THE ROYAL AUSTRALASIAN COLLEGE OF SURGEONS

ANNUAL REPORT

TO THE AUSTRALIAN MEDICAL COUNCIL

2003

COLLEGE DETAILS:

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1. INTRODUCTION

In the 12 months covering 2003 the College has experienced significant developments in a number of areas. The Australian Competition and Consumer Commission (ACCC) determination came into effect on 22 July 2003.

The ACCC have made recommendations across a broad spectrum of College activities. The ACCC have placed increased emphasis on participation of people external to the College in a range of College process including, selection, assessment of overseas trained doctors, College appeals and assessment of hospitals/posts for surgical training.

The ACCC have been quite detailed in their requirements for the College and although the focus of the ACCC is different to the AMC there are distinct parallels and overlap in common areas of consideration.

This Annual Report will address the specific questions as raised by the AMC and also draw a corresponding link with the ACCC where appropriate.

2. PROCESS OF SPECIALIST EDUCATION AND TRAINING

Provide details of any changes to the education and training programmes and any significant changes planned within the next 12 months, together with a brief statement of reasons and evidence for the change. This should include changes to:

- *The goals of education and training.*

The College has firmly focussed on the meaning and application of surgical competence and is developing explicit definitions about the levels and range of competency required for different surgical procedures in Basic and Advanced Surgical Training.

The College is working with a number of Federal Government departments and working groups to identify the goals of surgical education and training and the needs of particular groups of surgical trainees and specialists. Current initiatives include:

1) Medical Specialist Training Taskforce is researching the educational needs, training requirements and learning environments for medical specialist training
2) Research into the special needs of overseas trained doctors, in particular those filling a designated Area of Need surgical position
3) Research into the special needs of rural surgical specialists.

- *Structure and duration of training.*

General Surgery was structured along a 3 + 2 year training programme, providing general surgical experience in the first 3 years followed by 2 years of sub-specialty training. The 3 + 2 structure was reviewed and suggestions and feedback were received from the Fellowship in the following ways. A working group composed of Younger Fellows undertook a comprehensive survey of all younger fellows in Australasia. General Surgeons Australia and the New Zealand Association of General Surgeons performed a parallel review. This was followed by debate at the Boards of General Surgery, Advanced Surgical Training and Education Policy

Following this extensive review it was agreed that the training programme for General Surgery should be reduced to 4 years with the aim of producing a General surgeon capable of independent practice within this timeframe.

If further sub-specialty experience is required following Fellowship this will be achieved through specified positions to be accredited by the Specialist Societies with input from the various sub-specialty groups such as currently exits with the Colorectal Surgical Society of Australasia.

In addition to this change other specialty boards are reviewing assessment. It is important that trainees have a strong understanding of anatomy, physiology and pathology as well as relevant diagnostic procedures early in their course. This will provide them with the skills to effectively examine and diagnose patients. Based on the educational principles of life long and vocational learning the College is exploring

ways to introduce multiple forms of assessment into curricula to assist in translating learning into the clinical environment. The Orthopaedic Principles and Basic Sciences examination is already a requirement for Orthopaedic trainees. This is providing a model for the structure and implementation of examinations in the other surgical specialties.

The Boards of Plastic and Reconstructive Surgery have received approval to introduce a basic sciences exam in the first year of Advanced Surgical Training. This is a formative assessment that will occur towards the end of the first year of Advanced Surgical Training. **The Board of Paediatric Surgery** have introduced two basic science examinations, one in anatomy in the second year of the general surgical component and another in pathology at the beginning of the fourth year of advanced training. **Neurosurgery and Vascular Surgery** are also discussing the introduction of a basic sciences examination.

- *Content of education and training programme.*

In **Basic Surgical Training** detailed learning objectives and 25 self directed learning case studies to assist trainees in successful completion of their objectives are being developed. These case studies will cover the major systems in the body and through the presentation of clinical material are designed to help trainees learn the basic sciences related to the practice of surgery.

For **Advanced Surgical Training** the key areas for curricula development have included documenting the curricula for Advanced Surgical Training, developing online case studies and a range of other educational resources for Advanced Surgical Training and developing a strategy for evaluation of the training programmes.

The Advanced Surgical Training curriculum will include clearly articulated learning objectives and competencies, an explanation of the philosophy and goals of the training courses and learning materials for self directed learning. Learning resources will incorporate the CanMEDS recommendations. Curriculum maps for each specialty are being developed to provide an overview of the entire Advanced Surgical Training curriculum and the extent to which assessment is linked to content development.

The College has, on line, detailed information on 3 Advanced Surgical Training programmes, Neurosurgery, Paediatric Surgery and Urology. These programmes have explicit statements of competencies and objectives for each subject area and specific surgical procedures are regularly updated to reflect the developments in techniques and technology. It is intended to expand this to include all specialties. The Board of Paediatric Surgery have recently held a workshop on competencies and objectives for each subject.

The College is piloting the “Outer Metropolitan Specialist Training Programme”. This is a federally funded programme and is designed to provide advanced surgical trainees with the opportunity to undertake training in the private sector. This programme is examining the role of the private sector as a learning environment and aims at increasing the exposure of a trainee to a broader range of surgical procedures than currently exists in the public hospital sector. This will facilitate the development of

training programmes that provide trainees with a wide range of experiences required to provide services across the spectrum of health.

- *Formal educational courses.*

The College has developed a new course, “Statistics for Surgeons” available to both trainees and Fellows. This is primarily a two day workshop with the intention of providing participants with skills to identify and manipulate common types of data, express and graph summaries of data. The students will perform a selection of statistical tests and be able to interpret and express results. This is not a compulsory course and is designed to be complementary and extend on the principles of the existing Critical Literature Evaluation and Research course.

Provide details of any changes planned to the range of education and training programmes in sub-specialties.

The College is currently working with the Royal Australasian College of Dental Surgeons to instigate a joint Fellowship between the two Colleges in oral and maxillofacial surgery. This initiative formally recognises the synergies between these disciplines and contributes to the improvement of surgical skill and expertise in this area.

3. TRAINEE ASSESSMENT AND EXAMINATION

Provide details of any significant changes to assessment and examination policies and practices and any changes planned within the next 12 months, together with a brief statement of reasons and evidence for the change, including:

- *Changes to assessment policy and principles.*

In order to meet the challenges of educational development and to enhance alignment between educational content and assessment the College has been reviewing its methods of assessment.

In 2003 the Board of **Basic Surgical Training** convened a Working Party to undertake a pilot project to update the pass/fail standard setting process for the basic surgical sciences Multiple Choice Question (MCQ) examination. The working party reviewed current measurement approaches in analysing examination data for test quality and difficulty and recommended the adoption of the Rasch model of Item Response Theory for examination scaling, including test equating and criterion referenced standard setting. The project is being undertaken in collaboration with the University of Melbourne Assessment Research Centre. Following the results of the pilot undertaken in January 2004 the Board has approved the adoption of Rasch Scaling for live examination data beginning in June 2004.

The **Court of Examiners**, which is responsible for setting and conducting the Part 2 Fellowship examination, have recently developed a policy on Academic Misconduct. This policy defines what is constituted as a transgression during an examination and also the outcomes that can be applied to any person found breaching the policy.

- *Introduction of new methods of formative and/or summative assessment.*

The **Board of Paediatric Surgery** has introduced on line case studies as part of their formative assessment process. During December 2003 and January 2004 the Board of Paediatric Surgery conducted a pilot of an interactive online case study which in the future will be used in assessment. There is currently one case study on line with a further 3 scheduled for 2004. This is a pilot programme and will be subject to a formal ongoing evaluation with the objective of assessing the contributions made on-line and using it as a requirement for presenting for the Part 2 examination.

The Board of Paediatric Surgery has revised the assessment templates utilised for its Critical Appraisal Tasks (CATS), including an expansion of assessment criteria and modification applicable to each year of advanced training. Satisfactory completion of four CATS per year is a compulsory requirement of advanced training in paediatric surgery.

- *Changes to assessment to reflect changes in educational objectives and or/learning goals and methods.*

The Board of **Basic Surgical Training** has developed two on line data banks for the selection of examination questions for the Multiple Choice Question Examination and the Clinical Examination (formerly known as the Objective Structured Clinical Examination). This ensures effective administration of these examinations.

- *Changes to the process for identifying unsatisfactory performance by trainees.*

There have been no substantial changes in the process for identifying unsatisfactory performance other than the introduction of the policy on Academic Misconduct. In the Surgical Teachers Course there is a module relating to the identification and remediation of unsatisfactory performance in trainees. By this mechanism surgeons' skills are enhanced.

4 ACCREDITATION OF INSTITUTIONS, TRAINING PROGRAMMES AND POSITIONS

Provide a brief statement of any significant developments in the College's relations with the State, Territory or New Zealand health care services.

The Censor-in-Chief has collaborated with the New Zealand Accident Compensation Commission on matters pertaining to medical injury and compensation.

The President, the Censor-in-Chief and various staff represent the College in the deliberations regarding the Area of Need processes in collaboration with the other Colleges, the jurisdictions, the medical boards and other key stakeholders. The President is a member of the Joint Working Group of Overseas Trained Specialists. The
Censor-in-Chief has accepted the Chief Medical Officers recommendation to co-chair the Medical Specialist Taskforce working party on Educational Needs, Training Requirements and Learning Environments for medical specialists. This working party includes representation from a surgical trainee and another Fellow of the College.

Provide details of any significant changes to arrangements for the accreditation of training programmes, institutions or training posts such as:

- *Changes to accreditation policy or principles.*
- *Changes to the criteria for accreditation.*

This is one of the primary areas that the ACCC will be focussing on and the College has not altered its current practice of review of hospitals or hospital posts since the previous annual report. It is anticipated that there will be some recommendations arising from the ACCC review that may result in changes in the procedures for accreditation of Hospitals and Hospital Posts. The College has complied with the inclusion of jurisdictional representatives on the hospital post inspections as specified by the ACCC.

Provide a short report on the College's accreditation activities in the last 12 months.

In 2003 the College Board of Advanced Surgical Training accredited the following number of hospital posts:

Specialty	New Posts	Reaccredited Posts	Total
Cardiothoracic Surgery	3	4	7
General Surgery	27	12	39
Neurosurgery	2	3	5
Otolaryngology Head and Neck Surgery	3	2	5
Orthopaedic Surgery	7	11	18
Paediatric Surgery	1	4	5
Plastic and Reconstructive Surgery	1	1	2
Urology	3	20	23
Vascular Surgery	1	5	6
Total	48	62	110

Most specialties accredit their posts for 5 years and rotate the accreditations across a five year period.

Two specialties, Urology and Orthopaedic Surgery, accredit the majority of their training posts on a 5 year cycle, hence Urology have reviewed the majority of their posts in 2003.

Provide a short report on the developments concerning trainee clinical experience, such as

- *Access to outpatient and ambulatory experience*
- *Mechanisms for monitoring the adequacy, supervision and organisation of clinical placements.*
- *Changes to the range of hospitals/institutions accredited for training.*

The **Board of Basic Surgical Training** has made some amendments in the Basic Surgical Training programme to include:

a) The emergency medicine term has been reduced from 12 weeks to 10 weeks and any variation on this is at the discretion of the hospital and State/Regional supervisors. Trainees are encouraged to undertake this term as a single block of 10 weeks but can undertake a maximum of three rotations with the minimum per rotation to be four weeks. The required In-Training Assessment Report will apply to the total time.

b) Night duty in surgical terms may be approved at the discretion of the hospital and the State/Regional supervisors. Trainees may undertake a maximum of 8 weeks of night duty during the required 52 weeks of surgical rotations. The hospital BST supervisor will ensure adequate supervision of training during periods of night duty. The required In-Training Assessment Report will apply to the total term in which the period of night duty occurs.

c) Relief terms in surgery may be approved and assessed at the discretion of the hospital and the State/Regional supervisors. Trainees may undertake up to 12 weeks in relief terms during the required 52 weeks of surgical rotations. The hospital BST supervisor will ensure adequate supervision of training during periods of relief duty. The required In-Training Assessment Report will apply to the total term in which the period of relief surgery duty occurs.

d) Rotation of Basic Surgical Trainees outside of the accredited training hospitals in which these terms/rotations occur can be approved for Basic Surgical Training, surgical terms/rotations in country (rural) and urban hospitals (maximum total duration 12 weeks) at the discretion of the hospital and State/regional supervisors. Trainees can undertake a maximum of three such rotations with a minimum rotation of four weeks. The required In-Training Assessment Report will apply to the total term in which these terms/rotations occurs.

It is not anticipated that a single trainee would carry out all the training options in b), c) and d) which would result in a total 32 weeks of training as defined in those provisions. The Board recognises that trainees often undertake one of these rotations

and providing that there is sufficient surgical supervision and satisfactory in-training assessment forms then it may be appropriate to recognise the term for the purposes of surgical training. The Board will carefully monitor trainees on any of these rotations.

5. SUPERVISORS, ASSESSORS TRAINERS AND MENTORS

Provide details of any significant changes to the process by which supervisors are appointed and/or to the roles of supervisor, assessors, trainers and/or mentors.

There have been no changes to the processes for the appointment of supervisors or the roles of the assessors, trainers or mentors.

The Facilitated Personal Mentoring Scheme for basic surgical trainees has approximately 50 trainees matched to a volunteer Fellow mentor. Personal mentors are volunteers from the RACS Fellowship who offer their own time and personal support to assist and encourage basic surgical trainees. There is a training programme for Fellows who volunteer for this initiative and such work is considered a valid continuing professional development activity by the Board of Continuing Professional Development.

Provide details of any significant activities to support supervisors, assessors, trainers and mentors, such as training activities or written manuals.

The College updated the Guide to Surgical Training which has been renamed the "Surgical Education and Training Handbook" (copy attached). The Handbook outlines the duties of supervisors and also includes policies in regard to Part time and Interrupted Training, Special Consideration and other areas that supervisors could find useful. The Surgical Education and Training Handbook is issued to trainees. This is available on-line and in future all amendment to policies will be updated on the website.

The College conducted 4 "Surgical Teachers" courses with a total of 45 Fellows participating in courses that were conducted in Melbourne, Brisbane, Christchurch and the Hunter Valley. The courses are designed to improve the skills and knowledge of surgeons. The course includes modules on adult learning, teaching skills, feedback and assessment and effecting change.

Two Early Management of Severe Trauma (EMST) instructors' courses and one Care of the Critically Ill Surgical Patient (CCrISP) instructors' course were held in 2003, training a total of thirty seven new instructors improving their skills in the general area of teaching and with specific relationship to the delivery of the set curriculum of these programmes.

6. ISSUES RELATING TO TRAINEES

Provide a brief summary of significant changes planned or implemented:

- *To the policy and procedures for trainee selection.*
- *To the College's role in selection.*
- *To arrangements for trainee support and counselling and/or mentoring programmes.*

Provide details of actions planned or taken by the College to ensure that selection policies and practices comply with principles in the 1998 report "Trainee selection in Australian Medical Colleges" by the Medical Training Review Panel (Brennan Principles).

The College continues to scrutinise and refine selection procedures in Basic Surgical Training and Advanced Surgical Training. Prior to the annual selection process the **Board of Basic Surgical Training** convened a workshop dedicated to reviewing the selection procedures and confirming that these procedures are in alignment with the Brennan principles. In 2003 the Board of Basic Surgical Training invited a jurisdictional representative to the workshop and will continue to include such representatives in future workshops.

The **Boards of Advanced Surgical Training** annually review the selection processes and produce a report. These reports form the basis of reviews conducted prior to the subsequent years selection to continuously refine the process. One of the responses to concerns raised abut trainees who may have been disadvantaged by recent changes in the structure of Basic Surgical Training and articulation to Advanced Surgical Training was to establish an additional category of selection for trainees, being a "2004 Transitional Surgical Trainee" (TST). 2004 was the final year that trainees from the "old" Basic Surgical Training programme could apply for Advanced Surgical Training.

The College Council agreed on the following definition of a TST. "A 2004 TST is an applicant who met the eligibility and selection criteria as outlined by the Specialty Boards and whose application was unsuccessful only due to the limited number of available training positions, but would be permitted another application to Advanced Surgical Training in 2004 for entry to training in 2005. Trainees who did not meet the requisite criteria would no longer be eligible to apply to Advanced Surgical Training".

All the Boards in the College are highly attuned to the requirements of the Brennan principles and ensure that their selection processes are in accord with these principles. All of the nine Specialty Boards have reviewed the selection processes to ensure compliance with the Brennan principles.

The College is collaborating with the jurisdictions to ensure effective inclusion of jurisdictional representatives on College selection panels. Some Specialty Boards already have jurisdictional representatives in place.

The College ran a series of 10 interviewer training workshops in Australia and 4 in New Zealand. These workshops were designed to enhance the interview skills of

Fellows on trainee selection panels for both Basic and Advanced Surgical Trainee selection. Attendees were provided with a training manual for subsequent reflection and reference. The workshops were well attended and feedback from the Fellows was very positive.

Provide information on the number of trainees entering training programmes (if applicable, provide figures for basic and advanced training programmes). If the College has identified a disparity between the number of training posts/opportunities available and the number of applicants for the positions, please comment briefly on the reasons for this disparity and any actions by the College and other bodies to address it.

In **Basic Surgical Training** the total intake was 200. The intake in New Zealand was 36. The intake in Australia was 164 distributed across the following States:

Australian Capital Territory	3
New South Wales	58
Northern Territory	2
Queensland	24
South Australia	14
Tasmania	5
Victoria	51
Western Australia	7

Refer to the Medical Training Review Panel, seventh report, November 2003. Commonwealth of Australia. Table 10 on page 26.

In **Advanced Surgical Training** the total intake was 217. The intake in New Zealand was 35. The intake in Australia was 182 and is distributed across the following specialties:

Cardiothoracic Surgery	8
General Surgery	67
Neurosurgery	15
Orthopaedic Surgery	38
Otolaryngology – Head and Neck Surgery	20
Paediatric Surgery	4
Plastic and Reconstructive Surgery	15
Urology	12
Vascular Surgery	5

Refer to the Medical Training Review Panel, seventh report, November 2003. Commonwealth of Australia. Tables 18 and 19 on page 31.

In **Paediatric Surgery** there is a greater capacity to train surgeons than is demanded for future workforce projections. Unlike other specialties the ageing of the population has not increased demand however in response to perceived needs to supply service to communities not served by major metropolitan free standing children's hospital and because of an increasing range of services required to provide appropriate care for

children the Board of Paediatric Surgery has responded by increasing the number of trainees. It is expected that by 2006/7 all paediatric surgical posts will be filled.

Provide a short summary of the activities of and significant issues raised by the trainees' association, if one exists.

There are two trainees on the Curriculum Review Committee of the Board of **Basic Surgical Training**. These trainees are selected on an annual basis between the Australian States and New Zealand. The Board of Basic Surgical Training has an on line forum whereby trainees are able to contact each other as well as the College.

Feedback from trainees is received through a number of avenues. The Board of **Advanced Surgical Training** has two trainee representatives who are able to raise and discuss issues of concern to trainees. The Australian Orthopaedic Registrars Association is an avenue for orthopaedic trainees to raise issues related to training in general or specific to the Orthopaedic Surgery training programme.

7. OUTPUTS AND OUTCOMES OF TRAINING

Provide information on the following since the last report:

- *The components of summative assessment (e.g. Part 1 and Part 2 exams) and the number of candidates sitting and passing each component each time they were held. If applicable, comment briefly on actions taken by the College in response to significant changes in the percentage of candidates passing summative assessments.*

The Part 1 Examinations

Three Multiple Choice Question (MCQ) Examinations were conducted at which a total of 278 candidates presented of which 185 were successful providing an overall pass rate of 67%.

MCQ	Candidates presented	Candidates passed	Pass rate
February	93	51	59%
June	108	83	77%
November	77	51	51%

Two Objective Structured Clinical Examinations (which has been renamed the 'Clinical Examination' from 2004) were conducted at which 242 candidates presented and 224 successfully completed providing a pass rate of 92%.

OSCE	Candidates presented	Candidates passed	Pass rate
February	139	131	94%
June	103	93	90%

The Orthopaedic Principles and Basic Sciences Examination was also conducted with 44 candidates presenting and 42 successfully completing providing a pass rate of 95%.

The Part 2 Examinations

Four Part 2 Examinations were conducted in Wellington, Hong Kong, Brisbane and Melbourne. A total of 237 candidates were examined of whom 165 were successful providing a pass rate of 70%.

- *The number of trainees who completed training.*

Cardiothoracic Surgery	7
General Surgery	49
Neurosurgery	5
Orthopaedic Surgery	46
Otolaryngology – Head and Neck Surgery	15
Paediatric Surgery	2
Plastic and Reconstructive Surgery	18
Urology	15
Vascular Surgery	8

- *The initiatives introduced to determine outcomes/outputs*

This question is primarily answered in section 8 as part of the overall strategy of the College to evaluate and enhance surgical training competence.

8 EVALUATION OF THE PROGRAM

Provide details of any significant changes to the way in which the college monitors and evaluates the quality of its education and training programs and/or to methods used to monitor the trainees' and the supervisors' opinion of the programs.

Provide information on the following activities undertaken in the last 12 months:

- *new evaluation activities initiated*
- *evaluation activities completed*
- *changes in the resources available to support the program.*

The College recognises the importance of evaluating programmes and their components. These need to be mapped to integrate the relationships between programme objectives and programme activities in a manner that indicates appropriate data sources for particular evaluation questions.

The College has commenced evaluation in **Basic Surgical Training** by constructing an overall programme logic matrix of the BST programme. There are nominated components of the BST programme that have been expanded into separate programme logic matrices to begin evaluation of components of BST that are considered a high priority.

Understanding the relationships between all components within BST will allow greater flexibility and foresight in choosing data that will inform both individual and ongoing evaluations.

An Evaluation Co-ordinator was appointed in March 2004. The Evaluation Co-ordinator will provide direct strategic and planning support on specific projects related to the evaluation of the education and training programmes.

In 2003 the College made two staff appointments in the Education Development Department. An Education Fellow in Residence was appointed to develop a series of case studies for Basic Surgical Training Online. A Curriculum Developer was appointed to work with the specialist boards and societies to develop detailed curricula for Advanced Surgical Training.

9 ASSESSMENT OF OVERSEAS TRAINED SPECIALISTS

Describe the college's process for assessing the equivalence of the education, training and experience of overseas-trained specialists to that of Australian-trained specialists. Detail any changes to the process over the last 12 months or planned in the next 12 months, and comment briefly on the reasons.

The College procedure is generally in accordance with the process specified in the Australian Medical Council/Committee of Presidents of Medical College's (AMC/CPMC) "Assessment of Overseas Trained Specialists Templates for Colleges" The College reviews each overseas trained doctor on an individual basis, through reviewing a range of documentation, supplied by the doctor, covering their education, training, qualifications and surgical experience. This documentation is forwarded to an assessment team comprising the relevant Specialty Board Chairman and the Censor-in-Chief or nominee. Following assessment of the documentation an interview with the applicant is scheduled.

The interview panel comprises the relevant Specialty Board Chairman, the Censor-in-Chief or nominee. Interview panel members may also include other Board Chairmen or the College Executive Director of Surgical Affairs.

The interview evaluates their surgical practice, professional ethics, communication skills and familiarity with the Australasian health system. The interview allows the applicant to demonstrate their knowledge by responding to a series of standard questions and brief hypothetical scenarios. The recommendations arising from the interview are determined by the profile of the individual applicant according to their level of knowledge

In extremely rare cases, an interview may not be required. This would occur following review of the documentation that the applicant has supplied where it is clearly apparent that the applicant is not substantially comparable to that of an Australasian trained surgeon. In these cases the College will issue a written assessment with recommendations.

Surgeons for Areas of Need are of particular importance. There are significant reviews initiated by the Department of Health and Ageing focussing on the processes used by Specialist Colleges to assess suitability of overseas trained surgeons for Area of Need positions. The College is participating with other medical colleges, AMWAC and jurisdictional representatives in a Joint Working Party sponsored by the Commonwealth Government. The College has proposed to the Working Party a three category assessment of surgeons:

1) Recognised surgeon who is substantially comparable and will have access to the public and private sectors.
2) Surgeon-in-training who is not substantially comparable as training required for two years or more.
3) Career Medical Officers or General Practitioners with specific surgical skills.

10 CONTINUING PROFESSIONAL DEVELOPMENT PROGRAMS

Provide details of any significant changes to the college's continuing professional development programs and any changes planned within the next 12 months, together with a brief statement of reasons for the change, including:

- *changes to policy or principles relating to continuing professional development.*

The 2004 – 2006 Continuing Professional Development (CPD) Programme incorporates a number of changes to reflect the needs of Fellows and current educational principles.

The programme offers a points system for crediting activities, to enable weighting for educational value. One point is equivalent to one hour from the previous CPD Programme. The programme includes a greater emphasis on active learning, rewarding activities such as peer review of practice, interactive workshops/ small group learning activities and learning and development plans.

Individual CPD Programme requirements are determined by the type of practice a Fellow undertakes (Table 1). Two additional practice types (Type 6: Other non-procedural and non-clinical work, e.g. research, academic, administration and Type 8: Surgical assisting) have been added to the programme to better meet the needs of Fellows.

Table 1: 2004 – 2006 CPD Programme Practice Types

Number	Practice Type
1	Operative practice in hospitals or day surgery units
2	Operative procedures in rooms only
3	Clinical consulting (non-operative)
4	Medico legal practice – personal injury (non-operative)
5	Medico legal practice – medical negligence (non-operative)
6	Other non-procedural and non-clinical work, e.g. research, academic, administration
7	Locum work
8	Surgical assisting

- *changes to the categories of activity recognised for continuing professional development*

There have been minor changes to the categories offered for the 2004 – 2006 CPD Programme, which are listed below (Table 2). Hospital Credentialing (Category 2) was previously grouped with Surgical Audit and Peer Review (Category 1) and Medico Legal Workshops (Category 8) has been introduced for Fellows in medico legal practice to record their requirement to attend an approved medico legal workshop.

Table 2: 2004 – 2006 CPD Programme Categories

Number	Category Title
1	Surgical Audit and Peer Review
2	Hospital Credentialing
3	Clinical Governance and Evaluation of Patient Care
4	Maintenance of Clinical Knowledge and Skills
5	Teaching and Examination
6	Research and Publication
7	Other Professional Development
8	Medico Legal workshops

- *changes to the college's process for endorsement of educational activities/meetings*

The Board of CPD and Standards is currently reviewing the process of approving activities for the CPD programme, with particular emphasis on the weighting of educational activities that involve active learning.

- *initiatives to evaluate professional development programs.*

Please provide information on the rates of participation by college fellows in the college's last CPD cycle. If applicable, comment briefly on actions taken by the college in response to low participation rates or actions aimed at improving participation in continuing professional development programs.

The College is currently collecting 2003 data for the 2001 – 2003 triennium and will issue the Certificate of Continuing Professional Development to Fellows who have met the triennial requirements in early April 2004.

Participation in the 2002 CPD Programme is at 88%, with 86% of those Fellows complying with the annual requirements. The College issues reminder letters to Fellows who do not participate and also communicates to Fellows who participate, but do not comply. In addition, Specialty Society representatives on the Board of CPD and Standards are provided with a list of Fellows who are non-compliant and non-participant to contact and provide guidance (October 2003 and February 2004). If a Fellow's CPD status remains unchanged following contact from the Specialty Society, they will be notified in writing of their non-compliance or non-participation by the College President.

The Board of CPD and Standards is currently reviewing sanctions and incentives regarding participation and compliance in the CPD Programme.

11 REPORT ON ISSUES IDENTIFIED BY THE AMC

For colleges that have been formally reviewed by the AMC, provide a brief report on the college's response, since its last report, to the issues identified for attention in the AMC Accreditation Report.

- *Memorandums of Association with the Specialties.*

The College has signed Memorandums of Association with all 13 of the relevant specialties and is currently finalising service contracts with those specialties. The service agreements:
1) set out the rights and responsibilities of the parties,
2) set out services and funding arrangements to be provided by each party for training and education
3) ensures that the Advanced Surgical Training programme is carried out in a transparent accountable manner.
There are only four specialty groups remaining to sign the service agreements but negotiations are well advanced.

- *The further development and specification of the College's educational programmes, including continuing professional development programmes.*

In general this submission details a large number of continuing improvements in education and learning processes and outcomes for trainees and Fellows. There is more detailed information on the progression of the continuing professional development programmes in section 10.

The College has established several working parties being the:
1) Code of Conduct working party to develop a professional code of conduct for Fellows and trainees.
2) The Workforce working party which reviews AMWAC projections and workforce requirements.
3) The Skills Laboratories working party which has been established to provide advice regarding utilisation of the College skills centres.

- *Integration of the non technical aspects of surgical practice such as those set out in the CanMEDS document in training and assessment.*

The College is directly addressing the CanMEDS principles under the auspices of surgical competence. Currently the College is proposing a definition of surgical competence as embodying a training programme that provides specialist surgeons with the following attributes:
- Medical Expertise - Clinical Decision Maker
- Technical Expertise
- Communication
- Collaboration
- Manager
- Health Advocate
- Scholar and Teacher
- Professional.

These attributes will be demonstrated through clinical skills, patient care and professional judgement across five domains:

1) Cognitive (acquisition and use of knowledge to recognise and solve real life problems),
2) Integrative (appraisal of investigative data against patient needs in clinical reasoning, manage complexity and uncertainty, application of scientific knowledge in practice),
3) Psychomotor (procedural knowledge, technical skill, manual dexterity and adaptability),
4) Relational (the ability to communicate effectively, accountability, works with others, consultative, resolving), and
5) Affective/moral/cultural (self awareness, ethical, critically reflective, responsible, healthy, safe).

It is expected that the Specialty Boards will develop specific proposals for assessment of surgical competence in light of the above definitions. These definitions have been accepted by the Chief Medical Officers Medical Specialist Taskforce as a basis for consideration in the development of a framework for training a medical specialist in the future.

- *Development of systems for programme monitoring and evaluation.*

The appointment of the Evaluation Coordinator will provide the College with a significant resource for determining the effectiveness of the training programmes. The Evaluation Coordinator will cover the full range of training programmes offered by the College.

- *Requirements for selection consistent with the Medical Training and Review Panel Report - the Brennan principles.*

Selection of trainees is covered in section 6 of this report. Although it is important to emphasise that the College is well acquainted with the Brennan principles and is consistently striving to ensure that they are implemented in the selection process.

- *Further attention to the issues relating to non accredited training posts.*

As part of the ACCC review the College has considered a number of options in regard to non accredited posts, including the possibility of accrediting hospitals rather than posts for Advanced Surgical Training. This is an area that is under formal review by the ACCC.

- *Improved mechanisms for formative assessment of trainees.*

This aspect will be addressed under the CanMEDS principles.

- *Review of the criteria and processes for accreditation of training posts and institutions.*

As previously noted this is an area of review by the ACCC. It is anticipated that there will be recommendations, arising from this review, which will alter the accreditation process.

- *Review of the strategies and mechanisms for communication to and from the College, trainees, supervisors, mentors and trainers.*

The Surgical Education and Training Handbook (SETH) is available on the College website. It is intended that this will provide a primary reference for all persons involved in surgical training. The College is actively seeking to promote a culture that is based around electronic transmission of information and SETH is one of the tools that will facilitate this process. The College website is seen as a major provider of information for trainees. Surgical News is a popular vehicle for communicating with the Fellowship. Regular articles are written regarding Surgical Education and alerting the Fellowship to key issues in training. The Board of Basic Surgical Training issue a newsletter to their trainees three times a year following the Board meeting. The trainees newsletter advises of any significant changes or matters of interest that have arisen from the Board meeting.

- *Further attention to the issues relating to assessment of overseas trained doctors.*

As previously noted this is an area of review by the ACCC. It is anticipated that there will be recommendations, arising from this review this will impact on the procedures for assessment of overseas trained doctors.

12 SPECIFIC ISSUES FOR REPORT IN 2004

In 2003, the Australian Medical Council participated in a "Cultural Competence in Medical Education Workshop", under the sponsorship of the Centre for Culture and Health, the University of New South Wales. The Department of Health and Ageing has contracted the Centre to implement a program for the advancement of cultural competence in medical education and workforce development.

The workshop's aims included:

- *working collaboratively with universities and other stakeholders to develop key cultural competence learning objectives and recommendations for success;*
- *improving access to appropriate and effective cultural competence content for potential integration in medical curricula;*
- *commitment to improving health for all by graduating culturally competent medical practitioners likely to produce more successful health outcomes.*

Reports on the workshop by AMC representatives have been considered by the AMC's Medical School Accreditation Committee and Specialist Education Accreditation Committee, which noted plans for a scoping project to establish what modules exist in medical schools to develop students' knowledge of diversity awareness and to inform a decision as to whether further modules should be developed for use by medical schools and specialist colleges.

The Specialist Education Accreditation Committee also noted that the Medical Council of New Zealand intends that cultural competence become an ongoing requirement for registration and recertification of all registered medical practitioners working in New Zealand.

The AMC Accreditation Committees intend to consider what changes, if any, should be made to accreditation standards to encourage attention to the role of culture as a determinant of health outcomes and cultural barriers to quality health care. The Specialist Education Accreditation Committee will consult colleges before it proposes any changes to the Guidelines for Accreditation.

To assist the AMC to consider this matter, the Specialist Education Accreditation Committee is requesting information on ways in which colleges currently address cultural competence in their education and training programs, for example by specifying relevant learning objectives; curriculum modules or courses; or assessment tasks relevant to the topic.

Specialist Surgical groups (who are directly involved in the training of advanced surgical trainees) are currently developing statements of surgical competence that guide their on-going curriculum development. These statements include indicators/objectives such as:-

- manages patients in ways that demonstrate sensitivity to their physical, social, cultural, and psychological needs

- appropriately adjusts the way they communicate with patients to accommodate cultural and linguistic differences

The College is also in discussion with academic staff at Monash University, Centre for Medical and Health Science Education, about the development of a short interactive course on ethics.

In addition the College offers a range of professional development opportunities for Fellows that are approved in the RACS CPD Programme. The College offers a Risk Management workshop available to surgeons of all surgical specialties. The focus of the programme is communication skills in clinical interactions and consists of three modules: Practice Management, Mastering Your Risk and Mastering Consent.

The Mastering Consent module focuses on the ethical and legal issues around the consent process. A major focus of discussion is consideration of cultural aspects when communicating with patients from different ethnic and religious backgrounds (and their families), the use of interpreters and supporting decision-making about treatment options throughout the consent process.

In 2002, over 280 Fellows of the College participated in the Risk Management workshop in New Zealand (Wellington), Queensland, New South Wales, Victoria and Tasmania.