Med Teach [Internet]. 2016;on-line(0):1–6. Available from: https://www.tandfonline.com/doi/full/10.1080/0142159X.2016.1231913
7. Health Education and Training Institute. The Superguide: A handbook for supervising allied health professionals [Internet]. Sydney; 2011. Available from: http://www.heti.nsw.gov.au/Global/HETI-Resources/allied-health/Superguide-May-2012.pdf
8. Royal Australasian College of Surgeons. Surgical Supervisor Policy [Internet]. Available from: http://www.surgeons.org/media/21856014/2016-10-14_pol_eta-set-013_surgical_supervisors.pdf
9. Australasian College of Surgeons, Royal Australasian College of Surgeons. Surgical Competence and Performance: A guide to aid the assessment and development of surgeons. [Internet]. 2011 [cited 2017 Jan 23]. Available from: http://www.surgeons.org/media/18955288/surgical_competence_and_performance_guide__2011_.pdf

APPENDIX 10

Specialty responses to AMC recommendations and conditions

Information provided by specialty training boards, pertaining to individual specialty training programs, is presented verbatim in this appendix.

Standard 1: The context of training and education

Areas covered by this standard: governance of the college; program management; reconsideration, review and appeals processes; educational expertise and exchange; educational resources; interaction with the health sector; continuous renewal.

Summary of college performance against Standard 1

In 2017, this set of standards was found to be Substantially Met.

Summary of significant developments

Standard 1 Recommendation for improvement

AA	Broaden the definition of conflict of interest to include reflection on an individual's demography, committee roles, public positions or research interests that may bias decision making in areas such as selection or specialist international medical graduate assessment. (Standard 1.1.6)

Significant developments per specialty

Cardiothoracic Surgery

Conflict of interest, either perceived or pecuniary, is declared at every Board meeting. Researchers during the training are required to declare any conflict of interest which must be approved by the Board and relevant research ethics committees.

Declaration of conflict of interest policy is already in place for the IMG interview. The interview comprises a specialty representative, a representative of the Board of SET and a jurisdictional representative.

There are already policies in place for SET trainees' selection and interviewers are asked to declare any conflict of interest prior to the interview. A formal process will be implemented prior to selecting interviewers in 2019. (for discussion at the June board meeting) The selection process is transparent in scoring each section of the curriculum vitae, work experience, academic records, research, interview performance and standardisation of the referee reports. The scoring is done by two board members and scores must be equally matched. Unmatched scores are referred to the Chair for further marking.

There is also a diversity and inclusion plan with no discrimination policy.

General Surgery – Australia

Conflicts of interests are declared at the beginning of each Committee of Board meeting. For selection, interviewers must declare a conflict if they have run a commercial-based interview preparation course.

General Surgery – New Zealand

Nothing specific for NZ – we believe our current reminder is sufficient.

Orthopaedic Surgery – Australia

The AOA Board has given consideration to the need to be aware of three types of conflict of interest: actual conflict, perceived conflict and potential conflict. It is acknowledged that conflicts exist however; it is how they are managed that is most important.

Members of the Board sign a Board Protocol statement and members of AOA major committees are required to sign a Committee Duties and Liabilities Protocol which covers conflicts of interest. At the commencement of each meeting, the opportunity to declare any conflicts is provided.

The AOA Code of Conduct also covers conflicts of interest.

The AOA Position Statement on Medical Industry, Addendum 2 defines conflict of interest as follows:

> …a conflict of interest occurs when a member or an immediate family member has, directly or indirectly, a financial interest or positional interest or other relationship with industry that could be perceived as influencing the member's obligation to act in the best interest of the patient.

A 'financial interest', 'financial arrangement', 'financial inducement' or 'financial support' includes, but is not limited to:

- Compensation from employment;
- Compensation from patient referral pattern;
- Paid consultancy, advisory board service, etc.;
- Share ownership or options;
- Intellectual property rights (patents, copyrights, trademarks, licensing agreements, and royalty arrangements);
- Paid expert opinion;
- Honoraria, speakers' fees;
- Gifts;
- Travel; and
- Meals and hospitality.

A 'positional interest' occurs when an orthopaedic surgeon or family member is an owner, officer, director, trustee, editorial board member, consultant, or employee of a company with which the orthopaedic surgeon has or is considering a transaction or arrangement.

As part of the selection interviewer appointment process, potential interviewers are asked to sign a declaration with regard to conflicts of interest. During interviewer training, attention is drawn to the appropriate process where a conflict may exist and potential sources of bias are discussed. Conflicted interviewers are asked to step out for the duration of the interview.

Otolaryngology Head and Neck Surgery

The Board of Otolaryngology includes a broad-based Conflict of Interest statement at all meetings. All board members must declare any conflict of interest at the commencement of any meeting, whether face-to-face, via telephone or webinar.

Paediatric Surgery

The Board of Paediatric Surgery has introduced the RACS Aboriginal and Torres Strait Islander Surgical Trainee Selection Initiative and an Academic Pathway into the Training Regulations.

The Paediatric Pathophysiology Examination is now a pre-requisite for Senior SET training and the Board has developed a separate syllabus for the exam.

Plastic and Reconstructive Surgery – Australia

RACS Policy exists.

Concern exists that smaller specialties like plastic surgery may become ineffective if the number of available and suitably skilled educators or governance professionals are restricted from participation on important matters due to broad definitions of "Conflict of Interest". The Board relies on RACS' legal counsel's advice

and existing frameworks such as the Natural Justice Position Paper when making decisions that affect trainees and IMGs.

Plastic and Reconstructive Surgery – New Zealand

The New Zealand Board of Plastic and Reconstructive Surgery (NZBPRS) looks to RACS for guidance on bias and conflicts of interest and how to mitigate this, as this issue has a unique feature with respect to the Board. Supervisors of Training compose the majority of board members, so have the dual responsibility of being a direct supervisor. This means most board members have selected, trained, handed over trainees to other training units, and, in some situations, performance-managed trainees. Plastic and Reconstructive Surgery in New Zealand is a small speciality with four training units in New Zealand and trainees rotate through most, if not all, of these units. Conflict of interest is a standing agenda item and is also raised when issues containing potential conflict are discussed.

Urology

No progress

Vascular Surgery

The Board of Vascular Surgery conducted a review of the program in 2015, and the revised regulations included management of underperforming trainees; the role of the Board in rating of assessments; role of supervisors; and review of required rotations of each trainee. The regulations are now reviewed annually and in 2017 the Board introduced flexible (part-time) training regulations, and is currently developing a minimum standard for selection in response to the introduction of RACS Aboriginal and Torres Strait Islander Surgical Trainee Selection Initiative.

Activity aligned with conditions

Condition 1	Review the relationships between Council, the Education Board, the Board of Surgical Education and Training and the Specialty Training Boards to ensure that the governance structure enables all training programs to meet RACS policies and AMC standards. (Standard 1.2) To be met by 2019

Progress reported by specialty

Cardiothoracic Surgery

Currently, we have an elected Councillor as a co-opted member of the Cardiothoracic Training Board who provides direct reporting from Council. The Chair of the Board also attends the three annual Board of Surgical Education and Training meetings. These are usually held on the day before the Cardiothoracic Board meeting. Important issues relevant to the Cardiothoracic training as well as RACS matters are reported to the Board at each Board meeting. A standard agenda item is dedicated for these matters. It is envisaged that the current organisational structure is maintained in the future to maintain direct communication and policies implementation.

Neurosurgery

Feedback is being provided to RACS to amalgamate the Board of Surgical Education and Training and the Education Board and refine the membership with the priority being the specialty training board chairs.

Orthopaedic Surgery – Australia

The Australian Orthopaedic Association (AOA) has provided feedback on its preferences for governance arrangements for RACS boards via correspondence dated 27 March 2018.

Orthopaedic Surgery – New Zealand

The New Zealand Orthopaedic Association (NZOA) has made significant progress in this area. We have completed a rigorous review of our governance structure and appeals process. Revised terms of reference have been developed and approved by the NZOA Council.

Otolaryngology Head and Neck Surgery

The Board has a strong relationship with RACS Council. The RACS Vice President, Dr Catherine Ferguson, is an Otolaryngology Head and Neck surgeon; Dr Ferguson made a presentation in this capacity to the ASOHNS Annual Scientific meeting in March 2018. A/Prof Chris Perry OAM, Immediate Past President of ASOHNS, is a specialty elected member of RACS Council and is a member of the OHNS Training Board.

Paediatric Surgery

The Board Chair, Paediatric Surgery Councillor and the President of the Australian and New Zealand Association of Paediatric Surgeons (ANZAPS) met with the RACS President John Batten and RACS CEO Mary Harney in February 2018, to discuss any concerns the Board and ANZAPS may have.

Concerns were raised about the current structure of the RACS complaints process. This was echoed at the February 2018 BSET meeting by other specialty board chairs.

The Board and ANZAPS look forward to keeping the path of communication open.

Plastic and Reconstructive Surgery – Australia

Discussions commenced with follow up:

- Senior Leader's Forum presentation by the Australian Board of Plastic and Reconstructive Surgery (ABPRS) Chair, November 2017.
- Australian Society of Plastic Surgeons (ASPS) and RACS leadership meeting January 2018.
- BSET February 2018 discussion

Plastic and Reconstructive Surgery – New Zealand

The NZPRS Board views this review to be a RACS led initiative. The Board Chair attends the Board of Surgical Education and Training meetings and feeds back to the Board via a standing item on the Board agenda. The Board has also been party to discussion with RACS via the Surgical Leaders' Forum, October 2017 and the RACS leadership meeting February 2018.

Urology

No progress – RACS management initiative required.

Vascular Surgery

Members of the Australian and New Zealand Society for Vascular Surgery (ANZSVS) Executive (including the Board Chairman) recently met with the RACS President John Batten, the RACS CEO Mary Harney, and other executive staff at the College. The Board Chair raised concerns about the current structure of the RACS complaints process and the ability of the College to deal with discrimination, bullying, and harassment complaints in contrast to the Board's process when a complaint has been received. This feeling was echoed at the most recent BSET meeting by other specialty Board Chairs. The Board is currently writing Vascular Surgery-specific hospital accreditation regulations that detail how the Board will manage complains of discrimination, bullying, and harassment.

During the meeting with the College, the Board Chair also expressed concern that the workload among supervisors is increasing and while the hospitals have been very receptive to the Operating with Respect

conversation, there needs to be a unified message from the College that the employers need to resource supervisors effectively. This issue was also discussed at the most recent BSET meeting.

The President of the ANZSVS highlighted the main issue from the Society's point of view is the Partnering Agreement and how it relates to professional development. The President and CEO were made aware of how scope of practice is defined by the Society, and the Society's aim to have this adopted by the College via the Australasian Vascular Audit by introducing it into a Vascular Surgery specific CPD program facilitated by RACS.

Activity aligned with conditions

Condition 2	RACS must develop and implement a stronger process for ongoing evaluation as to whether each of these programs remain consistent with the education and training policies of the College. (Standard 1.2) To be met by 2020

Progress reported by specialty

Cardiothoracic Surgery

The Chair plays a significant role in the BSET meeting and in co-ordinating important policies and issues recommended by AMC, College Council, BSET and the Cardiothoracic Training Board. There is direct communication between the Chair of BSET and the Cardiothoracic Training Board. Important issues with regard to training are then disseminated to all board members.

Neurosurgery

Nothing to report

Orthopaedic Surgery - Australia

AOA considers this may be achieved through the Service Agreement

Orthopaedic Surgery – New Zealand

NZOA has reviewed the new curriculum and selection process to ensure they map to the RACS competencies.

Otolaryngology Head and Neck Surgery

Otolaryngology Head and Neck Surgery participated in the SET Selection Workshop, held in April 2018.

Paediatric Surgery

No developments yet.

Plastic and Reconstructive Surgery – Australia

RACS responsibility.

Plastic and Reconstructive Surgery – New Zealand

The New Zealand Board of Plastic and Reconstructive Surgery (NZBPRS) took part in the RACS SET selection workshop on 14 April, 2018 to learn from and share selection information collaboratively and to improve our processes.

Urology

No progress – RACS initiative required.

Vascular Surgery

The Board will work with the College to

- introduce training processes in professional behaviour.
- embed professional standards in education and training with regard to cost effectiveness, safety, and quality.
- assess perioperative management in the SET program.
- introduce cultural competence training to the SET program.

The Board is currently working on introducing these concepts into the annual Vascular Surgery Trainee Skills Course.

Activity aligned with conditions

Condition 3	Develop a common policy that makes it explicit that all Specialty Training Boards must develop and implement defined reconsideration, review and appeals policies which clearly outline the processes for each of the three phases. (Standard 1.3) To be met by 2018

Progress reported by specialty

Cardiothoracic Surgery

There are already in place common policies. There is a process for reconsideration, appeal and other ongoing review policies. Any major issues and decisions regarding a trainee's performance are evaluated and discussed at the Board meeting. This allows natural justice and an appropriate appeals process is offered to the trainee. Implementation and monitoring of any new policies are reviewed by the Cardiothoracic Board and at EB/BSET.

General Surgery

General Surgery already has a review and grievance policy for trainees and also for hospital inspections.

Neurosurgery

The Board of Neurosurgery has a Regulation, which sets out the mechanism for reconsideration, review and appeal by trainees adversely affected by a decision relating to their training program. This has recently been refined. The process consists of three clearly defined phases as follows:

- reconsideration of the original decision (Reconsideration);
- review of the original decision and the Reconsideration decision (Review); and
- a formal appeals process (Appeal).

Trainees are engaged in the process and it is working very effectively.

Orthopaedic Surgery - Australia

AOA has a well-established Reconsideration, Review and Appeal Policy. A copy of this has been provided to RACS following receipt of the AMC Report. The Policy is currently under review with a view to refining the existing process.

Orthopaedic Surgery – New Zealand

The process has been defined, and will be included into NZOA regulations for 2019.

Otolaryngology Head and Neck Surgery

The Otolaryngology Head and Neck Surgery Training Regulations adhere to the RACS Reconsideration, Review and Appeal policy.

Paediatric Surgery

Once the policy has been developed by RACS, it will be incorporated into the Paediatric Surgery Training Regulations.

Plastic and Reconstructive Surgery - Australia

A draft Training Regulation has been prepared (January 2018) and will be considered by the Australian Board of Plastic and Reconstructive Surgery, pending decisions from the June 2018 BSET meeting. In July 2018, the ABPRS approved its Training Regulation *Reconsideration, Review Appeal*

Plastic and Reconstructive Surgery – New Zealand

The NZBPRS amended the NZ PRS Training Regulations in November 2017, which included clarification of the review process for consideration of dismissal from the training program. The 2019 Training Regulations will be updated to provide clarity on the process for reconsideration and review of decisions. The NZBPRS adopts the RACS appeals process.

Urology

No progress. Policy development is required by RACS, rather than the specialty training boards. Once the RACS policy has been defined and approved, the Board of Urology will develop specific reconsideration and review processes which will be incorporated into the SET Urology Training Regulations.

Vascular Surgery

RACS to provide further information.

Activity aligned with conditions

Condition 4	Provide evidence of effective implementation, monitoring and evaluation of the: (i) Reconciliation Action Plan (ii) Building Respect, Improving Patient Safety (BRIPS) Action Plan (iii) Diversity and Inclusion Plan. (Standard 1.6 and 1.7) To be met by 2021

Progress reported by specialty

Cardiothoracic Surgery

(i) and (ii) above, all Fellows are FSSE and OWR compliant. All trainees are OWR compliant

(iii) above, the Cardiothoracic Board has inclusion policies for Aboriginal and Torres Strait Islanders and Māori trainees. The Flexible Training policy is already in place with the MOU signed with 14 teaching hospitals across the country.

General Surgery – Australia

The Board in General Surgery (BiGS) has attempted to identify all trainers in Australia and has provided this information to RACS.

A process of ensuring trainers are kept up to date is being implemented to ensure BiGS knows when to follow up compliance. Compliance for supervisors and trainers has also been included in hospital accreditation applications and inspection reports.

Neurosurgery

The Board has appointed an external representative who commenced in March 2018. The Board has been very active in promoting the compulsory training and has a high compliance rate. The Board has also modified its Training Post Regulations to reflect the new supervisor requirements.

Orthopaedic Surgery – Australia

The AOA Board approved the RACS Diversity Plan 2018-2023 at a board meeting held on 21 April 2018

Orthopaedic Surgery – New Zealand

We have met the requirements of Condition 4 (ii). Progress on 4(i) and 4(iii) is being made.

Otolaryngology Head and Neck Surgery

The Otolaryngology Head and Neck Surgery Training Board has considered the action plans in formulating the new curriculum and in development of regulations.

Paediatric Surgery

RACS to provide further information.

Plastic and Reconstructive Surgery – Australia

Planned to commence consideration by the Board in early 2019

Plastic and Reconstructive Surgery – New Zealand

BRIPS: The NZBPRS reviews data provided by RACS on progress of completion of the mandatory courses as part of Building Respect, Improving Patient Safety (BRIPS) reporting at their Board meetings. Supervisors actively encourage trainers in their units to complete the mandatory courses.

Diversity and Inclusion Plan: The NZBPRS has initiated communication with NZAPS to implement an annual scholarship for medical students of Māori and Pacific Island descent to attend the NZAPS Annual scientific meeting (ASM). The NZBPRS is also communicating with hospital training units with regard to how they could implement flexible training within their units.

Urology

No progress

Vascular Surgery

RACS to provide further information. The Board of Vascular Surgery is developing regulations in relation to newly introduced RACS policy, and is actively following up Vascular Surgery membership to ensure adherence to the BRIPS Action Plan.

Standard 2: The outcomes of specialist training and education

Areas covered by this standard: educational purpose of the educational provider; and, program and graduate outcomes

Summary of college performance against Standard 2

In 2017, this set of standards was found to be Substantially Met.

Summary of significant developments

Standard 2 Recommendations for improvement

BB	*Benchmark the graduate outcomes of each of the surgical training programs internationally. (Standards 2.2 and 2.3)*
CC	Improve the uniformity of presentation of training program requirements and graduate outcomes for each of the surgical specialties (particularly on the website), taking into account feedback from trainees, supervisors and key stakeholder groups. (Standards 2.2 and 2.3)
DD	In conjunction with the Specialty Training Boards, review and report on the reasons for the pervasiveness of post- fellowship training and any potential impact on the appropriateness of the Surgical Education and Training (SET) program. (Standard 2.3)

Significant developments per specialty

Cardiothoracic Surgery

BB and CC: Standard 2.2, 2.3 - No significant developments

DD: There is significant development in devices technology in cardiology and cardiac surgery. Most new technology driven procedures at present are regarded as a post-Fellowship training both in Australia and overseas. It is unlikely that the current SET training will provide trainees with adequate exposure during their SET training.

The Board and the Australian and New Zealand Society of Cardiac and Thoracic Surgeons (ANZSCTS) is working closely with the Australian and New Zealand Cardiac Society (ANZCS) and both have developed a multidisciplinary approach to manage this group of patients to get the best outcomes. This allows the cardiologist and surgeon to work together as a cohesive team. Under the new guidelines developed by the two societies and approved by the Federal Health Department, there will be dual operators allowing a cardiac surgeon to perform percutaneous valve implant as the primary surgeon.

General Surgery – Australia

CC General Surgery will be moving to a five-year program and as part of the redevelopment graduate outcomes will be identified more clearly through EPAs and PBAs.

DD Fellowship posts and their impact on training are reviewed during quinquennial inspections. Hospitals with fellows are required to have a delegation of responsibilities to ensure trainees are obtaining the appropriate and required training.

General Surgery – New Zealand

Nothing specific

Orthopaedic Surgery - Australia

BB The AOA 21 Training Program has been benchmarked globally and is considered best educational practice.

DD The AOA 21 Training Program produces general orthopaedic surgeons. The curriculum outlines the required competencies across the breadth of the specialty. Surgical skills are categorised into three levels. On their first day of independent practice, all trainees graduating from the AOA 21 training program will be able to competently perform all procedures listed in level one. They will have been provided with the opportunity to observe, assist with or perform under supervision those procedures listed in level two. In addition, they will be able to discuss how procedures in level three would be performed.

Many trainees will have a special interest and choose to sub-specialise. This is achieved through completion of Fellowship roles. As a feature of the AOA 21 Training Program, trainees will have to option to apply to complete a Fellowship as part of their Transition to Practice stage of training.

In addition, it is recognised that it is valuable for surgeons to gain additional experience in an overseas context and that this may broaden and deepen the training experience.

Orthopaedic Surgery – New Zealand

We are developing a shared competency-based curriculum with the AOA

Otolaryngology Head and Neck Surgery

BB The Board of Otolaryngology Head and Neck Surgery is currently finalising an update to the SET OHNS curriculum. The new curriculum articulates the expected graduate outcomes of the SET OHNS program.

Plastic and Reconstructive Surgery - Australia

BB In progress and is largely complete. Development has been through integration of Entrustable Professional Activities (EPAs) and appropriate assessment tools into the articulated draft curriculum (draft completed December 2017, internal stakeholders' comments considered in June, wider consultation due before end 2018). EPAs were drafted in March 2018 at a workshop with Australian and NZ representatives. In September 2018, the draft EPAs and new assessment tools will be considered with the view to finalising them.

CC No response.

DD Post-Fellowship education and training (PFET) programs enable sub-specialisation to complement the breadth of knowledge, skills and attributes obtained during SET. Several post-Fellowship educating and training programs exist already (hand surgery and craniomaxillofacial surgery).

Plastic and Reconstructive Surgery – New Zealand

BB This will be a clear outcome of the finalised curriculum which is currently in the review process.

CC The finalised curriculum will be published and easily accessible to stakeholders.

DD Several subspecialties in PRS are appropriately entered by post-fellowship education and training (PFET) programs e.g. hand surgery, craniofacial surgery. Specialist societies oversee these with input from STBs and complement SET.

Urology

No significant developments – there is considerable work in progress which has been outlined in other sections of this report.

Activity aligned with conditions

Condition 5	Define how the College's educational purpose connects to its community responsibilities. (Standard 2.1) To be met by 2020

Progress reported by specialty

Cardiothoracic Surgery

In September 2017, College Council and the Board of Cardiothoracic Surgery had appointed an external Board member. It is expected that the external Board member will provide input regarding the community's expectation around surgical training.

Neurosurgery

RACS reporting on this.

Otolaryngology Head and Neck Surgery

The OHNS Training Board has a community representative who is a full board member and actively participates in discussions, representing the community.

Paediatric Surgery

To be confirmed by RACS

Plastic and Reconstructive Surgery – Australia

RACS responsibility

Plastic and Reconstructive Surgery – New Zealand

No progress.

Urology

No progress

Vascular Surgery

To be confirmed by RACS

Activity aligned with conditions

Condition 6	Broaden consultation with consumer, community, surgical and non-surgical medical, nursing and allied health stakeholders about the goals and objectives of surgical training, including a broad approach to external representation across the College. (Standard 2.1) To be met by 2021

Progress reported by specialty

Cardiothoracic Surgery

In addition to the above, the Board has a trainee representative who is considered as a full board member. All trainees have direct communication with him/her and a full report is provided by them at each board meeting.

In the course of hospital inspections for re accreditation or new facilities requesting accreditation for SET training, surgical and non-surgical medical, nursing and allied health personnel are interviewed as a broader consultation process.

There are no significant developments with broader non-surgical consultation with consumer, community, and allied health stakeholders at present.

General Surgery

BiGS has appointed an external representative and jurisdictional representatives are always invited to quinquennial inspections.

Neurosurgery

External representative commenced on the Board in March 2018.

Orthopaedic Surgery – Australia

AOA is in the process of recruiting an external representative to the Federal Training Committee (FTC). The FTC already has jurisdictional and trainee representatives as full voting members.

Orthopaedic Surgery – New Zealand

We have expanded our Training Board to include a cultural and consumer adviser.

Otolaryngology Head and Neck Surgery

The OHNS Training Board has a community representative who is a full board member and actively participates in discussions, representing the community.

Paediatric Surgery

To be confirmed by RACS. A community representative has been appointed to the Board of Paediatric Surgery and is a full member of the Board. The Community Representative is involved not only in board meetings, but various undertakings of the Board such as review of training regulations, and hospital inspections. In addition to this the Board of Paediatric Surgery has undertaken consultation with consumer groups regarding the perceptions of trainees, paediatric surgeons and the needs of patients (Bowel Group Kids).

Plastic and Reconstructive Surgery – Australia

The Australian Board of Plastic and Reconstructive Surgery welcomed the appointment of Adjunct Professor Claire Langdon onto the Board. Adjunct Professor Langdon is actively contributing to the governance work of the Board.

Plastic and Reconstructive Surgery – New Zealand

The NZBPRS welcomed the appointment of Mrs Susan Lloyd, the RACS External Representative onto the Board, and is actively engaging in recommendations made by Susan such as governance skills training for board members.

Urology

An external representative is now a voting member of the Board of Urology. She is an active contributor at board meetings and often provides a different perspective, which is very much appreciated and considered.

Vascular Surgery

To be confirmed by RACS. An external member has been appointed to the Board of Vascular Surgery and is now involved not only in board meetings, but various undertakings of the Board such as review of regulations, and hospital accreditation standards.

Activity aligned with conditions

Condition7	Clearly and uniformly articulate program and graduate outcomes (for all specialties) which are publicly available, reflect community needs and which map to the nine RACS competencies. (Standard 2.2 and 2.3) To be met by 2021

Progress reported by specialty

Cardiothoracic Surgery

Freely available on the RACS website.

General Surgery

General Surgery will be moving to a five-year program and as part of the redevelopment graduate outcomes will be identified more clearly through EPAs and PBAs.

Neurosurgery

Available on the website. No change to the previous report.

Orthopaedic Surgery – Australia

Outcomes for Orthopaedic Surgery have been defined within the AOA 21 curriculum

Orthopaedic Surgery – New Zealand

This is currently being done

Otolaryngology Head and Neck Surgery

See response to Recommendation BB, Standard 2, regarding curriculum. Outcomes are clearly defined in the new curriculum

Paediatric Surgery

The Training Regulations are publicly available on the RACS website. RACS to map community needs.

Plastic and Reconstructive Surgery – Australia

Graduate outcomes have been articulated during the 2017 development of a refreshed draft curriculum (completed December 2017). Stakeholder engagement commenced in February 2018 at the SET 1 conference followed by the SET 2-5 conference in March. SET conferences include Australian and New Zealand SET trainees and selection of IMGs under clinical supervision.

Publically available documentation can be synthesised by RACS in 2019 following the Au and NZ Boards' agreement to implement an approved curriculum. Uniformity and clarity of publicly available information can be considered at that time.

Plastic and Reconstructive Surgery – New Zealand

The PRS curriculum has been rewritten and is shortly going to be reviewed by stakeholders prior to implementation. A focus of the revision has been to make it clear to trainers and stakeholders what the expectations of the training programme are. We will continue to be involved in this review in 2018.

Urology

The Education Subcommittee of the Board of Urology is currently undertaking a comprehensive review of the Urology curriculum. Significant modifications will be made and the revised curriculum will more clearly define the expectations and abilities (including technical skills) possessed by graduates of the SET Urology training program.

Vascular Surgery

RACS to map community needs.

Standard 3: The specialist medical training and education framework

Areas covered by this standard: curriculum framework; curriculum content; continuum of training, education and practice, and curriculum structure.

Summary of college performance against Standard 3

In 2017, this set of standards was found to be Substantially Met.

Summary of significant developments

Recommendations for improvement

EE	Develop explicit criteria to consider whether training periods of less than the standard six months can be approved, and ensure that prior learning, time and competencies acquired in non-accredited training are fairly evaluated as to whether they may count towards training. (Standard 3.1)
FF	Make available to all trainees the learning modules under the Building Respect, Improving Patient Safety (BRIPS) program, once most or all College Fellows are trained. (Standard 3.2)

Significant developments per specialty

Cardiothoracic Surgery

EE The Board has approved and supports competency based rather than time based training.

The Board also supports recognition of prior learning.

FF Standard 3.2 MET

Supervisors and trainers are mandated to complete the FSSE, “Operating with Respect” and SAT SET training as part of the BRIPS program. All trainees are mandated to do “Operating with Respect“ online modules as well as other compulsory courses as stipulated in the training regulations.

General Surgery – Australia

EE General Surgery regulations allow for recognition of prior learning for trainees who have been on the training program previously. Various requirements must be met before this is awarded however the requirements can be met within the first year of training. General Surgery is also reviewing their flexible training options in regards to trainees who only complete 2-3 months of a term.

Also see GS response to condition 13.

General Surgery – New Zealand

EE Nothing specific to NZ beyond BiGS proposals in this matter

Orthopaedic Surgery – Australia

EE The AOA 21 Training Program is competency-based and no longer requires accreditation of training time. There are minimum and maximum time limits, however, these are simply calculated by time spent in training and are not hinged on performance. The AOA 21 Flexible Training Policy allows for recognition of prior learning

FF Trainees are actively encouraged to participate in AOA 21 workshops (including those deemed comparable to the FSSE). Completion of the suite of workshops is a requirement of the Transition to Practice stage of training.

Orthopaedic Surgery – New Zealand

We are developing a competency based curriculum with the AOA

Otolaryngology Head and Neck Surgery

The Board of Otolaryngology Head and Neck Surgery has recently updated the Training Regulations to include provision for trainees to undertake flexible training in accordance with RACS policy. Trainees may apply to undertake flexible training. OHNS allows periods of 3 months full-time or 6 months half-time to be accredited.

The overall time required to complete training will be considered on an individual basis according to the trainee's circumstances, reflective of assessment of competence.

Paediatric Surgery

In May 2017, the Board of Paediatric Surgery wrote to the CEOs of each hospital accredited by Paediatric Surgery to confirm that the Board is committed to supporting the trainees and eliminating any barriers to paid parental leave. The Board suggested that the hospitals include the following clauses in all contracts for Paediatric surgical trainees on the SET program:

For doctors employed as part of the RACS SET program in Paediatric Surgery:

Notwithstanding any provisions of the Award, a doctor who has completed 40 weeks of continuous service in an accredited Paediatric Surgery SET training post in any state, shall have that service recognised for the purposes of determining eligibility for paid parental leave.

In order to determine any parental entitlement, the Trainee's employment status will be deemed permanent. For the avoidance of doubt, this clause means that a trainee will be entitled to full parental entitlements under this contract even where the Trainee's period of employment ceases and would otherwise result in a lesser entitlement

The response rate was low; however, one trainee at John Hunter Hospital was eventually granted an out of award entitlement to paid parental leave, following this correspondence. The Board will continue to advocate for the trainees and will raise flexible training at every hospital inspection.

Plastic and Reconstructive Surgery – Australia

EE Completed in July 2017 following 18 months of board level discussion and consultations. RACS approved the changes to associated training regulations in November 2017. Explicit criteria are available in the published Training Regulations 'Assessment of Clinical Training' and 'Variations to Training', which is further explained in the 2018 edition of the Training Handbook.

Plastic and Reconstructive Surgery – New Zealand

No progress to date. Less than 6m accreditation of full time training periods is an Agenda item for consideration at a future board meeting in May and August. Once the curriculum review is finalised it will be appropriate to consider competency versus time based training.

Urology

There are already processes in place within the SET Program in Urology to recognise prior learning when determining the level of entry into the training program. Additionally, the Training Regulations clearly articulate the processes by which trainees can apply for and be granted recognition of prior learning for

experience acquired in non-accredited training. The Board has not yet considered the development of explicit criteria for consideration of training periods less than six months.

The Board of Urology actively supports the participation of all trainees in the learning modules under the BRIPS program once most or all College Fellows are trained. It is likely that these modules will be incorporated into the curriculum as compulsory components of training.

The Board has already mandated the completion of the FSSE by all SET6 (final year) trainees and a dedicated FSSE course for SET6 trainees was held in 2017 with another planned for 2018.

Vascular Surgery

The Board of Vascular Surgery has recently introduced flexible training into the program regulations and is currently assessing whether a trainee undertaking a period of part-time training may be able to achieve competency at the end of a term.

Activity aligned with conditions

Condition 8	Enhance and align the non-technical competencies across all surgical specialties, including a consideration of the broader patient context. (Standard 3.2) To be met by 2021

Progress reported by specialty

Cardiothoracic Surgery

Incorporated in the SET training, non-technical competencies are assessed in the 360o feedback, DOPS, and Supervisor's Term Evaluation Form (TEF) assessment. The selection interview questions also have quite extensive non-technical skill questions.

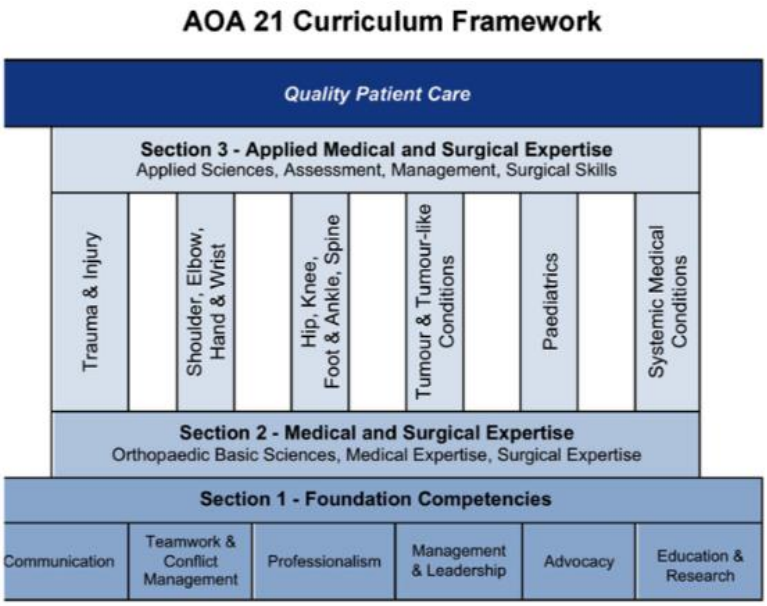
The Board is considering mandating the TIPS for SET training. The course concentrates on non-technical competencies which is a well-established course offered by RACS.

Neurosurgery

RACS reporting on this

Orthopaedic Surgery – Australia

AOA considers the non-technical competencies to be the foundation for quality patient care. As such, they are considered the foundation of the AOA 21 training program and are therefore referred to as 'Foundation Competencies'. This is graphically represented in the Curriculum Framework diagram.



The Introduction to Orthopaedics stage of training has a heavy focus on Foundation Competencies, which is then built on throughout training. Trainees will spend a minimum of 12 months in the Introduction to Orthopaedics stage. This phase of training is designed to facilitate the acquisition of basic orthopaedic surgical skills and foundation competencies of an orthopaedic consultant, from which trainees can develop further in the subsequent stages.

Orthopaedic Surgery – New Zealand

We are including non-technical competency based assessments in both selection and assessment of trainee performance. The introduction of the Feedback App will also encourage better assessment

Otolaryngology Head and Neck Surgery

Non-technical competencies form a significant part of PBAs. Trainees on performance management plans or learning action plans are required to undertake 360o evaluations. A board representative is scheduled to attend a TIPS course in 2018.

Otolaryngology Head and Neck Surgery

Non-technical competencies form a significant part of PBAs. Trainees on performance management plans or learning action plans are required to undertake 360^{o} evaluations. A board representative is scheduled to attend a TIPS course in 2018. OHNS NZ is including teaching on Non-Technical Skills for Surgeons (NOTSS) in each annual training week.

Paediatric Surgery

No development yet.

Plastic and Reconstructive Surgery – Australia

Update March 2018: Since December 2017, the refreshed draft curriculum articulates and aligns non-technical competencies for all topic areas within the curriculum. Associated assessment tools are planned for development throughout 2018 and for consultation in late 2018 and implementation in 2019.

Plastic and Reconstructive Surgery – New Zealand

The NZBPRS and ABPRS have been working during 2016 and 2017 on a comprehensive curriculum review including the non-technical competencies. This review will be continuing in 2018.

Urology

No progress – the Board believes this is something that RACS will need to facilitate.

Vascular Surgery

The Board is currently working to introduce the following concepts into the annual Vascular Trainee Skills course.

- Introduce training processes in professional behaviour.
- Embed professional standards in education and training with regard to cost effectiveness, safety, and quality.
- Assessing perioperative management in the SET program.
- Introducing cultural competence training to the SET program.

Last year the Board held a Foundation Skills for Surgical Educators during the Skills Course for SET 5 trainees and will continue to do this at the Skills Course.

Activity aligned with conditions

Condition 9	As it applies to the specialty training program, expand the curricula to ensure trainees contribute to the effectiveness and efficiency of the healthcare system, through knowledge and understanding of the issues associated with the delivery of safe, high-quality and cost-effective health care across a range of settings within the Australian and/or New Zealand health systems. (Standard 3.2.6) To be met by 2021

Progress reported by specialty

Cardiothoracic Surgery

Standard 3.2.6

Neurosurgery

No developments

Orthopaedic Surgery – Australia

These competencies are covered in the AOA 21 Curriculum under Leadership and Organisational Skills and Advocacy. Additional resources are to be developed for delivery through Bone School.

Orthopaedic Surgery – New Zealand

This is part of the curriculum review we are currently undertaking.

Otolaryngology Head and Neck Surgery

The curriculum review includes a process of understanding the ANZ healthcare systems.

Paediatric Surgery

No development yet.

Plastic and Reconstructive Surgery – Australia

Already implemented as per response to condition 8 above

Plastic and Reconstructive Surgery – New Zealand

No progress.

Urology

The current curriculum redevelopment project will incorporate and expand this aspect.

Vascular Surgery

Please see response to Condition 8 above.

Activity aligned with conditions

Condition10	Document the management of peri-operative medical conditions and complications in the curricula of all specialty training programs. (Standards 3.2.3, 3.2.4 and 3.2.6) To be met by 2021

Progress reported by specialty

Cardiothoracic Surgery

This is done in the trainees' three-monthly assessment in the form of log book, Mini-CEX and DOPs. The performance of the trainee must be discussed in an open disclosure fashion and subsequently recorded in the Term Evaluation Form. All these reports are scrutinised at board level. It is expected that the unit conducts a peer review, M and M quarterly. These quality activities will be scrutinised by the Board during the scheduled hospital inspection at 3–5 years for re-accreditation for SET.

There is no other significant development.

General Surgery

SEAM contains a peri-operative module that addresses this.

Neurosurgery

Already included in the curriculum.

Orthopaedic Surgery – Australia

The Surgical Expertise section of the AOA 21 Curriculum outlines competencies for pre-operative, intra-operative and post-operative care. Non-operative care is also covered under Medical Expertise.

Orthopaedic Surgery – New Zealand

This is part of the curriculum review we are currently undertaking.

Otolaryngology Head and Neck Surgery

Peri-operative management of medical conditions is now included as a topic in the updated SET OHNS curriculum.

Paediatric Surgery

Already implemented.

Plastic and Reconstructive Surgery – Australia

The updated curriculum (final draft December 2017) includes the management of peri-operative medical conditions, post-operative complications, and the management of the peri-operative patient more generally.

Plastic and Reconstructive Surgery – New Zealand

Included in curriculum review

Urology

This will be explicitly included in the revised curriculum, which is under development.

Vascular Surgery

Activity aligned with conditions

Condition 11	Include the specific health needs of Aboriginal and Torres Strait Islanders and/or Māori, along with cultural competence training, in the curricula of all specialty training programs. (Standard 3.2.10) To be met by 2021

Progress reported by specialty

Cardiothoracic Surgery

The Board has received approval for the inclusion of Aboriginal and Torres Strait Islanders into the SET training program provided they reach the minimum standards.

There is currently no cultural competence training in place.

Neurosurgery

Nothing to report.

Orthopaedic Surgery - Australia

Competencies around cultural competence are included in the AOA 21 Curriculum under Advocacy. AOA is currently reviewing the available cultural competence learning opportunities available. Discussions with the Australian Indigenous Doctors' Association (AIDA) have been initiated.

Orthopaedic Surgery – New Zealand

We are aware of this condition and acknowledge it is to be done.

Otolaryngology Head and Neck Surgery

The new SET OHNS curriculum includes the module: Aboriginal, Torres Strait Islander and Māori Health.

Paediatric Surgery

Need further information/guidance from RACS.

Plastic and Reconstructive Surgery - Australia

Completed December 2017: Section 3 ("Essential Surgical Competencies", a.k.a. non-technical competencies) of the draft curriculum (December 2017) include within the health advocacy section the requirement to improve the delivery of care to Indigenous populations via Aboriginal and Māori health care workers and support services.

Plastic and Reconstructive Surgery – New Zealand

The NZBPRS has encouraged, assisted and supported NZ PRS trainees to incorporate cultural awareness and competency into their annual NZ training weekend program. In 2018 the planned program includes Te Reo pronunciation (e.g. names) and the impact of surgical procedures common in PRS on cultural identity (e.g. amputation of a finger, mastectomy, burns, cleft lip and palate).

Urology

The RACS Indigenous modules have already been incorporated into the Urology training program. Further expansion will occur during the process of curriculum development.

Vascular Surgery

RACS broader guidelines will be required to meet this condition.

Activity aligned with conditions

Condition 12	Clearly and uniformly articulate program and graduate outcomes (for all specialties) which are publicly available, reflect community needs and which map to the nine RACS competencies. (Standard 2.2 and 2.3) To be met by 2021

Progress reported by specialty

Cardiothoracic Surgery

The competency-based, recognition of prior learning, and flexible training policies are in place.

General Surgery

The Board has approved a move to competency-based training which includes EPAs and PBAs together with an element of time. A detailed outline will be presented to RACS in June 2018.

Neurosurgery

Nothing to report.

Orthopaedic Surgery – Australia

AOA has adopted a modular entrustable professional activities (EPA) approach to progression through training. While the AOA 21 training program no longer considers accredited time, the stages of training have minimum and maximum completion timeframes.

Orthopaedic Surgery – New Zealand

We are working with the AOA to agree this.

Otolaryngology Head and Neck Surgery

The OHNS new curriculum identifies competence as: the ability to successfully meet complex demands through the integration and application of learned facts, skills and affective qualities needed to serve the patient, the community and the profession.

Whilst described separately, each of the nine RACS competencies is regarded as integrated – inter-dependent and equally important.

A competency-based curriculum is developed around stated objectives that can be observed and measured. It is characterised by:

- Standardization of learning outcomes
- Individualization of the learning process
- Integration of formal knowledge and clinical experience
- Learning is measured according to how well the learner performs in relation to competencies and standards
- Assessment is therefore criterion-referenced rather than in relation to other learners

The OHNS curriculum, implemented in 2018, delivers training in three stages: Novice, Intermediate and Competent. Behavioural markers describe standards of performance in each stage, assessed through a comprehensive program of work-based assessments: Mini-Clinical Evaluation Exercises (MiniCEX), Direct Observation of Procedural Skills (DOPS), Procedural Based Assessment (PBAs), Case-Based Discussions (CBDs), Mid-Term Assessments (MTAs) and End of Term Assessments (EOTAs).

Paediatric Surgery

RACS to confirm.

Plastic and Reconstructive Surgery – Australia

The refreshed Plastic Surgery curriculum (final draft December 2017) has introduced milestones for trainees and trainers to monitor progress through the training program, as well as articulating the level of competence to be achieved for each aspect of the training program. This will be paired with new assessment tools to allow for programmatic assessment throughout training.

Plastic and Reconstructive Surgery – New Zealand

This has been incorporated in the curriculum review project undertaken in conjunction with the ABPRS during 2016–2018 with the aim of implementation in 2019.

Urology

Assessment process under the curriculum in development will be based on a stricter determination of procedural competence, proposed at this early stage to utilise Ottowa scales as the basis for assessment of competence, with proficiency to be assessed by multiple assessors on several occasions before the trainee is determined as competent. Exact numbers of observed cases to achieve competence are yet to be defined.

Vascular Surgery

In the Vascular Surgery curriculum, work-based assessments are based on seven competencies. Performance standards are identified for each competency at each SET level.

Activity aligned with conditions

Condition 13	RACS has a policy that is applicable to all specialty training programs to remove the overt and hidden barriers to flexible forms of training. RACS must build on the existing policy and processes, and liaise with hospitals to implement flexible training. (Standard 3.4.3) To be met by 2018

Progress reported by specialty

Cardiothoracic Surgery

A Flexible Training policy in terms of parental leave, interruption and deferment of training is already in place and the Board will fully support and approve all applicants. The MOU on flexible training with the 14 teaching hospitals is currently in place.

General Surgery

The Board has submitted regulations that assist in recognising when trainees only partially complete a rotation due to illness, parental or carers' leave. This is in an attempt to recognise the training undertaken and to determine if it can be accredited towards the requirements. General Surgery has included a question on flexible training in the Hospital Accreditation Standards and Inspection Reports.

Neurosurgery

The Board has identified criteria for flexible training post accreditation and is in the process of contacting all accredited training units to see if any have posts, which would satisfy the requirements for accreditation. The main barrier to flexible training is the availability of posts.

Orthopaedic Surgery – Australia

AOA has a Flexible Training Policy. This is supported by requirements in the newly developed Accreditation Standards (to be rolled out in 2019) for training sites with 3 or more posts to make a part-time position available.

Given the competency-based progression structure of the AOA 21 training program, training part-time does not necessarily require an extension of training time provided competence is demonstrated.

AOA is actively working to increase diversity within the training program. Through our Diversity Strategy, AOA is working towards identifying and removing barriers to training for female junior doctors.

The Board approved Diversity Strategy 2018–2023 at its meeting on 21 April 2018.

Orthopaedic Surgery – New Zealand

NZOA fully supports this and is currently liaising with hospitals on this.

NZOA has recently listed those DHBs that can accommodate flexible training onto the NZOA website, this list is not an exhaustive list and will be added to as NZOA receives feedback.

Otolaryngology Head and Neck Surgery

The OHNS training board contacted regional training chairs regarding opportunities for flexible training and to identify potential posts that could be considered for flexible training. In 2017, three trainees requested and were granted part-time training positions. In 2018, all Victorian trainees were offered flexible training and all declined. NZ OHNS has an expectation that all posts have flexible options and this has been organised in a number of centres already. It is now part of the accreditation of existing and new posts.

Paediatric Surgery

Once the policy has been developed by RACS, it will be incorporated into the Paediatric Surgery Training Regulations.

RACS wrote to all hospitals in November 2017 to determine which hospitals can accommodate flexible training. Trainees will be notified of the hospitals that advised they can accommodate flexible training, particularly for future allocations. The Board agreed to write to each hospital with more than two SET posts to advise that if a centre has more than two SET posts, if feasible the centre must have a flexible training post.

The Board of Paediatric Surgery agreed that to help ensure that trainees are not disadvantaged financially; the Board agreed to allocate a trainee to a SET post for the entire year, even if they are aware the trainee may not be in that post for the entire year due to parental leave. Only if the trainee will be interrupted for the whole year, the Board will not allocate them to a SET post.

Plastic and Reconstructive Surgery – Australia

RACS to confirm policy. The Australian Board of Plastic and Reconstructive Surgery has already implemented a broad and enabling set of Training Regulations to accommodate flexible training requests. The Australian Society of Plastic and Reconstructive Surgery has surveyed all accredited hospitals on their ability to cope with requests for flexible training. As is already clear from employment law, institutions should already allow for flexible employment opportunities.

Plastic and Reconstructive Surgery – New Zealand

The NZ PRS Training Regulations specify conditions under which flexible training can occur and will be reviewed at the May and August 2018 board meetings. The Board is also engaging in communication with training units as to how the hospitals will be able to provide flexible training and assist in removing perceived barriers. This remains an active agenda item in 2018 for further review. Two trainees have applied for flexible training for 2019.

Urology

Whilst RACS is to develop the overarching policy, the Board of Urology is in the process of identifying suitable positions and establishing flexible training posts, with a trainee likely to commence flexible training in 2019. To date, the Board has received favourable responses from a number of hospitals across Australia.

Vascular Surgery

RACS broader guidelines will be required to meet this standard

Standard 4: Teaching and learning approach and methods

Summary of college performance against Standard 4

In 2017, this set of standards was found to be Met.

Summary of significant developments

Recommendation for improvement

GG	Consider options to mitigate the lack of training in some parts of Australia and New Zealand, such as in outpatient settings, endoscopy and aesthetic surgery. (Standard 4.2.1)

Significant developments per specialty

Cardiothoracic Surgery

Not relevant

General Surgery – Australia

GG Outpatients is an issue in NSW however, several hospitals have trainees seeing new patients through consultant rooms. Through the new PBAs endoscopy and colonoscopy, PBAs will be developed to combat issues with training in this area. General Surgery is also proposing a new accreditation standard for all new post applications whereby the new post must have access to outpatients, seeing both new and follow-up patients.

General Surgery – New Zealand

GG Options for increasing trainee access to endoscopy for General Surgery trainees remains a focus for the New Zealand Training Committee. At the Hospital accreditation visits in March 2017, several hospitals were noted to have the capacity to include more sessions for trainees but there lacked enthusiasm to change this. This is being followed up in 2018 with two hospitals where this was considered to be fairly easy to rectify within a short time span. The New Zealand Training Committee is also looking at basic endoscopy training skills which may lead to currently accredited hospitals being more willing to allow trainees access to endoscopy suites once completed.

Orthopaedic Surgery – Australia

GG AOA is actively working to address the lack of outpatient experience, in NSW in particular. In order to maintain accreditation, training sites are required to put alternative arrangements in place to ensure trainees have sufficient outpatient experience. For example, a training site may document an arrangement for trainees to go to a consultant's private rooms on a weekly basis.

The new accreditation standards (to be rolled out in 2019) are more streamlined and targeted. These standards, along with new monitoring processes, will ensure this requirement is met.

Orthopaedic Surgery – New Zealand

We currently achieve this.

Otolaryngology Head and Neck Surgery

No significant developments. OHNS insists on a comprehensive outpatient experience as part of hospital accreditation.

Paediatric Surgery

No significant developments.

The training program is bi-national and trainees are expected to spend a minimum period of twelve months in at least two training regions in Mid and Senior SET training.

The Board of Paediatric Surgery believes that diversity of training experience is acquired by spending time in a number of training centres. This facilitates exposure to the full scope Paediatric Surgery practice, and the breadth of training experiences.

Plastic and Reconstructive Surgery – Australia

The Commonwealth Government's Specialist Training Program (STP) was identified by the Board as an ideal mechanism for expanding SET opportunities into non-traditional settings (private hospitals and practice locations). In 2017, the specialty was informed that the government would cease funding for Plastic and Reconstructive Surgery. Following strong advocacy, funding was confirmed in late October 2017 for five hospitals (one being subject to an approved accreditation status). The major challenge for the specialty is changing the perceptions of aesthetic surgery and balancing those with the political pressures, which force public hospitals to limit exposure to aesthetic components of Plastic and Reconstructive surgical procedures.

Alternative funding models are being investigated, noting that these are institution-driven initiatives. The Board collaborates with the Australian Society of Plastic and Reconstructive Surgery Council to communicate the gap in training opportunities within the Australian Society of Plastic and Reconstructive Surgery membership. Advocacy with the subspecialty aesthetic association (February 2018) has led to greater transparency of appropriate conferences and activities for SET trainees to attend and augment their aesthetic training.

A deeper analysis of accredited SET PRS hospitals revealed three additional private hospitals involved in SET training that were not previously reported to RACS for its AMC reports. This brings the total to eight private / aesthetic training positions, of which four are STP posts and four are private hospitals.

Plastic and Reconstructive Surgery – New Zealand

The NZBPRS recognises the importance of aesthetic surgery within PRS and recommends trainees attend a minimum of 1 full day (2 sessions) per month. We continue to monitor access to this as it is an area of the Curriculum that we are concerned has the potential to be affected as exposure is dependent on access to private hospitals.

Urology

No progress

Vascular Surgery

No significant developments

The training program is bi-national and trainees are expected to spend at least one year in an interstate or overseas post. The concept is that trainees will be exposed to a variety of settings that may vary from state to state.

Activity aligned with conditions

Condition 14	For all specialty training programs, develop curriculum maps to show the alignment of learning activities and compulsory requirements with the outcomes at each stage of training and with the graduate outcomes. This could be undertaken in conjunction with the curricular reviews that are currently planned or underway. (Standard 4.1.1) To be met by 2021

Progress reported by specialty

Cardiothoracic Surgery

There is currently in place a comprehensive curriculum map for SET 1 to SET 6 trainees. All the compulsory activities are recorded in a spreadsheet and trainees are reminded of their progress. Supervisors are encouraged to report under-performing trainees and any trainees in question are discussed at board meetings (held three times per year). The trainee (and the unit supervisor) also submit a longitudinal mapping of their progress.

General Surgery

Will be undertaken as part of next curriculum review in line with the change in the training program to a five-year competency- and time-based program

Neurosurgery

Nothing new to report.

Orthopaedic Surgery – Australia

As part of the AOA 21 program, AOA has a framework which outlines expectations of performance for each stage of training. Learning opportunities have been broadly mapped to the curriculum competencies.

Orthopaedic Surgery – New Zealand

We have completed this. This is also part of the current curriculum review with the AOA.

Otolaryngology Head and Neck Surgery

This is an integral part of the new curriculum.

Paediatric Surgery

To be undertaken with our curriculum review.

Plastic and Reconstructive Surgery - Australia

Not yet occurred. To be advised.

Plastic and Reconstructive Surgery – New Zealand

This will be part of the curriculum review currently in process.

Urology

The new curriculum in formulation will have clearly-defined levels of progression with the required standards for the trainees documented to ensure consistency of educational goals and assessment.

Vascular Surgery

In progress.

Standard 5: Assessment of learning

Areas covered by this standard: assessment approach; assessment methods; performance feedback; assessment quality

Summary of college performance against Standard 5

In 2017, this set of standards was found to be Substantially Met.

Summary of significant developments

Recommendations for improvement

HH	Review the compulsory General Surgical Science Examination requirement in terms of usefulness, preparation time and financial burden for those who are not selected for entry into surgical training. (Standard 5.2.1)
II	Review whether the Clinical Examination remains an essential assessment task, given that the 2016 Review of Assessment Report notes its poor reliability and trainee feedback questions its validity. (Standard 5.2.1)
JJ	For all surgical specialties, adopt behaviour-related reporting (i.e. descriptive of the key features) rather than simple scoring for all work-based assessments. (Standard 5.2.3)
KK	Explore the use of multi-source feedback for all surgical training programs at set points throughout training. (Standard 5.3.1)
LL	Review whether the term 'essay-type' is appropriately used in all its current contexts. Where essay-type questions are used, consideration should be given as to whether they could be replaced with short-answer type questions. (Standard 5.4.1)

Significant developments per specialty

Cardiothoracic Surgery

HH Successful completion of the compulsory Generic Surgical Science Examination (GSSE) prior to SET application is a reinstated old policy. With the previous policy, there were many late-SET trainees who were dismissed from the training program for failing the GSSE.

II Standard 5.2.1 Work in progress.

The Board may consider abandoning the Clinical Examination (CE). The Board felt that the CE is too generic and has no relevance to Cardiothoracic training. The Board is currently waiting for the Examination Committee to provide a detailed report of any proposed changes. At the recent Selection Workshop held in April 2018 at RACS, we were informed that passing the CE is a strong predictor of success in passing exams later in SET.

JJ Behaviour-related reporting is in place via the end of term assessment. Supervisors are encouraged to report any inappropriate or unacceptable behaviour.

KK A 360^{o} multisource feedback is already in place for SET 1 trainees.

LL There is no significant development.

General Surgery – Australia

II: The Board has removed the Clinical Exam as a requirement for training, effective from 2019.

KK These are used for trainees on performance management plans (PMPs), however, introducing MSF for the number of trainees in General Surgery is not a viable option at this stage. The usefulness of this tool needs to be considered.

General Surgery – New Zealand

II: The Board has removed the Clinical Exam as a requirement for training, effective from 2019.

JJ: The new EPAs will detail behaviour more clearly in assessable scenarios.

KK Nothing specific to NZ, although they are widely used for struggling trainees and those on probation.

Orthopaedic Surgery – Australia

II The Clinical Exam is no longer a requirement for Orthopaedic training

JJ The AOA 21 Research Project included a phased introduction of workplace-based assessments, both *for* learning and *of* learning, based on the principles of programmatic assessment developed by van der Vleuten and Schuwirth. A suite of workplace-based assessment tools, all delivered through a smartphone App, including an eLogbook and a trainee-initiated Feedback App, encourage deeper learning through concepts of 'entrustability' and effective feedback.

The following purpose-built workplace based assessment tools have been implemented:

- Surgical Skills Assessment (observation of procedural skills)
- Patient Consultation Assessment (observation of initial assessment of a patient)
- Management Plan Assessment (observation of development and implementation of a patient management plan)
- Case-based Discussion (structured discussion with the trainee about the trainee's management of the case and rationale for clinical decision-making)

Workplace-based assessments are benchmarked at the competencies articulated in the curriculum. Trainees are then assessed against their demonstration of those competencies. Trainees are assessed on a global scale, indicating their ability to provide effective patient care for the next similar case. The trainee has achieved competence with that particular clinical activity when the assessor is confident that, for the next similar case, they or a colleague would not need to provide any input.

The aim of these assessments is trainee learning. Rather than a pass or fail assessment, these tools provide an opportunity for trainees to receive feedback on their clinical skills. Items on the WBA forms highlight specific aspects of the clinical activity, and prompt the assessor to prompt feedback on Foundation Competencies (non-technical skills) as well as competencies related to medical and surgical expertise.

AOA has also implemented completion of regular Feedback Entries. It takes approximately 60 seconds to make a Feedback Entry on the AOA Training App and allows for multiple samples of feedback across a range of contexts and competencies to be collected. Trainees are encouraged to initiate feedback entries.

Feedback focuses on foundation competencies, as well as medical and surgical expertise, e.g.:

- Communication on the ward

- Teamwork in theatre
- Decision-making while on call
- Presenting at a meeting
- Professionalism observed in the ED

Its process encourages 'in the moment' feedback when an observed trainee-trainer interaction occurs.

- Either party suggests a feedback discussion using the Feedback App
- A feedback conversation occurs about the specific event
- Trainer or trainee enters into the Feedback App a brief summary, for reflection on action or as a reminder regarding a suggested action for the future

Feedback is based on 'observation, review and reflection'. It is anchored in readiness for practice and provides for trainees a 'snapshot' of what is expected and how well they are doing in demonstrating competence and good professional practice. Its focus is on what went well and/or could be improved – and includes documenting a recommended action for next time in a similar setting.

Trainees are encouraged to seek feedback from a number of consultants and across a range of contexts and competencies.

Trainees complete a 3-monthly Performance Appraisal with their Trainee Supervisor to monitor performance and a 6-monthly Progress Review to monitor their progress through the stages of training. Progress through stages of training is competency based.

KK Covered below at condition 15, below.

Orthopaedic Surgery – New Zealand

KK We are exploring the use of multisource feedback for the surgical training program.

Otolaryngology Head and Neck Surgery

HH The Board of Otolaryngology Head and Neck Surgery has removed the requirement for trainees to complete the Generic Surgical Science Examination.

II The Board has also removed the requirement for SET trainees to complete the Clinical Examination.

JJ WBAs implemented in 2018 rely substantially on formative feedback to trainees.

KK Multi-source feedback via a 360^{o} evaluation is currently conducted for trainees who have been placed on probationary training. The Board is considering the use of multi-source feedback for all trainees at the Novice Level of training i.e. those trainees in the first 24 months of training.

LL There have been no significant developments against this. The OHNS Examination Board continues to find essay questions useful in the Fellowship examination.

Paediatric Surgery

HH The Generic Surgical Sciences Exam became a pre-requisite to selection in 2016.

II The Board of Paediatric Surgery agreed in February 2018 that the RACS Clinical Examination will be a pre-requisite to selection.

KK The Board of Paediatric Surgery conducts 360^{o} evaluation surveys in SET 1.

Plastic and Reconstructive Surgery - Australia

HH, II and LL are RACS managment responsibilities

JJ Under development via implementation of EPAs into assessment tools for draft revised curriculum (by mid-2018).

KK Multisource feedback (MSF) is mandated during probation and is encouraged for voluntary trainee-led self-development. In late 2017, one trainee voluntarily used the MSF tool.

Plastic and Reconstructive Surgery – New Zealand

II The NZBPRS has reviewed the Clinical Exam with regard to PRS and has provided feedback to the Surgical Sciences and Clinical Examination Committee that the NZBPRS would like the CE exam to be aligned with GSSE and be moved pre-SET

HH The GSSE is reimbursed in NZ so is not a financial burden to those who sit it and do not pursue a surgical career.

KK Multisource feedback is utilised where appropriate for Performance Management Plans.

Urology

The Board of Urology has discussed the role of the Clinical Examination and its timing. The ability of the examination as a predictor of trainee progression across multiple specialty areas must relate to its potential to discriminate on the basis of non-technical/foundation competencies. Targeting these as the primary assessment focus for the clinical exam may allow identification of trainees 'at risk' in these areas in the early stages of training, facilitating early remedial action as required.

Activity aligned with conditions

Condition 15	Respond to the 2016 Review of Assessments Report by Cassandra Wannan by noting whether recommendations have already been implemented, require implementation or are rejected, including a rationale for the latter. (Standards 5.2 and 5.4) To be met by 2018

Progress reported by specialty

Cardiothoracic Surgery

The Board are happy to work with RACS to improve our work-based assessments.

General Surgery

The Board has approved the move towards entrustable professional activities (EPAs) and procedure based assessments (PBAs). A more detailed plan will be presented over the next six months.

Neurosurgery

Nothing to report.

Orthopaedic Surgery – Australia

All recommendations have been addressed as part of the AOA 21 Research Project Assessment Strategy (see above).

With regard to recommendation 8 for implementation of an MSF, consideration was given to mandating the use of MSF routinely throughout training as part of the AOA 21 Project. However, the decision was made to focus on gathering feedback via the Feedback App.

MSF is used in circumstances where a trainee requires additional support as an element of a performance improvement plan. AOA is currently building an online version of the MSF tool for use by trainees and Fellows (as part of CPD).

Orthopaedic Surgery – New Zealand

The NZOA is currently working with the AOA to implement workplace-based assessments in 2019.

Otolaryngology Head and Neck Surgery

WBAs are being reviewed as part of curriculum development. The Board is considering implementation of EPAs and entrustability scales, the Board has established standards of performance at each stage of training. The Board will adopt the surgical supervision document produced by RACS which will augment training of raters. Clinical activities are assessed multiple times and are completed by different assessors where possible. OHNS surgical supervisors have completed the FSSE course. MSF is not used as a standard tool, but is used for trainees in difficulty. The new curriculum integrates programmatic assessment, providing trainees with a portfolio of assessments.

Paediatric Surgery

In 2017 the Board of Paediatric Surgery revised the trainee assessment forms to better reflect competency-based training and better track trainee progress. The Board altered descriptors and placed SET level appropriate benchmarks and as such created assessment forms for each SET level.

A Global Assessment for each area of assessment was added into the trainee assessment forms to clearly show the level of competency the trainee is at and whether further training and study is required.

A section titled “Current Learning Goals” was added to each assessment form to promote learning, track progress and highlight areas for development; also providing an opportunity for constructive feedback.

The revised forms were sent to all trainees and surgical supervisors for their feedback prior to submitting the forms to RACS Education Board for approval. Further feedback will be sought from the trainees and surgical supervisors now that the forms have been in use for 12 months.

360^{o} evaluation forms are mandatory for SET 1 trainees and are conducted twice a year. The Board recently reviewed the list of hospital contacts that trainees are required to nominate and increased the number from 6 to 8. Trainees are now required to nominate a Registrar at the same level as they are, a registrar from another specialty, and a resident. In addition, they must also nominate medical nursing staff and administration staff (non-medical).

The Board will look at reviewing the Mini-CEX and DOPS forms to provide behavioural descriptors in the coming months.

Plastic and Reconstructive Surgery – Australia

The Board’s Curriculum Review Working Group (CRWG) has completed a draft competency-based curriculum and is currently undertaking an initial consultation period with key internal stakeholders (trainees, trainers and supervisors). Thereafter, a wider stakeholder cohort will be consulted. The CRWG also has a list of EPAs that will be further discussed and approved in June. At that time, we will also be looking at Procedure Based Assessments (PBAs) and modified DOPS and Mini-CEX tools. There will also be considerable time spent on rating scales and real-world applicability.

Please note ABPRS responses to the Wannan report below. (Wannan report recommendations are numbered in bold font and ABPRS responses are in normal font.)

1. Review WBA tools and their implementation: specialties review the WBAs to increase validity, reliability and educational impact. This may entail increasing the frequency of assessments and the diversity of assessment methods.

Work in progress (WIP) via the CRWG. Workshops held: March 2018. Workshop scheduled June 2018

2. Improve clinical relevance: Review content of WBAs to make these formative assessments more meaningful, to promote learning and to better track trainee progress through training. The introduction of entrustable professional activities may contribute to this outcome.

Work in progress via CRWG workshop (June 2018) to develop clinically relevant EPAs, modified DOPS, Mini CEX and so forth. An initial list of applicable EPAs has been formulated. This list will be further developed at the next CRWG workshop.

3. Blueprint WBAs onto the curriculum: specialties establish standards of performance and clinical activities relevant to trainees at each stage of training. WBAs can then be appropriately configured to these activities and standards.

This is in place. The Senior Examiner for Plastic Surgery also commenced a blueprinting process in late 2017 to the competency-based curriculum. The process is pending release of a final approved curriculum.

4. Use Entrustability Scales to improve reliability of WBA ratings: entrustability evaluations are based on the amount of supervision a trainee requires to perform a task. Specialties need to determine levels of competence to be demonstrated by trainees in activities as they progress to independent practice.

As above for recommendation 2.

5. Train raters: raters/assessors should be trained in the use of assessment tools to maximise reliability and validity, e.g. Frame-of-reference training that ensures all raters are aligned to the scale principles.

To be done after new assessment tools are approved by the Australian and NZ boards.

6. Use multiple assessments and assessors: clinical activities should be assessed multiple times to track trainee progress and provide relevant feedback. Ideally, assessments would be completed by different assessors during a rotation.

In place for many years. All SET levels are subject to one formative and one summative assessment per 6-month rotation. All surgical unit assessors contribute to the professional performance assessment

SET 1 and SET 2 trainees must also submit one satisfactory assessment from each of DOPS and Mini CEX for every 6-month rotation. Any trainer can be nominated by a trainee to conduct the assessment.

Trainees on probation, or placed on performance management plans, must conduct additional formative assessments as specified by the Board or the trainee's supervisor. Multisource feedback is used for all trainees on probation with evaluators selected from a wide range of healthcare professionals and administrative personnel.

7. Provide meaningful, constructive feedback: WBA feedback should be structured and include a specific action plan that highlights future areas of development, agreed upon by the trainer and the trainee.

In place. Remedial Action Plans using SMART Goals are a requirement of formal performance management (2 or more borderline competencies, 1 poor competency from any PPA meeting)

8. Introduce multi-source feedback: specialties are advised to consider the use of multi-source feedback as a standard WBA tool.

In place since 2014 for trainees on probation. Not considered at this time as a standard for all trainees.

9. Introduce assessment portfolios: assessment portfolios may increase continuity in learning across rotations.

Not in place – the Board has concern for the introduction of unconscious bias.

Where a trainee's performance included one borderline competency grade at the summative assessment (end of term), the next supervisor is informed of the competency and any specific comments from the assessment form.

Trainees entering probation (unsatisfactory PPAs – two or more borderline grade scores or one poor score) must formulate a Remedial Action Plan within 10 days for the ensuing term – this is informed by the most recent assessments (final PPA at end of term).

Plastic and Reconstructive Surgery – New Zealand

The Board has written to RACS indicating their preference for the Clinical Examination to be a pre selection requirement. We are awaiting a response.

At present we are collaboratively revising the PRS curriculum with a focus on competencies (with ABPRS) and WBAs are a major focus of this. We are developing a communication tool to complement the mCEX and DOPs. Each tool is being evaluated and revised. Stakeholders will be included in the review prior to implementation as well as preparing and educating trainers and trainees on these revised WBAs at an appropriate time.

At present MSF is used for Performance Management Plans, especially for non-technical areas.

Routine assessments include formative and summative reviews which incorporate self-reflection and feedback. We have revised our PPA form to be clearer with respect to trainee behaviours, actions and outcomes, and the ratings on the form, with positive feedback from trainees. DOPs and mCEX would be the most commonly used WBAs and are required for SET 1 and SET 2 and are also incorporated in Performance Management Plans.

Urology

Modification of the structured oral exam has been undertaken, noting the poor inter-rater reliability evidenced for this component of the FEX by Wannan. The written component of the FEX remains short answer question, although the format has again been modified since the Wannan report, with a greater number of shorter length questions now implemented, with a clear template 'model answer' for each question. The implementation of MCQ type questions for the FEX written component instead of essay type questions as per Wannan recommendations (given the poor inter rater reliability in written components) at this juncture is not planned, given the substantial difficulty in validating the sizeable bank of MCQ type questions which would be required for the FEX.

In regard to work based assessments, DOPS and MiniCEX are employed as mandatory assessment components for trainees. Multisource feedback (MSF) is utilised selectively, currently for trainees suspected of having non-technical competency concerns. More widespread use of MSF will be considered during curriculum review, with concerns regarding the relatively small pool of relevant contributors for MSF should its use be employed too generously. The revised curriculum is anticipated to incorporate a much greater use of WBA, particularly EPAs, and is expected to be implemented as soon as feasible.

Vascular Surgery

These items have been addressed by the BRIPS action plan.

Activity aligned with conditions

Condition 16	Implement appropriate standard setting methods for all specialty-specific examinations (The AMC recognises that at least three specialties are already compliant in this respect). (Standard 5.2.3) To be met by 2019

Progress reported by specialty

Cardiothoracic Surgery

Specialty-specific examination is already in place at Mid SET.

General Surgery

SEAM has a standard-setting process approved by RACS and available in the Regulations.

Neurosurgery

There is no Neurosurgery specific examination during the training program. There is a Neurosurgery Anatomy Examination held as part of the selection process. Each question is reviewed by a committee of neurosurgeons and a difficulty level assigned. There is a set formula for the construction of the examination using a consist mix of difficulty levels. Statistical data on the performance of questions is then reviewed after the examination.

Otolaryngology Head and Neck Surgery

No change. OHNS continues to work with RACS to define standards of performance and set 'pass' scores at each sitting of the specialty SSE.

Paediatric Surgery

The Board of Paediatric Surgery has a Court of Examiners, and the Senior Examiner is a member on the Board, who is responsible for standard-setting in the exams.

Plastic and Reconstructive Surgery – Australia

The Australian Society of Plastic Surgeons and the Board are precluded from examination administration, management and standard-setting. RACS has absolute control over this area.

Plastic and Reconstructive Surgery – New Zealand

The Fellowship Examination (FEX) is written, delivered and marked by RACS.

Urology

The Specialty-Specific Surgical Sciences Examination (SSE) (Urology) altered the standard-setting process during the Wannan review period, and the effectiveness of current standard-setting methods will be subject to further review.

Vascular Surgery

The Board of Vascular Surgery has a Court of Examiners, and a member on the Board of Vascular Surgery who is responsible for standard-setting in the Exam. The Senior Examiner is also appointed as a member of the Board of Vascular Surgery.

Standard 6: Monitoring and evaluation

Areas covered by this standard: program monitoring; evaluation; feedback, reporting and action

Summary of College performance against Standard 6

In 2017, this set of standards was found to be Substantially Met.

Summary of significant developments

Recommendations for improvement

MM	Explore with trainees how response rates to surveys on training posts could be improved. (Standard 6.1.3)
NN	Implement the planned New Fellows' Survey to evaluate their preparedness to practice and the annual survey of trainees who leave surgery without completing the program. (Standard 6.2.2)

Significant developments per specialty

Cardiothoracic Surgery

MM Feedback via RACS Trainees' Association (RACSTA) is in place reporting to BSET and the Cardiothoracic Board. There is a co-opted trainee representative as a committee member for BSET and the Cardiothoracic Board. They both are full members of the respective boards and have equal right to vote.

NN Standard 6.2.2 - No major development

RACS runs regular workshop to prepare Fellows to enter surgical practice. However, there is no new Fellows survey to evaluate their preparedness to practice. Younger Fellows (<10 years from obtaining Fellowship) are actively recruited to join both the Board as well as ANZSCTS.

General Surgery

MM NZ specific - Responses to surveys, particularly after Term 1 remain quite poor which is considered to be partly due to the fact that trainees remain in the same training hospital all year and are not willing to participate in a survey where negative feedback can be traced back to them as individuals. Many hospitals only have 1 or 2 trainees, so feedback although collected anonymously, is often quite easy to match with individual trainees. It is considered that modest improvements might be achievable but even if completion of surveys is mandated, it is unlikely to achieve 100% compliance. Mandating completion of surveys will necessitate removing anonymity which is very likely to reverse any intended effect.

MM Au: GS struggles with this, however mandating a response would remove the natural feedback provided and the willingness of trainees to report issues, as mandating a response would remove the ability to de-identify trainees. Trainees may feel 'pushed' or forced to complete these surveys and meaningful data may be lost.

Orthopaedic Surgery – Australia

MM AOA has been working with the Australian Orthopaedic Registrars' Association (AORA) to increase the response rate on the twice-annual trainee survey. The response rate for the most recently completed trainee survey was 77%.

Orthopaedic Surgery – New Zealand

No change.

Otolaryngology Head and Neck Surgery

No significant developments. The Board is interested in implementing the planned new Fellows survey.

Paediatric Surgery

No significant developments.

Plastic and Reconstructive Surgery – Australia

MM Informal discussions with trainees have commenced (March 2018). Qualitative feedback was sought by survey at the annual SET conference (March 2018).

A mentor program is in place in WA (before 2017), and NSW (Dec. 2017). Mentoring sessions provide an opportunity for the mentor to convey board standards to the mentee in a supportive environment.

NN RACS responsibility

Plastic and Reconstructive Surgery – New Zealand

MM Improving the response rate and reviewing responses to the trainees' survey is a project recently taken on by the external and trainee representatives of the NZBPRS. There is a plan to schedule time for the survey at the annual training weekend to promote participation. Previously the survey was emailed out.

NN No progress

Urology

No progress

Vascular Surgery

No significant changes

Activity aligned with conditions

Condition 17	Develop an overarching framework for monitoring and evaluation, which includes all training and educational processes, as well as program and graduate outcomes. (Standard 6.1, 6.2 and 6.3) To be met by 2019

Progress reported by specialty

Cardiothoracic Surgery

The Board meets three times per year and all trainees are discussed in detail. Trainees' progress is monitored and evaluated via their log books, DOPS, MiniCEX, and TEF assessments. The Board and ANZSCTS are also tracking post-Fellowship surgeons' activities in terms of employment and any restriction of their practice by APHRA. RACS has records of all Fellows who are CPD compliant.

General Surgery

BiGS will commence an evaluation on the research requirement beginning with a survey in June 2018. The new GS program will also include a comprehensive evaluation process.

Neurosurgery

Nothing new to report.

Orthopaedic Surgery – Australia

AOA has a monitoring and evaluation framework already in place.

Otolaryngology Head and Neck Surgery

At its regular meetings, the OHNS Training Board continually monitors training, assessment, and research activities, and trainee performance and progress. The Board implements decisions arising from these discussions.

Paediatric Surgery

No progress to report.

Plastic and Reconstructive Surgery – Australia

To be advised.

Plastic and Reconstructive Surgery – New Zealand

No progress

Urology

No progress

Vascular Surgery

No progress to report.

Activity aligned with conditions

Condition 18	In conjunction with the Specialty Training Boards, develop a policy to manage the situation whereby a trainee has been inadvertently identified as a result of providing feedback. (Standard 6.1.3) To be met by 2018

Progress reported by specialty

Cardiothoracic Surgery

No significant development

Will meet standard 6.1.3 by formalising the policy below:

The Board has an unwritten policy to protect the trainee and their anonymity and any complaint is respected. The trainee maintains the right to remain silent unless he/she chooses not to. If this is breached, the Chair will discuss this with the trainee and the other party involved.

Neurosurgery

Neurosurgery collects evaluation forms from trainees regarding experiences in their training posts on a 6 monthly basis. Individual submissions which are identifiable are only released to the Trainee Representative on the Board. The Board only sees a combined report for all positions with no identifiable data. Collated data over a five-year period is used for the hospital accreditation purposes to minimise the possibility of individual trainees being identified. In a small specialty, this is a big challenge.

Orthopaedic Surgery – Australia

AOA is happy to contribute to development of such a process

Orthopaedic Surgery – New Zealand

This is a RACS policy

Otolaryngology Head and Neck Surgery

Once the policy has been developed by RACS, it will be incorporated into the OHNS training regulations.

Paediatric Surgery

Once the policy has been developed by RACS, it will be incorporated into the Paediatric Surgery training regulations.

Plastic and Reconstructive Surgery - Australia

Information on RACS complaints management processes (standard operating procedures) was requested to compare against Australian Society of Plastic Surgeons processes.

All complaints received by board representatives are reported confidentially at a board meeting and, where permission is granted from the complainant and further reporting is warranted, the complaint could be reported to the complaint hotline or RACS Legal Counsel. Board meeting records are confidential and not disclosed.

Summary of complaints in 2017 and 2018:

Region NSW; Year 2017; board action taken: Complaint held over on request of the trainee until conclusion of employment. Thereafter, the complaint was noted at board meeting. The trainee's name was not disclosed. No further actions taken.

Region WA; Year 2017-2018; board actions taken: A trainee flagged some concerns to the Board. The trainee did not provide consent to the Australian Society of Plastic Surgeons to escalate the concerns or progress them to a formal complaint. Australian Society of Plastic Surgeons informed RACS Complaints Department and RACS General Counsel of the de-identified concerns.

Plastic and Reconstructive Surgery – New Zealand

This is a major concern to the Board – in particular as some training hospitals may only have one or two trainees. The Board will review and comment on the document circulated from BSET at its next meeting and actively seek involvement from the external and trainee representatives.

Urology

Awaiting further guidance from RACS as to how to proceed. Currently confidential post assessment information from trainees is not passed directly to the training posts. DBSH issues are referred to RACS and not processed via the Board of Urology. In the event of a trainee being considered at risk to their wellbeing or training opportunities, either related to inadvertent identification from feedback or to the underlying issue raised, the Board of Urology would relocate the trainee from the post.

Vascular Surgery

RACS to provide a policy at BSET for specialty board review.

Activity aligned with conditions

Condition 19	Establish methods to seek confidential feedback from supervisors of training, across the surgical specialties, to contribute to the monitoring and development of the training program. (Standard 6.1.2) To be met by 2019

Progress reported by specialty

Cardiothoracic Surgery

All surgical supervisors and heads of department convene at the ANZSCTS annual meeting. This meeting is also minuted. There is easy access to the Chair and any board members should there be any concerns regarding any training issues. All the trainees have either direct access to a board member, the Chair and the Trainee Representative to raise concerns regarding their training.

All feedback regarding training is taken seriously by the Board, is tabled at every Board meeting and appropriate action taken.

Neurosurgery

The NSA and Board of Neurosurgery hold supervisors' meetings every two years. This has resulted in significant input by supervisors into the structure and management of the training program and the assessment tools used. The next meeting is in 2019.

Orthopaedic Surgery – Australia

AOA routinely seeks feedback from supervisors twice annually. Feedback is also sought specifically at various touchpoints of involvement (e.g. bone camp, workshops, trial exams etc.)

In addition, supervisors are actively involved in committees and working groups involved in review and development.

Orthopaedic Surgery – New Zealand

We currently receive this feedback.

Otolaryngology Head and Neck Surgery

The surgical supervisors of each state meet bi-annually to discuss training issues. This feedback is provided to the Board through the regional chairs.

Paediatric Surgery

The Board of Paediatric Surgery meets with the surgical supervisors once per year. This meeting provides the supervisors with opportunities to provide any feedback regarding the training program. We have also requested financial support to have annual seminars with supervisors of training and the Board of Paediatric Surgery to further improve communication and skill development of supervisors.

Plastic and Reconstructive Surgery – Australia

Handled via subcommittee relationships to filter up to the Board in a confidential manner where appropriate.

Plastic and Reconstructive Surgery – New Zealand

All Supervisors are NZBPRS members so have a forum for discussing and improving the SET programme.

Urology

No progress

Vascular Surgery

The Board conducts two supervisor meetings each year, which are specifically held to seek supervisor feedback on the training program.

Activity aligned with conditions

Condition 20	Develop and implement completely confidential and safe processes for obtaining—and acting on—regular, systematic feedback from trainees on the quality of supervision, training and clinical experience. (Standards 6.1.3 and 8.1.3) To be met by 2019

Progress reported by specialty

Cardiothoracic Surgery

This is done via the Trainee Representative on the Board and all feedback is directed to any board members. Actions have been taken based on this feedback.

General Surgery

General Surgery has regulations pertaining to hospital post feedback from trainees which details the process on how the feedback is de-identified

Neurosurgery

See above. Already in place and has been for more than 7 years.

Orthopaedic Surgery – Australia

AOA routinely seeks feedback from trainees twice annually. Feedback is also sought specifically at various touchpoints of involvement (e.g. bone camp, workshops, trial exams etc.).

In addition, trainees are actively involved in committees and working groups involved in review and development.

Orthopaedic Surgery – New Zealand

This is done as part of the hospital inspection.

Otolaryngology Head and Neck Surgery

Feedback from trainees is discussed with the Board through the trainee representative. In 2017, following an extensive systematic review of Otolaryngology training, numerous changes were implemented into the training regulations. OHNS NZ conducts yearly anonymous surveys to obtain trainee feedback. At the training week interviews, feedback is sought on the posts and any other issues.

Paediatric Surgery

Currently all trainees are interviewed at our Registrar Annual Training Seminar. More formal feedback during this process will be developed to achieve this goal.

Plastic and Reconstructive Surgery - Australia

The Australian Board of Plastic and Reconstructive Surgery routinely seeks trainee feedback (at the conclusion of each 6-month rotation). These reports are statistically analysed ahead of the re-accreditation of hospital training posts and also reviewed individually for signals requiring attention by the Board. Data is confidential, with only aggregated (de-identified) information shared, where relevant.

Plastic and Reconstructive Surgery – New Zealand

There is an annual trainee survey (anonymous) that will be included in the annual training conference to ensure responses are obtained. The trainee representative and external representative will review responses and report back to the Board.

Urology

The curriculum review is likely to encompass an assessment of graduate outcomes, which would include confidential feedback assessment from trainees exiting the program. In addition, the current trainee representative system affords trainees the opportunity for confidential feedback to their elected peer who can raise issues directly at the Board of Urology level.

Urology conducts a confidential training post feedback process with all trainees annually. A summary of findings is provided to the Board and to hospital post inspectors.

Vascular Surgery

The Board of Vascular Surgery is currently in the process of reviewing the trainee evaluation forms submitted annually for each accredited hospital post.

Activity aligned with conditions

Condition 21	Develop formal consultation methods and regularly collect feedback on the surgical training program from non-surgical health professionals, healthcare administrators, and consumer and community representatives. (Standard 6.2.3) To be met by 2020

Progress reported by specialty

Cardiothoracic Surgery

A mandatory 360º evaluation survey and feedback form are sought from non-surgical health professionals when assessing the progress of SET 1 trainees.

Neurosurgery

Nothing to report.

Orthopaedic Surgery – New Zealand

The Orthopaedic Training Board now has a Cultural and Consumer Adviser to provide this feedback.

Otolaryngology Head and Neck Surgery

No progress.

Paediatric Surgery

RACS to provide.

Plastic and Reconstructive Surgery – Australia

To be advised.

Plastic and Reconstructive Surgery – New Zealand

No progress.

Urology

Mandatory 360º evaluation surveys and feedback are sought from non-surgical health professionals when assessing the progress of SET 1 trainees.

Vascular Surgery

RACS to provide.

Activity aligned with conditions

Condition 22	Report the results of monitoring and evaluation through governance and administrative structures, and to external stakeholders. It will be important to ensure that results are made available to all those who provided feedback. (Standard 6.3) To be met by 2020

Progress reported by specialty

Cardiothoracic Surgery

Reporting and monitoring of complex issues are guided by the recommendations of College Council, BSET policies and the College's legal counsel to mitigate adverse risk.

Neurosurgery

Nothing to report.

Otolaryngology Head and Neck Surgery

No progress.

Paediatric Surgery

RACS to provide.

Plastic and Reconstructive Surgery - Australia

Monitoring and evaluation is well-established via mechanisms of the regional subcommittees through to the Training Board and then the Board of SET.

The Australian Society of Plastic Surgeons invites RACS management and surgical leadership to Board meetings on a regular basis to support sharing of information. For example, the Director of Education and Training and Administration in early 2017 and the Dean of Education in late 2017 and planned again for 2018. Similarly, RACS Manager, SET has been invited to a board meeting.

Plastic and Reconstructive Surgery – New Zealand

No progress

Urology

No progress

Vascular Surgery

RACS to provide

Activity aligned with conditions

Condition 23	Develop and implement an action plan in response to the 2016 Leaving Surgical Training study. (Standard 6.2) To be met by 2019

Progress reported by specialty

Cardiothoracic Surgery

No significant development

Exit interviews, including vocational counselling and employment options, are usually conducted in-house and via Board members.

Neurosurgery

Nothing to report.

Orthopaedic Surgery – New Zealand

We have not had this issue to address at this stage.

Otolaryngology Head and Neck Surgery

The OHNS Training Board is addressing the need for flexible training. Flexible training positions have been filled in New Zealand, Victoria and Queensland. All requests for maternity leave are granted. The Board has encouraged the visibility of role models.

Paediatric Surgery

RACS to provide.

Plastic and Reconstructive Surgery – Australia

RACS responsibility

Plastic and Reconstructive Surgery – New Zealand

No progress

Urology

No progress

Vascular Surgery

RACS to provide

Standard 7: Issues relating to trainees

Areas covered by this standard: admission policy and selection; trainee participation in education provider governance; communication with trainees; trainee wellbeing; resolution of training problems and disputes

Summary of college performance against Standard 7

In 2017, this set of standards was found to be Substantially Met.

Summary of significant developments

Recommendations for improvement

OO	In relation to selection into the surgical training programs:
(i)	Evaluate the objectives of the selection process to ensure they are both clear and consistent across all surgical training programs.
(ii)	Develop a process to ensure that updates and changes to entry prerequisites undergo a consultation process, and provide appropriate lead time for prospective applicants to meet them.
(iii)	Explore the means by which prevocational work performance and technical ability may be more appropriately assessed as part of the selection process.
(iv)	Examine the key discriminators (e.g. academic record, research, experience, interview performance) in the current selection process and whether these are the most relevant for predicting performance both as a trainee and as specialist. (Standard 7.1.1)
PP	Implement a program to increase awareness of the presence and role of the RACS Trainees' Association (RACSTA). (Standard 7.2 and 7.3)

Significant developments per specialty

Cardiothoracic Surgery

OO(i) The selection process information is available and the scoring system is clearly outlined. Any ambiguity is revised by the Board. The scoring system is marked by two board members and any unmatched scoring is referred to the Chair for re-marking. The Board recognises that scoring can be quite subjective and this approach provides the best consistency.

OO(ii) The Board reviews the selection process and scoring system yearly and any changes are approved by EB. Implementation of these changes, take place in the following year of that approval.

OO(iii) The selection process accepts recognition of prior learning subject to Board approval. RACS is currently evaluating work place assessment, which is difficult to administer with the current resources available.

OO(iv) The referee reports have been recognised as a challenging predictor of training performance. The Board will be evaluating its scoring system in the selection process. Recommendations from the recent selection process workshop held in April will be available shortly.

PP RACSTA is already playing a significant role in the training program. Its awareness is well advertised on the RACS website. All trainees have direct access to the Association. The

previous RACSTA representative sent out regular surveys to all the trainees. Whilst the number of trainee responses is variable, RACSTA is continuously engaging all trainees to raise any issues during their training. The BDSH survey was monitored in 2017. The RACSTA representative provided a quarterly report at the BSET meeting.

General Surgery – Australia

OO(ii) Changes to selection have been steady for 2-3 years and the Board provides at least 12 months' notice of any major changes to minimum eligibility.

OO(iv) Data on trainees who commenced in 2016, 2017 and 2018 has been collected to determine if performance and ranking in selection is a predicator to performance in the training program across assessments, exams and SEAM

General Surgery – New Zealand

OO(ii) The NZ Training Committee will continue to ensure major changes to pre-requisites are signalled well in advance when possible.

OO(iii) The selection process for 2018 has been changed with regard the sourcing of referee reports in that referees will no longer be able to identify the "answer" giving the candidate the highest score via randomisation of the order of options.

OO(iv) NZ annually reviews the selection process to identify possible improvements. The NZ Training Committee is keen to explore the possibility of using new selection tools, with support from RACS to validate these, with the view to finding more discriminatory tools.

Orthopaedic Surgery – Australia

OO AOA has a process whereby significant changes to the selection process are flagged within the Regulations at least a year prior to implementation.

AOA is currently investigating a more state-based approach to selection to facilitate applicants training in their region of preference. This approach may utilise more formal banding of applicants where scores are statistically equivalent. Planning is also underway to trial situational judgement tests as part of the selection process.

Orthopaedic Surgery – New Zealand

We have an Education and Training Working Group that is currently progressing with this work. This work is clearly documented.

Otolaryngology Head and Neck Surgery

The OHNS board is embarking on a thorough review of selection processes. Board representatives participated in the selection workshop in April 2018. Recommendations from this workshop are being implemented, specifically to evaluate prevocational work performance and technical ability as part of the selection assessment. The key discriminators in the current selection process are being extensively modified to ensure that they are relevant.

Paediatric Surgery

No significant developments.

Plastic and Reconstructive Surgery – Australia

OO(ii) Commenced in February 2018 via the formation of a Selection Subcommittee with defined terms of reference. The GSSE is a pre-requisite for selection since 2017. The Board

encourages RACS to build capacity within its examinations department to enable the Clinical Examination as a pre-requisite

PP RACS responsibility

Plastic and Reconstructive Surgery – New Zealand

The NZBPRS attended the recent SET Selection Workshop held by RACS and as part of the exercise met with the ABPRS to discuss a combined approach to SET selection tools. We agreed that we would work with RACS to develop SJTs and introduce these. We agreed that the CV and referee reports could be minimum requirements (as shown to be non-discriminatory with respect to SET performance by RACS data) and interview referees with red flags on their reports. We would like the CE to be pre SET and the score and attempts to pass available. As with other STBs we would then like SJTs to be performed to help refine the potential applicants selected for structured interviews. The Board would welcome further interview training to improve and refine this tool – which appears to be the only with an association with SET performance. We would also like a limitation on the number of SET applications to no more than 3 if this is consistent across all specialities.

Urology

No significant progress.

Vascular Surgery

No significant developments.

Activity aligned with conditions

Condition 24	Further develop the selection policies for each surgical training program, particularly with regard to the provision of transparent scoring of each element in the curriculum vitae and the standardisation in the structure of referee reports. (Standard 7.1) To be met by 2020

Progress reported by specialty

Cardiothoracic Surgery

Two Board members mark the scoring system and any unmatched scoring is referred to the Chair for re-marking. The Board recognises that scoring can be quite subjective and this approach provides transparency.

All interviewers are required to declare any conflict of interest. The scoring must be unanimous and all records of the interview are kept.

Work is in progress to update selection process.

General Surgery – Australia

Regulations from 2018 have included the publishing of the scoring system for CV. Referees and interview scoring have been published for several years.

Neurosurgery

Well defined and transparent selection process regulations are already in place and no significant changes are anticipated. Data is being collected to evaluate the process over a five-year period.

Orthopaedic Surgery – Australia

Increasing the transparency of scoring of the curriculum vitae will be reviewed at the forthcoming Federal Training Committee meeting.

AOA already utilises a standardised referee reporting tool.

Orthopaedic Surgery – New Zealand

This is currently done

Otolaryngology Head and Neck Surgery

OHNS has a transparent scoring system that is publicly available for the CV. The referee reporting process is currently undergoing review.

Paediatric Surgery

The Selection Regulations are reviewed by the Board each year and are submitted to the RACS Education Board for review.

Plastic and Reconstructive Surgery – Australia

Since 2009, the maximum scores for each selection tool were published for candidate applicants.

Since 2018 (approved 2017), the Selection Regulations provide clear and transparent maximum scores for each question of the structured CV scores

Plastic and Reconstructive Surgery – New Zealand

NZBPRS reviews (and will amend if appropriate to improve the process) its selection process annually. In 2018 the referees will participate in telephonic interviews with the SET selection subcommittee. The Board will discuss potential improvements at the next meeting following SET selection and the RACS SET selection workshop with an aim to further improve selection.

Urology

Further selection refinements have occurred, with a highly standardised and transparent CV scoring scheme already in place. Referee reports are also in the process of evolution, but the structure is well established.

Vascular Surgery

RACS to advise if this is not being met by the Board of Vascular Surgery

Activity aligned with conditions

Condition 25	Clearly document and make publicly available the standard of entry into each surgical training program. (Standard 7.1) To be met by 2018

Progress reported by specialty

Cardiothoracic Surgery

The policy is already in place for Cardiothoracic Surgery.

General Surgery

Selection regulations already identify the standard of entry.

Neurosurgery

Already satisfied.

Orthopaedic Surgery – Australia

Eligibility requirements for applications to Orthopaedic training are clearly outlined on the AOA website.

Orthopaedic Surgery – New Zealand

This is included in our Regulations on our website.

Otolaryngology Head and Neck Surgery

Selection Regulations into the SET OHNS program are being updated for the 2020 intake.

Paediatric Surgery

The minimum eligibility requires for Paediatric Surgery are publicly available on the RACS website via the Selection Regulations.

Applicants must score a minimum of 35 or more out of 55 for the combined structured Curriculum Vitae and online referee report to be invited to attend an interview. Applicants who fail to achieve the minimum standard score of 35 will not be considered further in the selection process.

Applicants must score a minimum of 15 marks out of a maximum of 25 of the total interview score to be eligible to progress to the final stage of the selection process and be ranked with an overall score

The minimum standard score needed to be appointed to Paediatric Surgery training is 72%. Applicants who do not achieve a combined score of 72% or above will be deemed unsuitable for training and therefore unsuccessful in the selection process.

Plastic and Reconstructive Surgery – Australia

Completed since 2009.

Plastic and Reconstructive Surgery – New Zealand

The SET selection requirements are publically available on the RACS website via the SET Selection Regulations and state eligibility requirements and the selection process (referee and candidate structured interviews).

Applicants who satisfy the eligibility conditions in Section 2 of the NZBPRS Selection Regulations will be ranked by the combined score of the CV and Reference Reports. Interviews will be offered based on a ratio of four applicants to one post (i.e. 4:1). Applicants will be invited to interview based on ranked order. The Board has established a subcommittee to investigate the possibility of introducing a minimum standard for selection and their report is due by the end of September 2018.

Urology

The minimum entry standard for admission to the SET Program in Urology for selection in 2019 (2020 intake) has now been established and endorsed by the Board of Urology. This will be published in November 2018 on the USANZ website.

Vascular Surgery

The Board advertises the selection regulations on the College website. These regulations outline the selection process and standard for entry into Vascular Surgery.

Activity aligned with conditions

Condition 26	Develop a policy that leads to the increased recruitment and selection of Aboriginal and Torres Strait Islander and/or Māori trainees in each surgical training program. (Standard 7.1.3) To be met by 2019

Progress reported by specialty

Cardiothoracic Surgery

The Board had approval for the inclusion of Aboriginal and Torres Strait Islanders to apply to the advanced SET training program provided they reach the minimal standards

General Surgery – Australia

General Surgery has quarantined posts for the 2019 selection process

Neurosurgery

Nothing to report.

Orthopaedic Surgery – Australia

AOA endorses RACS 'Aboriginal and Torres Strait Islander Surgical Trainee Selection Initiative' policy. Where scores are statistically equivalent at the cut off for offers, the Selection Committee will determine which candidates receive an offer and in making any such determination will have regard to promoting diversity within the training program.

Orthopaedic Surgery – New Zealand

We support components of the RACS Māori Action Health Plan

Otolaryngology Head and Neck Surgery

The Board has implemented the Aboriginal and Torres Strait Islander (ATSI) Selection Initiative.

Paediatric Surgery

The Board implemented the RACS Aboriginal and Torres Strait Islander Surgical Trainee Selection Initiative for the 2019 intake.

Plastic and Reconstructive Surgery – Australia

Completed in 2017 and implemented for 2018.

Zero applicants identified themselves as Aboriginal and Torres Strait Islanders during RACS' registration for selection process in early 2018.

Plastic and Reconstructive Surgery – New Zealand

NZBPRS has initiated dialogue with NZAPS regarding an annual scholarship available to Māori and Pacific Island medical students to attend the NZAPS ASM as a way of increasing awareness of PRS as a specialty and a future career. This approach has been taken as we have received advice from several cultural advisors including the Māori adviser to the MCNZ and a Māori advisor to RACS that this is culturally acceptable whereas a selection pathway approach would not be.

Urology

The Board has acquiesced with proposed preferential selection for those meeting the minimum criteria, but active processes will be explored to encourage and facilitate a greater number of Aboriginal and Torres Strait Islanders applicants and mitigate any impediment to them meeting the selection criteria.

Vascular Surgery

The Board intends to implement the College policy on selection of Aboriginal and Torres Strait Islander and/or Māori trainees in the 2019 selection process. The Board is working with the College to develop a minimum standard for selection, which will allow the above to be implemented.

Activity aligned with conditions

Condition 27	Promote and monitor the Diversity and Inclusion Plan through the College and Specialty Training Boards to ensure there are no structural impediments to a diversity of applicants applying for, and selected into, all specialty training programs. (Standard 7.1) To be met by 2019

Progress reported by specialty

Cardiothoracic Surgery

Policy is already in place.

Neurosurgery

Nothing to report.

Orthopaedic Surgery – Australia

AOA has adopted a Diversity Strategy with a vision to create a culture of inclusion that promotes and enables all people into and within the profession of orthopaedic surgery to the benefit of the Australian people.

Orthopaedic Surgery – New Zealand

We have reviewed the selection process to ensure diversity barriers, both real and perceived are removed.

Otolaryngology Head and Neck Surgery

OHNS has moved to minimise any impediments to diversity in selection. The OHNS trainee cohort is culturally diverse and 32% of current OHNS trainees are women.

Paediatric Surgery

See response to Condition 26.

Plastic and Reconstructive Surgery - Australia

Planned commencement of discussion/consideration by the Australian Board of Plastic and Reconstructive Surgery in July 2018

Plastic and Reconstructive Surgery – New Zealand

The NZ PRS trainees currently cover a diverse range of cultures and has a percentage of female trainees which fluctuates between 45 – 61% in recent years.

Urology

The Urology selection interviews include assessment of Aboriginal and Torres Strait Islander and Māori cultural awareness.

Vascular Surgery

See response to Condition 26.

Activity aligned with conditions

Condition 28	Increase transparency in setting and reviewing fees for training, assessments and training courses, while also seeking to contain the costs of training for trainees and specialist international medical graduates. (Standards 7.3.2 and 10.4.1) To be met by 2019

Progress reported by specialty

Cardiothoracic Surgery

Fees for training are well publicised on the RACS website

Neurosurgery

The training fee determined by the NSA is set on a cost recovery basis. The Board does not charge additional fees for NSA run training seminars which form a compulsory part of training. The examinations ran during training by the NSA are also at no additional charge to trainees which include an MCQ examination and Intermediate examination (Fellowship Examination practice written paper).

Orthopaedic Surgery – Australia

AOA undertook a facilitated costing exercise, which aimed to evaluate the actual cost of the activities undertaken and delivered as part of the raining program in order to determine appropriate fees on a cost recovery basis. This exercise effected both the Training Fee and fees for particular training activities such as in training exams and courses. The process took into account staffing requirements, including time commitments and levels of activity. This information feeds into work planning and role definitions within the AOA team. Trainees were fully briefed on the costing exercise.

Orthopaedic Surgery – New Zealand

This is currently met.

Otolaryngology Head and Neck Surgery

The training fee determined by ASOHNS is set on a cost recovery basis and is published on the RACS website. The OHNS board strives to minimise costs to trainees.

Paediatric Surgery

RACS to provide information.

Plastic and Reconstructive Surgery – Australia

Australian Society of Plastic Surgeons has been transparent with trainees in how its activity costing was used to set the annual SET training fee in 2014 (the commencement of the five-year collaboration agreement) and subsequent increases have been in line with education CPI.

Annual SET conferences are run to make a small surplus profit or break even.

Newsletter communications are used to communicate the annual SET fee.

Fees for 2019 are under consideration.

Plastic and Reconstructive Surgery – New Zealand

Training fees are publicly available on the RACS website. The NZ PRS Training fee is set by NZAPS annually and the Board Chair and Trainee Rep have input into this.

Urology

Trainees are well informed of the direct costs of Urology training, and are provided with a breakdown of these. Indirect costs are less clearly defined, and include RACS fees and indirect USANZ costs. Cost control remains a priority.

Vascular Surgery

Usually the Specialty Board increases the cost with CPI.

Activity aligned with conditions

Condition 29	Address trainee concerns about being able to raise issues and resolve disputes during training by ensuring there are mechanisms for trainees to do so without jeopardising their ongoing participation in the training program. (Standard 7.5) To be met by 2019

Progress reported by specialty

Cardiothoracic Surgery

Trainees are encouraged to raise concerns with regard to their quality of training. There are many avenues for reporting to RACS. These can be reported directly to the Board, Department of Surgical Affairs and complaints (on Line), via the trainee representative and directly through RACSTA.

The Board plans to engage the newly appointed external board member in the inspection process.

Neurosurgery

Trainees have been very engaged in the review and reconsideration process available in the training program Regulations as previously reported.

Orthopaedic Surgery - Australia

AOA acknowledges trainee concerns regarding their ability to raise issues without impacting on their training. AOA has seen a trend toward more willingness by trainees to speak out and will continue to foster this confidence.

Orthopaedic Surgery – New Zealand

Informal feedback is regularly received from the trainees. Our Appeals Process has recently been developed and approved by the Council.

Otolaryngology Head and Neck Surgery

The SET OHNS Training Regulations include Review and appeal processes in line with RACS policy. The hospital accreditation process provides a mechanism to address trainee concerns with training positions in a confidential environment.

Paediatric Surgery

To be confirmed.

Plastic and Reconstructive Surgery – Australia

Trainees are encouraged to deal with disputes locally in the first instance. Disputes that cannot be managed locally can be escalated to the Regional Chair, Trainee Representative, Australian Society of Plastic Surgeons office or the Board Chair directly.

Accreditation of training posts and approval processes for supervisors (that require at least three surgeons in a surgical PRS unit) are complementary to support trainees and enable local resolution to issues. We require independent supervisor from the head of unit positions, with exemptions applying to regional centres.

Several recent instances where trainees have raised concerns about the training environment, or the local medical staff have been handled with the trainees best interests in mind. The Board's governance structure, including an external member and a trainee representative, ensures training matters are given a fair hearing.

Plastic and Reconstructive Surgery – New Zealand

Some units have appointed mentors who are not Supervisors and from other specialties.

Urology

No progress

Vascular Surgery

To be confirmed

Standard 8: Implementing the program – delivery of education and accreditation of training sites

Areas covered by this standard: supervisory and educational roles, and training sites and posts

Summary of college performance against Standard 8

In 2017, this set of standards was found to be Substantially Met.

Summary of significant developments

Recommendations for improvement

QQ	Develop a policy that is adhered to by all Specialty Training Boards which stipulates the minimum advanced notice required prior to requiring commencement of new rotations and which also minimises the number of interstate /international rotations. (Standard 8.2.2)
RR	Work with the jurisdictions to assist in preventing the loss of employment benefits when trainees transfer between jurisdictions. (Standard 8.2.3)
SS	Consider how to expand the surgical training programs in rural and regional locations. (Standard 8.2.2 and 8.2.3)
TT	Support collaboration amongst the Specialty Training Boards to develop common accreditation processes and share relevant information. (Standard 8.2.4)

Significant developments per specialty

Cardiothoracic Surgery

QQ Before any hospital post allocations, the trainees are advised to select their preferred post for the following year. This policy is implemented in an attempt to minimise interstate and international rotation disruption. Those who missed out on their allocation have ample time as the decision is made at the Board Meeting in June and the new term commences the following February.

RR All the employment awards are transferable from state to state and in New Zealand.

SS All Cardiothoracic Surgery in Australia and New Zealand are completed in major teaching hospitals in metropolitan and regional centres. Therefore rural attachment does not apply here.

TT Does not apply in Cardiothoracic Surgery. A policy for recognition of prior learning is in place and approval is at the discretion of the Board.

General Surgery – Australia

QQ Trainees do not rotate interstate in Australia except for a small percentage that rotate through Tasmania, NT and ACT. With ACT trainees usually request to be allocated to this network. With NT, again trainees usually request to be rotates to Darwin or Alice Springs in order to gain particular experience.

SS The Board attended the Rural Workshop to address this issue. The Board also provided feedback regarding the IRTP scheme, which does not address this issue.

General Surgery- New Zealand

SS The New Zealand Training Committee remains supportive of applications for accreditation from smaller hospitals, and has a number of accredited posts in centres where there are no trainees from any other surgical specialty. Where possible opportunities for trainees in the smaller centres, such as access to endoscopy etc., will be viewed favourably where other accreditation criteria such as minimum logbook numbers may be marginal.

Orthopaedic Surgery - Australia

RR AOA works closely with jurisdictions to ensure processes are in place to prevent the loss of employment benefits on rotation interstate or to a private training post

SS AOA has been working with RACS to ensure timelines for STP funding effectively align with accreditation timelines

Otolaryngology Head and Neck Surgery

QQ The Board endeavours to allocate trainees their first preference for new rotations. There are no international rotations. NSW is the only state with interstate rotations; this is to accommodate a rural training post in Darwin and the Northern Territory. The Regional Chair of NSW makes every effort to ensure the trainee allocated to Darwin is prepared to fill the position.

RR: The Board considers that RACS is best placed to work with jurisdictions to prevent the loss of employment benefits when trainees transfer. The Board is working with jurisdictions to support this endeavour.

SS The Board is not considering expansion of the program into rural and regional locations as there are currently numerous regional locations with accredited positions.

TT The Board supports the development of common accreditation processes.

Paediatric Surgery

No significant developments.

Plastic and Reconstructive Surgery – Australia

QQ Since 2017, 31 January was made publically known as the deadline for potential training posts in the following year. The Australian Plastic and Reconstructive Surgery Board initially conducts paper-based reviews to determine if a physical inspection is required. Where required, and held before May, and if approved the training positions are added to the pool for selection the next year.

RR RACS responsibility

SS The PRS SET training program already has several positions located outside major capital cities (Geelong in Victoria, Launceston in Tasmania (recently approved), and rotations that include regional centres such as Gosford in New South Wales).

The Board is also aware of regional centres exploring the requirements for accreditation including the Sunshine Coast (QLD), Cairns (QLD), Gold Coast (QLD) and Warrnambool (VIC). The Board supports regional positions subject to those centres meeting the accreditation criteria. Unfortunately, a training post in Darwin was recently removed due to persistent concerns regarding supervision.

The greatest barrier to regional training the lack of local workforce which is a pre-requisite to expanding training into regional or rural locations. RACS has already commenced a process of consultation to progress with this issue.

TT The Australian Society of Plastic Surgeons and the Australian Board have advocated for RACS to centralise common criteria and standards for all specialties and relay these to Specialties prior to them undertaking re-accreditation reviews.

Plastic and Reconstructive Surgery – New Zealand

RR Not reported to be an issue due to a Collective Employment agreement in NZ

SS Not an issue as PRS units in NZ only in main cities due to the nature of the cases treated and existing visits to outlying town already occur and involve trainees on a regular basis.

Urology

No significant developments.

Vascular Surgery

No significant development.

Activity aligned with conditions

Condition 30	Mandate cultural safety training for all supervisors, clinical trainers and assessors. (Standard 8.1) To be met by 2020

Progress reported by specialty

Cardiothoracic Surgery

All surgical supervisors, trainers and Fellows with exposure to trainees, are required to complete all RACS mandatory courses i.e.: FSSE, SAT SET and OWR

Neurosurgery

Nothing to report.

Orthopaedic Surgery – New Zealand

As a Training Board we are considering requiring this for our Education Committee. RACS should provide generic training modules.

Otolaryngology Head and Neck Surgery

All surgical supervisors and trainers are required to complete all RACS mandatory courses i.e.: FSSE, SAT SET and OWR

Paediatric Surgery

RACS to implement policy.

Plastic and Reconstructive Surgery – Australia

The refreshed curriculum (final draft December 2017) includes cultural sensitivity awareness within the health advocacy competency. RACS to consider training standards for all Fellows.

Plastic and Reconstructive Surgery – New Zealand

No progress.

Urology

No progress.

Vascular Surgery

RACS to introduce policy.

Activity aligned with conditions

Condition 31	In conjunction with the Specialty Training Boards, finalise the supervision standards and the process for reviewing supervisor performance and implement across all specialty training programs. (Standard 8.1) To be met by 2021

Progress reported by specialty

Cardiothoracic Surgery

All Surgical Supervisors, Trainers are required to complete all RACS mandatory courses i.e.: FSSE, SAT SET and OWR

Neurosurgery

Feedback being provided to RACS.

Orthopaedic Surgery – Australia

AOA will provide comment on the Standards for Supervisors shortly.

Otolaryngology Head and Neck Surgery

The Board has advised RACS that it is in agreement with the Standards for Supervisors document.

Paediatric Surgery

This was discussed at BSET in June 2018. RACS to finalise standards.

Plastic and Reconstructive Surgery – Australia

June 2017 through February 2018: In development in collaboration with all Specialty Boards via the Board of SET mechanism.

Plastic and Reconstructive Surgery – New Zealand

NZBPRS will provide feedback to the June BSET meeting on the Supervisor Standards document.

Urology

The Supervisor Standards have been reviewed, and through ongoing consultation with RACS, these appear satisfactorily developed to be nearing implementation.

Vascular Surgery

RACS to introduce policy

Activity aligned with conditions

Condition 32	Promote the Building Respect, Improving Patient Safety (BRIPS) program and encourage the positive participation of all fellows and trainees, including supporting all surgeons to "call out" bad behaviour in work and training. (Standard 8.2.2) To be met by 2019

Progress reported by specialty

Cardiothoracic Surgery

The Operating with Respect (OWR) online module is compulsory for all Fellows and trainees. The college have also mandated the face to face OWR workshop for all Fellows. The BRIPS program is well embedded in most teaching hospitals.

Neurosurgery

Actively promoted.

Orthopaedic Surgery – Australia

AOA continues to support the BRIPS program.

Orthopaedic Surgery – New Zealand

This has been complied with.

Otolaryngology Head and Neck Surgery

The Board has encouraged and promoted the BRIPS program by strongly advocating for the completion of the OWR online module and face-to-face course.

Paediatric Surgery

TBC.

Plastic and Reconstructive Surgery – Australia

RACS responsibility

Plastic and Reconstructive Surgery – New Zealand

Completion of RACS mandated courses as part of the BRIPS campaign is a standard Agenda item for all NZBPRS meetings. The NZBPRS has taken an active role in encouraging Fellows to meet the mandatory requirements.

Urology

The compliance rates amongst Urology Supervisors and Trainers has been very high in terms of completion of the mandatory training requirements as part of the BRIPS program. The Board actively encourages fellows and trainees to report any concerns regarding inappropriate behaviour.

Vascular Surgery

The Board of Vascular Surgery promotes the BRIPS program among Vascular Surgery Supervisors and Trainers.

Activity aligned with conditions

Condition 33	In the hospital and training post accreditation standards for all surgical training programs include a requirement that sites demonstrate a commitment to Aboriginal and Torres Strait Islander and/or Māori cultural competence. (Standard 8.2.2) To be met by 2019

Progress reported by specialty

Cardiothoracic Surgery

No significant development. It is compulsory in all teaching hospitals in Queensland. The Board will meet in June 2018 to implement its commitment to Aboriginal and Torres Strait Islanders and Māori cultural awareness and competency.

Neurosurgery

Changes to the Training Post Accreditation Regulations are anticipated in July 2018 to include specific reference for training sites to demonstrate a commitment to Aboriginal and Torres Strait Islander and/or Māori cultural competence.

Orthopaedic Surgery – New Zealand

This is included as part of the hospital accreditations. We intend to add a question “does your hospital demonstrate a commitment to Māori cultural competence?”

Otolaryngology Head and Neck Surgery

Accreditation standards are set by RACS. The Board would readily accept a commitment to Aboriginal and Torres Strait Islander and/or Māori competence.

Paediatric Surgery

RACS to include in the accreditation booklet.

Plastic and Reconstructive Surgery – Australia

Planned for mid-2018 for inclusion in standardised Board inspection template and site inspection reports

Plastic and Reconstructive Surgery – New Zealand

From 2018 the annual SET Registrars’ weekend will include a cultural competency agenda item. We will report more specifically in 2019. There is an intention that this becomes an annual training requirement and we have liaised with Mr Pat Alley in the development of this. In 2018 there is a planned teaching session on Māori pronunciation and the impact of common PRS operations, which alter the form of the body on the Māori view of self and identity and the impact of this on individuals and whanau which NZ healthcare providers – particularly reconstructive surgeons – need to be adept at addressing as part of the management plan.

Urology

No progress

Vascular Surgery

RACS to introduce policy.

Standard 9: Continuing professional development, further training and remediation

Areas covered by this standard: continuing professional development; further training of individual specialists; remediation

Summary of college performance against Standard 9

In 2017, this set of standards was found to be Met.

Summary of significant developments

Recommendations for improvement

UU	Implement a mechanism for the newly established CPD Audit Working Group to provide more robust feedback to Fellows, with a particular focus on the breadth of surgeons' individual practice. (Standard 9.1.3)
VV	As part of the reflective practice category consider including cultural competence as an area of reflection. (Standard 9.1.3)
WW	Explore the College's role in identifying the poorly performing fellow. (Standard 9.2.1)

Significant developments per specialty

Cardiothoracic Surgery

UU All CPD activities must have supportive documents before it is approved during the audit. This is all entered on line via RACS.

VV Standard 9.1.3 - No major development.

WW Standard 9.2.1 - The College has the right to report an underperforming Fellow to AHPRA. This is also linked to CPD compliance.

General Surgery – New Zealand

WW NZAGS is developing a pilot programme of practice visits which will attract CPD points for reflective practice. It is likely that the pilot will be running later in 2018.

Orthopaedic Surgery – Australia

AOA is currently working towards addressing the recommendations of the MBA Framework within the AOA CPD Program.

A response is currently being prepared to RACS consultation on CPD.

Orthopaedic Surgery – New Zealand

The NZOA CPD Programme is specific to orthopaedics. The NZOA Practice Visit Programme provides opportunity for reflective feedback.

Otolaryngology Head and Neck Surgery

UU The Board would accept relevant, robust feedback to fellows concerning CPD compliance.

VV The Board supports cultural competence as an area of reflection and supports the College in identifying the poorly performing Fellow.

Paediatric Surgery

No significant developments.

Plastic and Reconstructive Surgery – Australia

Recommendations UU, VV and WW are not applicable to Australian Society of Plastic Surgeons

Plastic and Reconstructive Surgery – New Zealand

No progress.

Urology

No progress

Vascular Surgery

No significant developments

Activity aligned with conditions

No Conditions for this standard.

Standard 10: Assessment of specialist international medical graduates

Areas covered by this standard: assessment framework; assessment methods; assessment decision; communication with specialist international medical graduate applicants

Summary of college performance against Standard 10

In 2017, this set of standards was found to be Substantially Met.

Summary of significant developments

Recommendations for improvement

XX	Provide greater support for specialist international medical graduate surgeons working towards specialist/vocational registration, and including access to educational resources, such as examination revision course, and other resources that are accessible to trainees. (Standard 10.2.1)
YY	Make information available to future applicants that may allow them to assess the likelihood of their application achieving substantially or partially comparable status prior to them making a substantial financial payment that historical evidence might suggest is unlikely to succeed. (Standard 10.4.1)

Significant developments per specialty

Cardiothoracic Surgery

XX and YY There have been two workshops in 2018 to address fast tracking the recognition of International Medical Graduates. A work place assessment is proposed to recognise supervision and Fellowship examination. A more consistent interview and evaluation process of IMGs is currently being considered across all Specialty Boards. A full report of the workshop will be available in due course

General Surgery – New Zealand

XX Nothing NZ specific as it is not the usual pathway

Orthopaedic Surgery – Australia

XX AOA has recently established an IMG Assessment Committee to facilitate better support of the IMG process. The first meeting of the committee is scheduled for May 2018

Otolaryngology Head and Neck Surgery

XX IMGs are invited to attend the same weekly tutorials that are attended by trainees, either in person or via webinar, in the state in which they are based. IMGs are also invited to attend the annual OHNS trainee meeting. The process of assessment, supervision and support of specialist IMGs working towards specialist/vocational registration is currently undergoing rigorous review. New policies will be in place in January 2019; this information will be made publicly available.

Paediatric Surgery

No significant developments.

Plastic and Reconstructive Surgery – Australia

XX Since 2017, International Medical Graduates have reliably been sent invitation to attend state-based educational activities as well as national SET Conferences. In 2018, five IMGs attended the SET 2-5 Conference in Adelaide; some participated in the trial examination activity. All participated in dissection workshops and didactic lectures. In 2016 and 2017, the SET Conference was managed by the New Zealand Board and Society.

YY RACS responsibility as per Collaboration Agreement.

Plastic and Reconstructive Surgery – New Zealand

IMGs in New Zealand are managed by MCNZ. Those who apply to Fellowship are able to access information via RACS. When the SET 2-5 PRS meeting was held in NZ in 2016 + 2017 we invited IMGs to attend (all of those who attended were based in Australia).

Vascular Surgery

No significant developments.

Activity aligned with conditions

Condition 34	All College and Specialty Training Board SIMG assessment processes and associated documentation must reflect the Medical Board of Australia and Medical Council of New Zealand guidelines by ensuring that both training and post-training experience are appropriately considered in assessments of comparability. (Standard 10.1) To be met by 2019

Progress reported by specialty

Cardiothoracic Surgery

Work in progress.

Neurosurgery

RACS activity

Otolaryngology Head and Neck Surgery

The Board supports RACS' progress in this area.

Paediatric Surgery

In progress.

Plastic and Reconstructive Surgery – Australia

In February 2017, the Board co-opted an IMG representative and established an IMG Subcommittee Panel to coordinate the harmonisation of RACS' IMG policies with plastic surgery standards. Feedback about collaboration with RACS has been positive

Plastic and Reconstructive Surgery – New Zealand

This is managed by RACS Wellington on behalf of the MCNZ. The Board participates by joining a panel that assess IMGs' training and post training, education and experience referenced to FRACS; the Board reports directly to the MCNZ.

Urology

The IMG representative is an active member of the IMG Committee. The Board believes that reported progress relating to this condition should come from the IMG Committee.

Vascular Surgery

In progress.

Activity aligned with conditions

Condition 35	Develop and adopt alternative external assessment processes, such as workplace-based assessments, to replace the Fellowship Examination for selected specialist international medical graduates. (Standard 10.2.1) To be met by 2020

Progress reported by specialty

Cardiothoracic Surgery

The IMG workshop will be held on 13 April 2018 to address this. A full report will be prepared.

Neurosurgery

Nothing to report.

Orthopaedic Surgery – Australia

Feedback is currently being sought from the Federal Training Committee and the new IMG Assessment Committee on RACS proposed assessment process.

Otolaryngology Head and Neck Surgery

In progress through the RACS IMG committee. The Board is developing work-based assessment processes to replace the FEX for selected IMGs.

Paediatric Surgery

In progress through the IMG committee.

Plastic and Reconstructive Surgery – Australia

As above for Condition 34.

The IMG workshops convened by RACS are a suitable and effective vehicle for bringing about change.

Plastic and Reconstructive Surgery – New Zealand

This should be consistent across all specialties and bi national boards for specialties such as PRS to ensure fairness and natural justice – so we look to RACS for guidance on this.

Urology

The IMG representative is an active member of the IMG Committee. The Board believes that reported progress relating to this condition should come from the IMG Committee.

Vascular Surgery

RACS – in progress