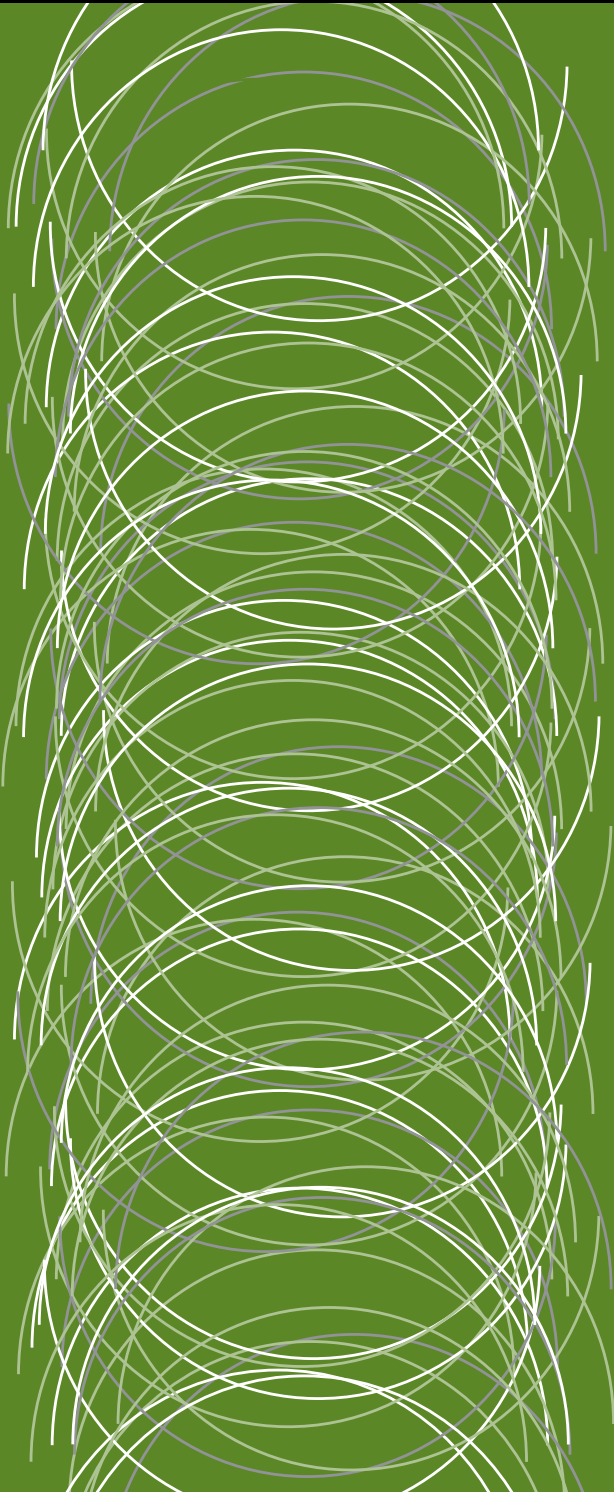


Australian Medical Council Limited

Accreditation Report: The Training and Education Programs of the Royal Australasian College of Surgeons

AMC



Specialist Education Accreditation Committee
December 2017

January 2018
Edition 1 – Digital
ABN 97 131 796 980

ISBN 978-1-938182-77-8

Copyright for this publication rests with the
Australian Medical Council Limited

Australian Medical Council Limited
PO Box 4810
KINGSTON ACT 2604

Email: amc@amc.org.au
Home page: www.amc.org.au
Telephone: 02 6270 9777
Facsimile: 02 6270 9799

Contents

Executive Summary: Royal Australasian College of Surgeons.....	1
Introduction: The AMC accreditation process.....	19
1 The context of training and education.....	22
1.1 Governance	22
1.2 Program management	24
1.3 Reconsideration, review and appeals process.....	29
1.4 Educational expertise and exchange	30
1.5 Educational resources.....	31
1.6 Interaction with the health sector	32
1.7 Continuous renewal	34
2 The outcomes of specialist training and education	36
2.1 Educational purpose	36
2.2 Program outcomes	38
2.3 Graduate outcomes	39
3 The specialist medical training and education framework.....	42
3.1 Curriculum framework.....	42
3.2 The content of the curriculum.....	48
3.3 Continuum of training, education and practice	52
3.4 Structure of the curriculum.....	54
4 Teaching and learning.....	57
4.1 Teaching and learning approach.....	57
4.2 Teaching and learning methods.....	58
5 Assessment of learning	61
5.1 Assessment approach	61
5.2 Assessment methods	62
5.3 Performance feedback.....	67
5.4 Assessment quality	69
6 Monitoring and evaluation	71
6.1 Monitoring	71
6.2 Evaluation	73
6.3 Feedback, reporting and action	75
7 Trainees.....	78
7.1 Admission policy and selection.....	78
7.2 Trainee participation in education provider governance.....	82
7.3 Communication with trainees.....	83
7.4 Trainee wellbeing.....	84
7.5 Resolution of training problems and disputes	85

8	Implementing the program – delivery of education and accreditation of training sites	88
8.1	Supervisory and educational roles	88
8.2	Training sites and posts.....	90
9	Continuing professional development, further training and remediation ...	95
9.1	Continuing professional development	95
9.2	Further training of individual specialists.....	99
9.3	Remediation.....	100
10	Assessment of specialist international medical graduates	101
10.1	Assessment framework	101
10.2	Assessment methods	104
10.3	Assessment decision	107
10.4	Communication with specialist international medical graduate applicants.....	108
11	Surgical Training Programs	111
Appendix One	RACS Governance Map	127
Appendix Two	Membership of the 2017 AMC Assessment Team	128
Appendix Three	List of Submissions on the Programs of RACS in 2017	129
Appendix Four	Summary of the 2017 AMC Team’s Accreditation Program	130

Executive Summary: Royal Australasian College of Surgeons

The Australian Medical Council (AMC) document, *Procedures for Assessment and Accreditation of Specialist Medical Education Programs and Professional Development Programs by the Australian Medical Council 2017*, describes AMC requirements for reaccreditation of specialist medical programs and their education providers.

The Royal Australasian College of Surgeons (RACS) was first accredited by the AMC in 2001. In 2002, the AMC granted accreditation to the College and its programs for the maximum period of six years, until July 2008.

In its 2006 progress report to the AMC, RACS outlined plans for a new Surgical Education and Training (SET) program to be phased in from 2008. The AMC decided SET was a major change to the accredited education and training program of RACS, and therefore the plans for the SET program required a review by an AMC accreditation team before its introduction. An AMC assessment of the College's plans was completed in July 2007 and the SET program and continuing professional development program was granted accreditation until December 2011, subject to a satisfactory report responding to recommendations in the accreditation report related to implementation activities for the SET program. The assessment of the College's report was to include a follow up visit by an AMC review team. In 2008, the AMC conducted the follow-up visit and confirmed accreditation to December 2011.

In 2011, the College submitted its comprehensive report for extension of accreditation. The AMC found that the College met the standards, and extended the accreditation of the College for six years until December 2017, taking accreditation to the full period of ten years.

In 2017, an AMC team completed a reaccreditation assessment of the specialist medical programs and continuing professional development programs of the Royal Australasian College of Surgeons, which lead to the award of fellowship of RACS.

The AMC team reviewed the College's education, training and continuing professional development programs in the specialty of surgery and the fields of specialty practice in cardio-thoracic surgery, general surgery, neurosurgery, orthopaedic surgery, otolaryngology – head and neck surgery, paediatric surgery, plastic surgery, urology and vascular surgery.

The team reported to the 12 October 2017 meeting of the Specialist Education Accreditation Committee. The Committee considered the draft report and made recommendations on accreditation to AMC Directors in accordance with the options described in the AMC accreditation procedures.

This report presents the Committee's recommendations, presented to the 24 November 2017 meeting of AMC Directors, and the detailed findings against the accreditation standards.

Decision on accreditation

Under the *Health Practitioner Regulation National Law*, the AMC may grant accreditation if it is reasonably satisfied that a program of study and the education provider meet an approved accreditation standard. It may also grant accreditation if it is reasonably satisfied that the provider and the program of study substantially meet an approved accreditation standard, and the imposition of conditions will ensure the program meets the standard within a reasonable time. Having made a decision, the AMC reports its accreditation decision to the Medical Board of Australia to enable the Board to make a decision on the approval of the program of study for registration purposes.

The AMC's finding is that it is reasonably satisfied that the education, training and the continuing professional development programs of the Royal Australasian College of Surgeons substantially meet the accreditation standards.

The College is commended for its achievements in relation to its education and professional development programs since the last AMC assessment. These achievements are especially notable considering the size and complexity of the College. The College's significant investment in its educational programs, and the expertise supporting them, is delivering considerable results. However, the College recognises that further work is required in several other aspects of its education programs, resulting in a range of initiatives that are either in development or in planning. The team notes that some of the areas identified in the report for further development and consideration are underway and the team's observations are to be seen as encouragement in these areas.

The College has considerable respect locally, regionally, nationally and internationally for its standards and training. Overall, the College's graduates are well-trained and surgically capable and are recognised as such across the healthcare community as well as the wider public.

The College showed courage and leadership in 2015 by establishing a broadly constituted Expert Advisory Group to undertake the substantial review of concerns relating to discrimination, bullying and sexual harassment. This resulted in the development and implementation of the Building Respect, Improving Patient Safety (BRIPS) Action Plan. There is evidence from multiple sources that the BRIPS program is an excellent initiative and the culture of surgical training is changing. The College is commended on its leadership with this initiative. The team recommends that each Specialty Training Board, with the support of the College, maintain momentum with the BRIPS Action Plan, by promoting the program and the positive participation of all fellows and trainees, including supporting all surgeons to "call out" bad behaviour in work and training. The College must also develop and implement completely confidential and safe processes for obtaining—and acting on—regular and systematic feedback from trainees on the quality of supervision, training and clinical experience.

The College is commended for the good progress that has been made with the Surgical Education and Training (SET) program since its introduction in 2007. Further work is required by the College through the Specialty Training Boards to clearly articulate program and graduate outcomes for all specialties which are publicly available and reflect community needs. The College should also work to improve the uniformity of presentation of the training program and graduate outcomes for surgical specialties, taking into account feedback from trainees, supervisors and key stakeholder groups.

The College must define how its educational purpose connects to its community responsibilities. The specific health needs of Aboriginal and Torres Strait Islanders and/or Māori peoples, along with cultural competence training, should also be included and have ongoing emphasis in the curricula for each surgical specialty.

The issue of diversity of trainees and flexibility of training was a recurrent theme across all specialties. Very few trainees have worked part-time, with a few more having interrupted their training. The College 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.

It is recommended that the College further develop its selection policy, particularly with regard to the transparent scoring of each element in the curriculum vitae and standardisation in the structure of referee reports. This policy must be implemented across all nine surgical specialties. The College should examine what are 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.

The College is commended for the Diversity and Inclusion Plan and the intention to explore both the real and perceived impediments to diversity of applicants for the training programs. The planned survey of final year medical students, and PGY1 and PGY2 doctors may be key to learning why current applicants are predominantly male. The team recommends that the College promote

and monitor its Diversity and Inclusion Plan through the College and all Specialty Training Boards to ensure there are no structural impediments to a diversity of applicants for the training programs, and applicants selected into each program, as well as participation in the practice of surgery.

All College and Specialty Training Boards' specialist international medical graduate assessment processes and associated documentation must reflect the Medical Board of Australia's Good Practice Guidelines for the Specialist International Medical Graduate Assessment Process, as well as Medical Council of New Zealand Guidelines. This will ensure that both training and post-training experience are appropriately considered in the assessment of comparability, and not in any way suggest that vocational training and examination should each be independently comparable (without considering the additional impact of post-training experience and further training in mitigating any deficiencies in initial training and examinations). Alternative assessment processes such as workplace-based assessment must be developed and adopted as an alternative to the Fellowship Examination for selected specialist international medical graduates.

The November 2017 meeting of the AMC Directors resolved:

- (i) That the Royal Australasian College of Surgeons' specialist medical programs and training and continuing professional development programs in the recognised specialty of surgery are granted accreditation for four years until 31 March 2022, subject to satisfying AMC monitoring requirements including progress reports and addressing accreditation conditions.
- (ii) That this accreditation is subject to the conditions set out below:
 - (a) By the 2018 progress report, evidence that the College has addressed the following conditions from the accreditation report:
 - 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)
 - 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)
 - 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. (Standard 5.2 and 5.4)
 - 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)
 - 25 Clearly document and make publicly available the standard of entry into each surgical training program. (Standard 7.1)
 - (b) By the 2019 progress report, evidence that the College has addressed the following conditions from the accreditation report:
 - 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 1.1)

- 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)
 - 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)
 - 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)
 - 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. (Standard 6.1.3 and 8.1.3)
 - 23 Develop and implement an action plan in response to the 2016 Leaving Surgical Training study. (Standard 6.2)
 - 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)
 - 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)
 - 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. (Standard 7.3.2 and 10.4.1)
 - 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)
 - 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)
 - 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 Maori cultural competence. (Standard 8.2.2)
 - 34 All College and Specialty Training Board specialist international medical graduate 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)
- (c) By the 2020 progress report, evidence that the College has addressed the following conditions from the accreditation report:
- 2 RACS must develop and implement a stronger process for ongoing evaluation as to whether each of the specialty training programs remain consistent with the education and training policies of the College. (Standard 1.2)
 - 5 Define how the College’s educational purpose connects to its community responsibilities. (Standard 2.1)

- 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'. (Standard 3.4.2)
 - 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)
 - 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)
 - 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)
 - 30 Mandate cultural safety training for all supervisors, clinical trainers and assessors. (Standard 8.1.3, 8.1.5 and 8.2.2)
 - 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)
- (d) By the 2021 progress report, evidence that the College has addressed the following conditions from the accreditation report:
- 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)
 - 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)
 - 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. (Standard 2.2 and 2.3)
 - 8 Enhance and align the non-technical competencies across all surgical specialties including a consideration of the broader patient context. (Standard 3.2)
 - 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)
 - 10 Document the management of peri-operative medical conditions and complications in the curricula of all specialty training programs. (Standard 3.2.3, 3.2.4 and 3.2.6)
 - 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)

- 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)
- 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)

The accreditation conditions in order of standard are detailed in the following table:

Standard	Condition	To be met by
Standard 1	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)	2019
	2 RACS must develop and implement a stronger process for ongoing evaluation as to whether each of the specialty training programs remain consistent with the education and training policies of the College. (Standard 1.2)	2020
	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)	2018
	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)	2021
Standard 2	5 Define how the College's educational purpose connects to its community responsibilities. (Standard 2.1)	2020
	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)	2021
	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. (Standard 2.2 and 2.3)	2021
Standard 3	8 Enhance and align the non-technical competencies across all surgical specialties including a consideration of the broader patient context. (Standard 3.2)	2021
	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	2021

Standard	Condition	To be met by
	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)	
	10 Document the management of peri-operative medical conditions and complications in the curricula of all specialty training programs. (Standard 3.2.3, 3.2.4 and 3.2.6)	2021
	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)	2021
	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'. (Standard 3.4.2)	2020
	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)	2018
Standard 4	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)	2021
Standard 5	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. (Standard 5.2 and 5.4)	2018
	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)	2019
Standard 6	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)	2019
	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)	2018
	19 Establish methods to seek confidential feedback from supervisors of training, across the surgical specialties, to	2019

Standard	Condition	To be met by
	contribute to the monitoring and development of the training program. (Standard 6.1.2)	
	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. (Standard 6.1.3 and 8.1.3)	2019
	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)	2020
	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)	2020
	23 Develop and implement an action plan in response to the 2016 Leaving Surgical Training study. (Standard 6.2)	2019
Standard 7	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)	2020
	25 Clearly document and make publicly available the standard of entry into each surgical training program. (Standard 7.1)	2018
	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)	2019
	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)	2019
	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. (Standard 7.3.2 and 10.4.1)	2019
	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)	2019
Standard 8	30 Mandate cultural safety training for all supervisors, clinical trainers and assessors. (Standard 8.1)	2020
	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)	2021

Standard	Condition	To be met by
	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)	2019
	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 Maori cultural competence. (Standard 8.2.2)	2019
Standard 9	Nil	
Standard 10	34 All College and Specialty Training Board specialist international medical graduate 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)	2019
	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)	2020

This accreditation decision relates to the College’s continuing professional development programs and its specialist medical programs in the specialty of surgery and the fields of specialty practice in cardio-thoracic surgery, general surgery, neurosurgery, orthopaedic surgery, otolaryngology – head and neck surgery, paediatric surgery, plastic surgery, urology and vascular surgery.

In March 2022, before this period of accreditation ends, the College will undergo a follow up accreditation assessment. The AMC will consider if the College is continuing to satisfy the accreditation standards, the AMC Directors may extend the accreditation by a maximum of two years (to March 2024).

In March 2024, the College may submit a comprehensive report for extension of accreditation. The report should address the accreditation standards and outline the College’s development plans for the next four years. The AMC will consider this report and, if it decides the College is continuing to satisfy the accreditation standards, the AMC Directors may extend the accreditation by a maximum of four years (to March 2028), taking accreditation to the full period which the AMC may grant between assessments, which is ten years. At the end of this extension, the College and its programs will undergo a reaccreditation assessment by an AMC team.

Overview of findings

The findings against the nine accreditation standards are summarised below. Only those sub-standards which are not met or substantially met are listed under each overall finding.

Conditions imposed by the AMC so the College meets accreditation standards are listed in the accreditation decision (pages 1 to 9). The team's commendations in areas of strength and recommendations for improvement are given below for each set of accreditation standards.

1. The context of education and training (governance; program management; reconsideration, review and appeal processes; educational expertise and exchange; educational resources; interaction with the health sector; continuous renewal)	This set of standards is SUBSTANTIALLY MET
---	---

Standard 1.2 (program management), standard 1.3 (reconsideration, review and appeals processes), standard 1.6 (interaction with the health sector), standard 1.7 (continuous renewal) is substantially met.

Commendations

- A The strong policy framework within which the College operates, including principle-based service agreements with Specialty Societies and Associations.
- B The College's contemporary and appropriate educational resources, in particular the Digital College initiative.
- C The Reconciliation Action Plan, and the Diversity and Inclusion Plan and progress made to date with regard to their implementation.
- D The enormous courage and leadership shown by the College in 2015 in establishing a broadly constituted Expert Advisory Group to undertake the substantial review of concerns relating to discrimination, bullying and sexual harassment. This resulted in the development and implementation of the Building Respect, Improving Patient Safety (BRIPS) program which is an excellent initiative and is evidencing a change in the culture of surgical training.

Conditions to satisfy accreditation standards

- 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)
- 2 RACS must develop and implement a stronger process for ongoing evaluation as to whether each of the specialty training programs remain consistent with the education and training policies of the College. (Standard 1.2)
- 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)
- 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)

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. (Standard 1.1.6)

2. The outcomes of specialist training and education (educational purpose; program outcomes; graduate outcomes)	This set of standards is SUBSTANTIALLY MET
---	--

Standard 2.1 (educational purpose), standard 2.2 (program outcomes) is substantially met. Standard 2.3 (graduate outcomes) is not met.

Commendations

- E The College's commitment to producing surgeons who are viewed by supervisors, hospital administrators and other health professionals as being well-trained and surgically capable.

Conditions to satisfy accreditation standards

- 5 Define how the College's educational purpose connects to its community responsibilities. (Standard 2.1)
- 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)
- 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. (Standard 2.2 and 2.3)

Recommendations for improvement

- BB Benchmark the graduate outcomes of each of the surgical training programs internationally. (Standard 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. (Standard 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)

3. The specialist medical training and education framework (curriculum framework; content; continuum of training, education and practice; structure of the curriculum)	This set of standards is SUBSTANTIALLY MET
--	--

Standard 3.2 (content of the curriculum), standard 3.4 (structure of the curriculum) is substantially met.

Commendations

- F The progress that has been made with the Surgical Education and Training (SET) program since its introduction in 2007.

- G The formal surgical competency framework in the form of the nine RACS competencies for use across all surgical specialties.
- H Ongoing desire for improvement as indicated by a number of surgical specialties undertaking curriculum review, as well as the move by the College and some surgical specialties to introduce curricula based on competencies expected at each stage of training.

Conditions to satisfy accreditation standards

- 8 Enhance and align the non-technical competencies across all surgical specialties including a consideration of the broader patient context. (Standard 3.2)
- 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)
- 10 Document the management of peri-operative medical conditions and complications in the curricula of all specialty training programs. (Standard 3.2.3, 3.2.4 and 3.2.6)
- 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)
- 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’. (Standard 3.4.2)
- 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)

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)

4. Teaching and learning (teaching and learning approach; teaching and learning methods)	This set of standards is MET
---	---------------------------------

Standard 4.1.1 (teaching and learning approaches mapped to the curriculum) is substantially met.

Commendations

- I All specialty training programs are based firmly in relevant clinical practice with trainees experiencing a wide range of acute and elective cases.
- J The growing array of courses and resources with an increasing number of these available online, as well as the development of an appropriate suite of basic courses, such as Early Management of Severe Trauma (EMST), Care of the Critically Ill Surgical Patient (CCrISP), and Critical Literature Evaluation and Research (CLEAR).

K The College's support for the increasing use of simulation in surgical training.

Conditions to satisfy accreditation standards

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)

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. (Standard 4.2.1)

5. Assessment of learning (assessment approach; assessment methods; performance feedback; assessment quality)	This set of standards is SUBSTANTIALLY MET
--	---

Standard 5.2 (assessment methods and standard setting), standard 5.4 (assessment quality) is substantially met.

Commendations

L The overall conduct of the Fellowship Examination including its careful moderation and blueprinting which serves to integrate standards across surgical specialties and satisfy external stakeholders of the adequacy of surgical training.

M The commissioning of the 2016 Review of Assessments by Cassandra Wannan.

N The Keeping Trainees on Track program which assists supervisors and trainers in the early detection of trainees in difficulty.

Conditions to satisfy accreditation standards

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. (Standard 5.2 and 5.4)

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)

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)

6. Monitoring and Evaluation (monitoring; evaluation; feedback, reporting and action)	This set of standards is SUBSTANTIALLY MET
--	---

Standard 6.1 (monitoring), standard 6.3 (feedback, reporting and action) is substantially met. Standard 6.3 (evaluation) is not met.

Commendations

- O The significant systems in place for the collection of data from internal stakeholders to monitor programs.
- P As a result of the findings from the 2016 Leaving Surgical Training study, the College’s plans to introduce an annual survey in 2017 of those trainees who leave the training program prior to completion.

Conditions to satisfy accreditation standards

- 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)
- 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)
- 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)
- 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. (Standard 6.1.3 and 8.1.3)
- 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)
- 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)
- 23 Develop and implement an action plan in response to the 2016 Leaving Surgical Training study. (Standard 6.2)

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)

<p>7. Trainees (admission policy and selection; trainee participation in education provider governance; communication with trainees, trainee wellbeing; resolution of training problems and disputes)</p>	<p>This set of standards is SUBSTANTIALLY MET</p>
---	---

Standard 7.1 (admission policy and selection), standard 7.3.2 (clear and accessible information about the training program, costs and requirements), standard 7.5 (resolution of training problems and disputes) is substantially met.

Commendations

- Q The commitment of the RACS Trainees' Association (RACSTA) in implementing a rolling five-year survey of the trainee experience, and by advocating on behalf of trainees.
- R The College's clear commitment to trainee participation in governance by dedicating both human and financial resources to ensure the RACS Trainees' Association (RACSTA) is well supported.
- S The specialties of Otolaryngology Head and Neck Surgery and Cardiothoracic Surgery that reserve a place for an Aboriginal and Torres Strait Islander applicant who reaches the minimum standard for selection.

Conditions to satisfy accreditation standards

- 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)
- 25 Clearly document and make publicly available the standard of entry into each surgical training program. (Standard 7.1)
- 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)
- 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)
- 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. (Standard 7.3.2 and 10.4.1)
- 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)

Recommendations for improvement

- 00 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)

<p>8. Implementing the program – delivery of educational and accreditation of training sites (supervisory and educational roles; training sites and posts)</p>	<p>This set of standards is SUBSTANTIALLY MET</p>
--	--

Standard 8.1 (supervisory and educational roles), standard 8.2.2 (criteria for accreditation of training sites link to outcomes of the training program) is substantially met.

Commendations

T The College's dedicated, high-quality, paid and pro-bono workforce that is committed to training.

U The large scale implementation of the Foundation Skills for Surgical Educators (FSSE) and Operating with Respect (OWR) courses as part of the Building Respect, Improving Patient Safety (BRIPS) program.

Conditions to satisfy accreditation standards

30 Mandate cultural safety training for all supervisors, clinical trainers and assessors. (Standard 8.1.3, 8.1.5 and 8.2.2)

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)

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)

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 Maori cultural competence. (Standard 8.2.2)

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)

9. Continuing professional development, further training and remediation (continuing professional development; further training of individual specialists; remediation)	This set of standards is MET
--	------------------------------

Commendations

- V The CPD program is the means by which mandatory training and greater awareness of discrimination, bullying and sexual harassment has been brought into the ongoing professional lives of all fellows.
- W The promotion of the importance of self-reflection through the addition of a Reflective Practice category with all participants required to undertake at least one such activity per year.
- X Reducing the burden of reporting for fellows by organising for providers of RACS CPD activities to report attendances to the College which is updated directly onto each fellow's online CPD profile.

Conditions to satisfy accreditation standards

Nil

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 surgeon's 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)

10. Assessment of specialist international medical graduates (assessment framework, assessment methods; assessment decision; communication with specialist international medical graduate applicants)	This set of standards is SUBSTANTIALLY MET
--	--

Standard 10.1 (assessment framework), standard 10.2.1 (methods of assessment are fit for purpose) is substantially met.

Commendations

- Y The recent formation of the College's International Medical Graduates Committee and the expanded role of the Clinical Director of IMG assessment along with the College's plans to increase support for specialist international medical graduate (SIMG) surgeons.
- Z The quality of the advice provided to the Medical Council of New Zealand (MCNZ) on eligibility for vocational registration, which satisfies the MCNZ guidelines and embodies the principle that fellowship cannot be recommended as a pre-requisite for vocational registration by MCNZ.

Conditions to satisfy accreditation standards

- 34 All College and Specialty Training Board specialist international medical graduate 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)
- 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)

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)

Introduction: The AMC accreditation process

The Australian Medical Council (AMC) was established in 1985. It is a national standards body for medical education and training. Its purpose is to ensure that standards of education, training and assessment of the medical profession promote and protect the health of the Australian community.

The process for accreditation of specialist medical education and training

The AMC implemented the process for assessing and accrediting specialist medical education and training programs in response to an invitation from the Australian Government Minister for Health and Ageing to propose a new model for recognising medical specialties in Australia. The AMC and the Committee of Presidents of Medical Colleges established a working party to consider the Minister's request, and developed a model with three components:

- a new national process for assessing requests to establish and formally recognise medical specialties
- a new national process for reviewing and accrediting specialist medical education and training programs
- enhancing the system of registration of medical practitioners, including medical specialists.

The working party recommended that, as well as reviewing and accrediting the training programs for new specialties, the AMC should accredit the training and professional development programs of the existing specialist medical education and training providers – the specialist medical colleges.

Separate working parties developed the model's three elements. An AMC consultative committee developed procedures for reviewing specialist medical training programs, and draft educational guidelines against which programs could be reviewed. In order to test the process, the AMC conducted trial reviews during 2000 and 2001 with funding from the Australian Government Department of Health and Ageing. These trial reviews covered the programs of two colleges.

Following the success of these trials, the AMC implemented the accreditation process in November 2001. It established a Specialist Education Accreditation Committee to oversee the process, and agreed on a forward program allowing it to review the education and training programs of one or two providers of specialist training each year. In July 2002, the AMC endorsed the guidelines, *Accreditation of Specialist Medical Education and Training and Professional Development Programs: Standards and Procedures*.

In 2006, as it approached the end of the first round of specialist medical college accreditations, the AMC initiated a comprehensive review of the accreditation guidelines. In June 2008, the AMC approved new accreditation standards and a revised description of the AMC procedures.

A new National Registration and Accreditation Scheme for health professions began in Australia in July 2010. The Ministerial Council, on behalf of the Medical Board of Australia, has assigned the AMC the accreditation functions for medicine.

From 2002 to July 2010, the AMC process for accreditation of specialist education and training programs was a voluntary quality improvement process for the specialist colleges that provided training in the recognised specialties. It was a mandatory process for bodies seeking recognition of a new medical specialty. From 1 July 2010, the *Health Practitioner Regulation National Law Act 2009* makes the accreditation of specialist training programs an essential element of the process for approval of all programs for the purposes of specialist registration. Similarly, the Medical Board of Australia's registration standards indicate that continuing professional development programs that meet AMC accreditation requirements meet the Board's continuing professional development requirements.

From 1 July 2010, the AMC presents its accreditation reports to the Medical Board of Australia. Medical Board approval of a program of study that the AMC has accredited forms the basis for registration to practise as a specialist.

In 2015, following a period of consultation, the AMC completed a review of the accreditation standards for specialist medical programs and continuing professional development programs. The Medical Board of Australia approved new accreditation standards. The new accreditation standards apply to AMC assessments conducted from 1 January 2016. The relevant standards are included in each section of this report.

Assessment of the programs of the Royal Australasian College of Surgeons

The AMC first assessed the education, training and continuing professional development programs of the Royal Australasian College of Surgeons (RACS) in 2001. In 2002, the AMC granted accreditation to the College for a period of six years until 2008, with a requirement for satisfactory annual reports to the AMC.

In 2007, the College introduced a new Surgical Education and Training (SET) program. The AMC decided SET was a major change to the accredited education and training program of RACS, and therefore the plans for the SET program required a review by an AMC accreditation team before its introduction. On the basis of this assessment, accreditation was granted by the AMC until December 2011. The accreditation was subject to a follow-up assessment in 2008 which confirmed that the program had been implemented as planned and confirmed the accreditation period.

In 2011, the College submitted a comprehensive report to the AMC seeking extension of accreditation. In a comprehensive report, the AMC seeks evidence that the accredited college continues to meet the accreditation standards and information on plans for the next four to five years. If the AMC considers that the college continues to meet the accreditation standards, it may extend the accreditation. The assessment of the College's comprehensive report included a short visit because of the number of conditions on the College's accreditation. On the basis of the comprehensive report review, the AMC found that the College met the accreditation standards, and extended the accreditation until 31 December 2017, taking accreditation to the full period of 10 years.

Between accreditation assessments, the AMC monitors developments in education and training and professional development programs through progress reports. The College has provided progress reports since its accreditation in 2001. These reports have been reviewed by a member of the AMC team that assessed the program. The reviewer's commentary and the progress report is then considered by the AMC progress reports working party. Through these reports the AMC has been informed of developments in the College's educational strategy, and education and training policies and programs. The AMC has considered these reports to be satisfactory.

In 2016, the AMC began preparations for the reaccreditation assessment of the RACS' programs. On the advice of the Specialist Education Accreditation Committee, the AMC Directors appointed Professor Chris Baggoley AO to chair the 2017 assessment of the College's programs. The AMC and the College commenced discussions concerning the arrangements for the assessment by an AMC team.

The AMC assesses specialist medical education and training and continuing professional development programs using a standard set of procedures.

A summary of the steps followed in this assessment is given below:

- The AMC asked the College to lodge an accreditation submission encompassing the three areas covered by AMC accreditation standards: the training pathways to achieving fellowship of the Royal Australasian College of Surgeons; College processes to assess the qualifications and experience of overseas-trained specialists; and College processes and programs for continuing professional development.

- The AMC appointed an assessment team (called ‘the team’ in this report) to complete the assessment after inviting the College to comment on the proposed membership. A list of the members of the team is provided as Appendix 2.
- The team met on 8 and 9 February 2017 to consider the College’s accreditation submission and to plan the assessment.
- The team met RACS office bearers and senior education staff on 9 February 2017.
- The AMC gave feedback to the College on the team’s preliminary assessment of the submission, the additional information required, and the plans for visits to accredited training sites and meetings with College committees.
- The AMC surveyed trainees and supervisors of training of the College. The AMC also surveyed overseas-trained specialists whose qualifications had been assessed by the College in the last three years.
- The AMC invited other specialist medical colleges, medical schools, health departments, professional bodies, medical trainee groups, and health consumer organisations to comment on the College’s programs.
- The team met by teleconference on 22 March 2017 to finalise arrangements for the assessment.
- The team held meetings during the College’s Annual Scientific Congress in Adelaide in May 2017 and conducted site visits in New South Wales, Queensland, Victoria, South Australia and New Zealand in March and May 2017. The AMC held teleconferences with trainees and Supervisors in Northern Territory, Western Australia, Tasmania and the Australian Capital Territory.
- The team met with outgoing College office bearers, College committees and education staff from 3 to 5 April 2017.

The assessment concluded with a series of meetings with incoming College office bearers/the new Council and College staff from 28 to 29 June 2017. On the final day, the team presented its preliminary findings to College representatives.

Australian Medical Council and Medical Council of New Zealand relationship

Since most of the specialist medical colleges span Australia and New Zealand, the Medical Council of New Zealand (MCNZ) has been an important contributor to AMC accreditation assessments.

In November 2010, the AMC and the MCNZ signed a Memorandum of Understanding to extend the collaboration between the two organisations. The two Councils are working to streamline the assessment of organisations which provide specialist medical training in Australia and New Zealand. The AMC continues to lead the accreditation process and assessment teams for bi-national training programs and continues to include New Zealand members, site visits to New Zealand, and consultation with New Zealand stakeholders. While the two Councils use the same set of accreditation standards, legislative requirements in New Zealand require the bi-national colleges to provide additional New Zealand-specific information.

Appreciation

The team is grateful to the fellows and staff who prepared the accreditation submission and managed the preparations for the assessment. It acknowledges with thanks the support of fellows and staff in Australia and New Zealand who coordinated the site visits, and the assistance of those who hosted visits from team members.

The AMC also thanks the organisations that made a submission to the AMC on the College’s training programs; these are listed at Appendix 3. Summaries of the program of meetings and visits for this assessment are provided at Appendix 4.

1 The context of training and education

1.1 Governance

The accreditation standards are as follows:

- The education provider's corporate governance structures are appropriate for the delivery of specialist medical programs, assessment of specialist international medical graduates and continuing professional development programs.
- The education provider has structures and procedures for oversight of training and education functions which are understood by those delivering these functions. The governance structures should encompass the provider's relationships with internal units and external training providers where relevant.
- The education provider's governance structures set out the composition, terms of reference, delegations and reporting relationships of each entity that contributes to governance, and allow all relevant groups to be represented in decision-making.
- The education provider's governance structures give appropriate priority to its educational role relative to other activities, and this role is defined in relation to its corporate governance.
- The education provider collaborates with relevant groups on key issues relating to its purpose, training and education functions, and educational governance.
- The education provider has developed and follows procedures for identifying, managing and recording conflicts of interest in its training and education functions, governance and decision-making.

The Royal Australasian College of Surgeons (RACS) was formed in 1927. RACS is a company limited by guarantee under Australian corporations' law. In New Zealand, RACS is registered with the New Zealand Companies Office.

RACS is responsible for the training, assessment, examination, qualification and continuing professional development of surgeons for standards of surgery in Australia and New Zealand. The RACS mission is to be the leading advocate for surgical standards, education and professionalism in Australia and New Zealand.

As outlined in the RACS constitution, the purpose of the College is to:

- advance education, training and research in the practice of surgery
- determine and maintain professional standards for the practice of surgery in Australia and New Zealand
- provide an environment promoting fellowship development and support
- provide authoritative advice, information and opinion to other professional organisations, to governments and to the public.

The College has one category of membership which is Fellow. There were 7373 active and retired fellows at the end of 2015, 5972 of whom were resident in Australia, 951 in New Zealand and 450 overseas. The College assesses on average 72 (based on 2012-16 RACS Activities Report) specialist international medical graduates each year. The College awards fellowship in the surgical specialty. The fields of specialty practice are cardio-thoracic surgery; general surgery; neurosurgery; orthopaedic surgery; otolaryngology – head and neck surgery; paediatric surgery; plastic surgery; urology; and vascular surgery. For the field of specialty practice in plastic surgery, trainees complete the SET Plastic and Reconstructive Surgery Program.

The RACS **Council** is the governing body and the councillors have fiduciary responsibility for the organisation. There are 16 fellows elected from the membership at large; nine elected fellows (one from each of the nine specialties); three co-opted members, including two expert community

advisors and the RACS Trainees' Association's (RACSTA) representative; and one co-opted representative, being the president of the Australian and New Zealand College of Anaesthetists (ANZCA). The Younger Fellows representative is an invited observer. Chairs of the New Zealand national board and regional committees are invited to attend council meetings on rotation. The full RACS Council meets three times a year.

The activities of the College are described under four portfolios, each with a senior board or committee providing oversight. These are:

- 1 the delivery of the education and training program for trainees and assessment of specialist international medical graduates (**Education Board** (responsibility of the Censor-in-Chief))
- 2 the ongoing maintenance of standards and support to fellows throughout their professional careers (**Professional Development and Standards Board** (responsibility of the chair of Professional Development and Standards Board))
- 3 the ongoing nurturing of key relationships, through advocacy (the **Governance and Advocacy Committee** and **Board of Regional Chairs** (responsibility of the Vice-President))
- 4 stewardship of resources (**Resources Committee** and **Risk Management and Audit Committee** (responsibility of the Treasurer)).

More than 100 committees report to the RACS Council. The terms of reference for all boards and committees are publicly available on the RACS website. There are more than 200 College staff with reporting lines largely mirroring the governance structure and this is shown within the RACS Governance Map at Appendix 1. The College functions and delivers its services at bi-national, national and regional levels.

Regional Committees and the **New Zealand National Board** were appointed by Council in 1927. Each is supported by a regional office. The committees represent the local regional fellowship in whatever forum is necessary, including:

- advocacy to government representatives
- communicating the decisions of Council to fellows and trainees in their region
- providing educational opportunities for fellows and trainees in their region
- providing advice to Council on regional issues
- assuming responsibility for regional issues and, if necessary, providing recommendations to Council; and supporting selection and training on behalf of the College.

The committees assist the Council in the implementation of the continuing professional development program; a key role being the running of at least one annual regional meeting for the benefit of the local fellowship and making local arrangements for the Annual Scientific Congress of the College, as requested by the Council.

The **Board of Regional Chairs** (BoRC) comprises the Chairs of the Regional Committees (State and Territory Regional Committees in Australia, and in New Zealand, the New Zealand National Board). The BoRC has been established to:

- ensure that Council receives high-level advice, informed by the Regional Committees, on the College's strategic priorities, policy development and policy implementation
- ensure that the College's activities meet the requirements of the fellows and trainees of the College and address key strategic issues in the fellowship
- advise Council on key current and strategic issues impacting the surgical workforce, informed by regional and rural fellowship and training data, regional strategies of surgical specialty societies and associations, and activities of the regional health jurisdictions

- provide a forum to share knowledge and skills collectively amongst the Chairs of the Regional Committees
- provide support to Chairs in discharging their duties.

The College has policies and procedures for identifying, managing and recording conflicts of interest in its training and education functions, governance and decision making. The College's Conflict of Interest Policy complies with the Commonwealth Corporations Act 2000.

1.1.1 Team findings

The College's governance model is mature. It is of necessity a very complex structure as it spans two nations, nine specialties, 13 Specialty Societies and Associations with which RACS has service agreements or memoranda of understanding (MOUs). There are over 100 committees, including a Governance and Advocacy Committee. The terms of reference are defined for each committee.

The College operates within a strong policy framework, including principle-based service agreements with Specialty Societies and Associations. The College, Specialty Societies and Associations demonstrate a commitment to strong governance and continuous improvement including an overt willingness to review and articulate areas for development and improvement.

Membership of Council and its committees is becoming more inclusive of women, trainees and community representatives. Community advisors sit as full members of key RACS boards, with two community advisors on the RACS Council. For example, of the 28 members on the 2017 Council, nine are women, and there are two external co-opted representatives. Fellows on the RACS Council are regularly trained in good governance, strategy and the role of the board through the Australian Institute of Company Directors. Some of the challenges of the College are the different legislative, social and healthcare environments in Australia and New Zealand. Yet, the team found that College governance works well in New Zealand, for several reasons: it is relatively small; the New Zealand office takes a strong coordinating role; and there is a close relationship between the Specialty Societies and Associations and RACS in New Zealand. New Zealand members feel well represented in RACS governance in Australia for the most part.

The College operates according to a constitution, along with a large raft of relevant policies, all of which are publicly available on the RACS website. This includes the Conflict of Interest Policy.

There are relevant conflict of interest policies and they are mentioned in the RACS code of conduct. However, the team recommends that the College considers broadening its definition of conflict of interest to include reflection upon 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.

1.2 Program management

The accreditation standards are as follows:

- The education provider has structures with the responsibility, authority and capacity to direct the following key functions:
 - planning, implementing and evaluating the specialist medical program(s) and curriculum, and setting relevant policy and procedures
 - setting and implementing policy on continuing professional development and evaluating the effectiveness of continuing professional development activities
 - setting, implementing and evaluating policy and procedures relating to the assessment of specialist international medical graduates
 - certifying successful completion of the training and education programs.

The College's education, training, and continuing professional development programs are overseen by the following boards and committees.

The **Education Board** is the senior board responsible for overseeing RACS' education policy, maintaining standards of surgical education, training and assessment standards and approving doctors eligible for admission to fellowship. The chair is the Censor-in-Chief, the most senior fellow on the RACS Council responsible for educational issues. The Censor-in-Chief is supported by other councillors, who chair the committees that report to the Education Board. Together, they and the New Zealand Censor form the Education Board Executive. The authority of the Education Board to develop, regulate and approve all education activities is delegated by Council.

Some of the roles of Education Board are to:

- advise the Council with regard to its educational activities
- be responsible to Council for developing, coordinating and monitoring the implementation of the College Strategic Plan for education
- be responsible for quality assurance in respect of the delivery of surgical training programs as determined by the Partnering Agreements or Partnering Deeds with Specialty Societies and Associations
- be responsible for developing the educational standards which guide and direct the delivery of the surgical education programs and the assessment of international medical graduates
- ensure that examinations conducted by the College are in accordance with requirements for accreditation and authorisation and key College policy documents including the Strategic Plan
- develop the educational framework and standards for the delivery of the training programs in accordance with AMC and MCNZ requirements and educational best practice
- approve doctors eligible for admission to fellowship
- advise on budget priorities for educational activities and to make recommendations to the Resources Committee on the budgetary implications of new educational initiatives and existing programs
- advise on education policy issues brought forward by other Boards and Committees to ensure adherence to College policy and standards for education
- receive reports and other information from the Board of Surgical Education and Training, the Court of Examiners, the Prevocational and Skills Education Committee and other Boards and Committees
- review of specialty training board decisions prior to progressing to an appeals committee.

The Board holds three face-to-face meetings per year and such other meetings as it deems necessary. The Executive meets by teleconference, usually fortnightly.

The College delivers surgical education and training in a devolved model, working closely with 13 Specialty Societies and Associations in Australia and New Zealand. Each surgical specialty has a Specialty Training Board. Activities such as curriculum development, eLearning development, monitoring and evaluation occur across the nine specialties depending on the critical mass and expertise of the specialty concerned, in collaboration with RACS' departments, such as the Education Development and Research Department.

Specialty Training Boards, or their Regional Subcommittees (where they exist and if delegated), are responsible for some or all of the following activities as specified in the relevant Terms of Reference and other associated College policies and procedures.

- Approval, without reference to superior boards:
 - standards to be achieved for eligibility to apply for fellowship
 - curricula content for technical competencies
 - training regulations within approved principle-based policies (developed by the Board or adoption of College model regulations)
 - selection of trainees
 - accreditation of clinical training posts
 - assessment of performance in clinical rotations
 - criteria to be achieved by trainees to be eligible to present for the Fellowship Examination
 - status of trainees in the program (interruption, deferral, probation, etc.)
 - quality assurance reporting to the Education Board, as agreed in the Partnering Agreement with the College
 - assessment of clinical practice of international medical graduates
 - review of poor performance in an examination
 - changes to individual training requirements resulting from failed rotations, examination reviews, etc.
 - recommendation of dismissal from training.
- Recommendation to superior and other boards and committees:
 - recommendation of changes to international medical graduate pathways to fellowship
 - appointment of Board representatives to the Surgical Sciences and Clinical Examinations Committee, who represent the views of the Specialty Training Board
 - changes to existing and draft College policies.

Support of the Specialty Training Boards is provided by either RACS or Specialty Societies, in accordance with the relevant Service, Collaboration or Partnering Agreement. Where supported by a specialty society that society is responsible for the provision of data (as specified in the Agreement) to enable the College to meet its internal and external reporting requirements.

Depending on the training program, a Specialty Board may cover both Australia and New Zealand or be limited to Australia or New Zealand. The Chair is elected from the fellows of that specialty in the relevant country. Specialty Boards report directly to the Board of Surgical Education and Training.

Four of the training boards are bi-national (Australian and New Zealand) with no subsidiary regional boards/committees:

- Board of Cardiothoracic Surgery
- Board of Neurosurgery
- Board of Paediatric Surgery
- Board of Vascular Surgery.

Three are bi-national (Australian and New Zealand) boards with regional subsidiary boards and committees:

- Board in General Surgery
- Board of Otolaryngology Head and Neck Surgery

- Board of Urology.

One has subsidiary regional boards and committees:

- Australian Board of Plastic and Reconstructive Surgery.

There are two New Zealand boards, which have no regional boards/committees:

- New Zealand Board of Orthopaedic Surgery
- New Zealand Board of Plastic and Reconstructive Surgery.

For orthopaedic training in Australia, RACS has delegated the powers of a RACS Specialty Training Board to the Federal Training Committee of the Australian Orthopaedic Association (AOA). Further detail on training programs are provided in the surgical specialties section of this report.

The Chairs of each of the Specialty Training Boards sit on the **Board of Surgical Education and Training** (BSET). This Board monitors and coordinates activities associated with each surgical training program. The Board proposes policy to the College's Education Board for review and approval. In turn, the Board is accountable to Council through the Education Board for fulfilment of the duties and responsibilities. BSET meets in February, June and October.

Other College committees relevant to program management include:

The **Court of Examiners** reports to the Education Board and is responsible for conducting the summative fellowship examinations. The Court is comprised of surgeons representing the nine specialties in which the College conducts fellowship examinations. Individual surgeons are members of one of nine specialty courts that report to the Court of Examiners.

The **Royal Australasian College of Surgeons Trainees' Association (RACSTA)** reports directly to the Education Board and represents trainees in all specialties, regions, states and New Zealand. The Association plays a role in advocating for trainees through representation to external organisations, the activities of the RACSTA Board and as trainee representatives on RACS' boards and committees.

The **Professional Standards Committee** oversees the development of the RACS continuing professional development program and monitors the compliance of all fellows. It also oversees the development of standards documents and position papers relevant to the practice of surgery in Australia and New Zealand. The Committee reports to the Professional Development and Standards Board.

The **International Medical Graduate Committee**, formed in 2016, is responsible for reviewing and developing international medical graduate assessment tools and overseeing assessment to ensure consistency between specialties. The Committee reports to BSET and the chair is a member of the Education Board. The committee includes representatives from all Specialty Training Boards, two international medical graduates who have completed the pathway, and a community representative.

1.2.1 Team findings

The College enjoys considerable respect locally, regionally, nationally and internationally for its standards and training.

Education and training have a strong focus in the College. Yet, the team found there were several issues with the current governance structure, especially as it related to training curricula, site accreditation and specialist international medical graduate assessment. These issues are discussed in more detail in subsequent standards. Of note, the team found considerable heterogeneity in the specialty training programs, with some more easily meeting AMC accreditation standards than others. Moreover, there is ongoing uncertainty for the College over the direction of curricula development and timeframes for delivery. Several stakeholder groups felt under-represented in decision making.

The devolved model and service agreements operating on 'principle-based' policies have resulted in a lack of clear accountability for critical program elements such as curriculum design, evaluation, management of underperforming trainees, accurate data collection and data sharing. Some agreements are working better than others. There was dissonance expressed as to whether the specialty training programs were more similar or different from the programs prior to devolution five years ago. Individual Specialty Training Boards have more autonomy than previously. There were differing views within RACS as to whether this was desirable or not. The team considers that there are more aspects of curricula that could be common, given that all graduates earn a FRACS. These would include the curriculum and assessment of non-technical (professional) aspects of surgical practice, including cultural competence. This is also discussed under standard 3.

The team found the Board of Surgical Education and Training (BSET) to be a critically important committee in the governance structure. The College can only know what is happening in the jurisdictions by relying on the specialty training boards to feed back through BSET. BSET is the forum for discussion on training and learning from each other. There is usually agreement at BSET; however, members have concern with the lack of transparency as to what is then discussed at the Education Board or College Council, with the possibility that conclusions may be different to the original sentiment.

Several societies, associations, regional boards and other stakeholders expressed frustration with the current governance structure which they described as excessive, rigid, unresponsive or too expedient in approvals without due consideration. An example was the rapid development and implementation of the Operating with Respect (OWR) and Foundation Skills for Surgical Education (FSSE) face-to-face courses. Information regarding these mandatory modules were not felt to have been adequately communicated to all fellows.

Some New Zealand fellows and staff commented to the team that the College needs to remember that it is an Australasian College. The time difference and New Zealand statutory holidays need to be borne in mind when meetings are scheduled. Most of the meetings/pilots/workshops and face-to-face interactions occur in Australia. This places extra time demands on New Zealanders to travel and may disadvantage the New Zealand-based programs from both a time commitment and financial perspective. Greater use of teleconferencing would reduce time demand as well as costs and carbon utilisation. In its response to the draft accreditation report, the College advised that it strives to rationalise and balance the needs of all parties when scheduling meetings.

Several specialty societies and associations commented that the College does not fully understand, or value, the role they play in the administration of the surgical training programs. Nor do they consider they are sufficiently involved in the development of policy which affects the training programs. Further, societies and associations consider there are insufficient mechanisms for senior society personnel to meet with key RACS personnel and other society/association peers. Senior professional staff in the New Zealand office and CEOs in societies reported feeling excluded from some relevant communication, which may go only to the Specialty Board chair who is voluntary and elected. As such, Society CEOs and senior staff may be under-utilised in the implementation of RACS' initiatives.

Timelines for reporting do not always consider the complexity and volume of data from societies. A suggestion to improve the veracity of data as well as efficiency was that the College might recognise the training data provided by societies as the one source of truth for the specialty, and not duplicate the entry of this data into other systems. The double-handling and duplication of data leads to the risk of errors and inconsistencies in aggregate data, which is then reported to internal and external stakeholders. Another suggestion to reduce duplication is for societies to have at least 'read' access to the RACS database, the integrated management information system (iMIS), or any future trainee database. Societies are dependent on the College for information regarding their trainees (for example, course completion). Having limited 'write' access would

allow trainee information (for example, term completion) to be uploaded by the societies directly to the RACS database.

Trainees relate and pay training fees to both their Specialty Society and the College. Many trainees commented on a far closer association with their Specialty Society/Association than with the College, although they acknowledged and recognised the role of the College and the excellent RACS library and online resources. Despite this, many questioned the level of RACS annual fees. This is also covered under standard 7.3.

The team considers that the responsibility for evaluation of the College's training programs and assessment functions is not sufficiently clear. Further details are covered under standard 6. The team considers that the College needs an overarching, efficient evaluation framework for all training programs and assessment that makes it clear what information is collected and why, from whom, by whom and when; in addition to how that information is received, collated, acted upon, and results disseminated. This is not to say that the College has to do it all, see it all, or act on it all. The College must take the lead on the collaboration with specialty societies/associations on the development of the overall plan and in its delivery.

The team considers the College must review the relationships between Council, the Education Board, BSET and the Specialty Training Boards to ensure that the governance structure enables all training programs meet College policies and AMC standards.

Given that the College is delegating some or all of the administration of the training programs and some aspects of assessments of international medical graduates to Specialty Training Boards, the College must provide a stronger process for ongoing evaluation as to whether each of the specialty training programs remain consistent with the education and training policies of the College. This is discussed under standard 6.

1.3 Reconsideration, review and appeals process

The accreditation standards are as follows:

- The education provider has reconsideration, review and appeals processes that provide for impartial review of decisions related to training and education functions. It makes information about these processes publicly available.
- The education provider has a process for evaluating de-identified appeals and complaints to determine if there is a systems problem.

The College's accreditation submission describes its considerable effort in reviewing and improving the systems for making complaints, and requesting reconsideration or review of a decision, or making a formal appeal over the past two years. The College has developed a 12-page Complaints User Guide.

The College plans to report annually on complaint metrics and progress on the program, which will be analysed to identify any problems needing to be addressed. The handling of all complaints is being progressively centralised along with associated resourcing and infrastructure. All complaints are referred to the Manager, Complaints Resolution, and are registered, assessed and assigned for resolution. A key role of the Manager, Complaints Resolution is to establish policies and processes, as well as undertake education about correct processes.

The College has an Appeals Mechanism policy which is publicly available on the RACS website. This details the mechanism and grounds for appeal by any person or organisation adversely affected by a College decision that is inconsistent with College policy.

1.3.1 Team findings

Longstanding and significant concerns have been expressed about the management of training problems or inappropriate behaviour within surgical workplaces. The team heard comments throughout the visit about the need for the College and Specialty Societies and Associations to

increase the transparency and independent external scrutiny of their educational operations including complaints management.

In 2015, the College commissioned an Expert Advisory Group (EAG) to undertake the substantial review of concerns relating to discrimination, bullying and sexual harassment in surgery. Inter alia, the EAG report highlighted a lack of trust in College mechanisms for handling complaints. As a result, improved complaints handling is a major pillar of the Building Respect, Improving Patient Safety (BRIPS) program.

The team was impressed with the implementation in January 2016 of a centralised complaints management process and database managed by an experienced staff member. Complaints relating to bullying, harassment or clinical competence may be received via a hotline or email from trainees, fellows, jurisdictions, public or others. Complaints may be made anonymously, in confidence or with full disclosure. Anonymous complaints are logged so that they may be used in the future if there are repeated problems. The Manager, Complaints Resolution, works closely with senior staff in the College, in particular, the Executive Directors for Surgical Affairs.

There is increased awareness of the new complaints system with the number of complaints received increasing, from 17 as at March 2016, to a total of 60 by April 2017. The team considers this could place pressure on the Manager and College staff and it is important that the College continues to provide sufficient resources to fully implement the new complaints management system.

Trust in the system is not yet complete. Trainees would like more assurance that the new system is a safe one in which to make a complaint. Through AMC interviews and from extensive comments in the trainee survey, the team found that trainees consider they may be disadvantaged in career progression if they are to be a 'whistle blower'. There are concerns that it is impossible to report without being identified. Given their key role in training matters, it will be important for Specialty Training Boards to work closely with the College with respect to how complaints are resolved according to best practice and RACS' policies and processes. This is also discussed under standard 7.5

The team considers there is not a clear enough process outlined for each of the three phases of reconsideration, review and appeal in either the RACS Appeals Mechanism or the material provided by the surgical specialties. In particular, reconsideration and review processes are only briefly referred to, and seem to be a blend of reconsideration and review into a single process, rather than two distinct processes. Reconsideration by the original decision maker in the light of new information does not seem to be explicitly stated. The College should review its Appeals Mechanism to make it explicit that Specialty Training Boards must have clear reconsideration, review and appeals processes. The team notes that the Australian Orthopaedic Association has a clearly defined reconsideration, review and appeals policy which could be considered by the Specialty Training Boards.

The rate of appeal is low given that every College or society/association decision is appealable. With only five appeals in the past three years, the team was left with the impression that there may be a fear of making an appeal or that there may be processes happening at other levels, of which the College is unaware. The team recommends that the College continue to monitor and evaluate the types of appeals and complaints.

1.4 Educational expertise and exchange

The accreditation standards are as follows:

- The education provider uses educational expertise in the development, management and continuous improvement of its training and education functions.
- The education provider collaborates with other educational institutions and compares its curriculum, specialist medical program and assessment with that of other relevant programs.

Many surgeons have formal educational qualifications and other postgraduate academic qualifications. The College has established the Academy of Surgical Educators (ASE) to foster excellence in surgical education as a core component of ongoing professional development. The ASE now has more than 700 members and promotes formal training of fellows involved in the education and training of trainees. The College has placed particular emphasis on the recognition, support and training of surgeons in their role as educators. The ASE provides for the generic education needs of surgeon-teachers, trainers, supervisors, assessors and examiners in all surgically-related areas. The ASE actively engages international educational and standards bodies of excellence, as well as individuals, to enable ongoing benchmarking and exchange of ideas. It provides links through in-house educational programs, such as the mandatory Foundation Skills for Surgical Educators, and to graduate programs in surgical education with the University of Melbourne. The development of the ASE and its involvement with international surgical education and postgraduate medical education has been important in ensuring that local and national needs in health care and health-related education are highlighted and incorporated into programs across the College.

RACS was an initial partner in the development of the tri-nations (RACS, Royal Australasian College of Physicians and the Royal College of Physicians and Surgeons of Canada) educational forum and has maintained close ties with the other founding partners.

Examples of the use of expertise and educational exchange given were:

- RACS awards scholarships and grants to examiners within the Court of Examiners to review examination processes internationally.
- The Australian Orthopaedic Association engaged a fellow of the Royal College of Physicians and Surgeons of Canada to conduct a comprehensive review of its curriculum and engage with the development of the AOA21 educational program.
- The Early Management of Severe Trauma (EMST) course is based on the international equivalent Advanced Trauma Life Support (ATLS™) from the US.

1.4.1 Team findings

The College enjoys high levels of commitment and educational expertise from the Specialty Training Boards, and a wide range of fellows and professional staff who are engaged in the training of surgeons.

The team was impressed with the level of educational expertise in the College, as well as the College's interaction and collaboration at multiple levels with an extensive network of postgraduate medical colleges, universities, and professional organisations in Australia and New Zealand. The College conducts its own well-attended scientific meetings and participates in international surgical meetings where all international surgical colleges discuss issues of surgical standards and education. This is repeated among the nine surgical specialties of the College. The College in Australia interacts through the Council of Presidents of Medical Colleges (CPMC). The networks for medical educators and those responsible for international medical graduate assessment are particularly strong and the colleges work together on initiatives. In New Zealand, all medical colleges interact through the Council of Medical Colleges (CMC).

1.5 Educational resources

The accreditation standards are as follows:

- The education provider has the resources and management capacity to sustain and, where appropriate, deliver its training and education functions.
- The education provider's training and education functions are supported by sufficient administrative and technical staff.

The College continues to expand its management and educational resources to support education and training activities. The Digital College initiative was to enhance online interaction with the RACS and its educational activities. The College has developed substantial resources and expertise in this area, however, pressure to update and improve the infrastructure and function, while providing strict data security and privacy protection, is considerable, and has increased the costs of delivering education activities.

The College funds this through a number of means, predominantly through trainee fees and fellow subscriptions. Trainee fees are reviewed annually to ascertain funding requirements for surgical education and training.

Service agreements with specialty societies stipulate funding to ensure the provision of adequate resources so the specialty societies can support the educational requirements of their trainees.

1.5.1 Team findings

The team was impressed with the large amount of pro bono work undertaken by fellows. The work of fellows is complemented by over 200 staff, many of whom have roles and expertise in education and training. The College appears to have adequate capacity within its administrative team, and has processes to ensure the most appropriate use of its members and human resources.

There are two specific RACS education divisions: Education Development and Assessment, and Education and Training Administration. These outreach to the specialty societies and associations as needed. The Dean of Education is a fellow with a 0.8 FTE position who reports to the Chief Executive Officer.

With regard to the RACS website, the Specialty Societies and Associations repeat much of the key education material also on their websites. This has the potential to duplicate work, or introduce errors when material changes, and is an issue that the College should continue to monitor.

The College's educational resources are contemporary and appropriate, and the Digital College initiative is commended. Among the resources are those designed to help fellows and trainees improve their skills, including online courses such as Operating with Respect. The Digital College concept has been broadly welcomed by fellows and trainees.

1.6 Interaction with the health sector

The accreditation standards are as follows:

- The education provider seeks to maintain effective relationships with health-related sectors of society and government, and relevant organisations and communities to promote the training, education and continuing professional development of medical specialists.
- The education provider works with training sites to enable clinicians to contribute to high-quality teaching and supervision, and to foster professional development.
- The education provider works with training sites and jurisdictions on matters of mutual interest.
- The education provider has effective partnerships with relevant local communities, organisations and individuals in the Indigenous health sector to support specialist training and education.

The College's management team and fellows regularly engage with health departments, district health boards and ministries in their jurisdictions and at a national level. As RACS is represented in New Zealand and in each state and territory of Australia, the local committee/board chair and regional manager regularly meet with health ministers, senior department staff, and opposition health representatives. These meetings have a strong focus on advocacy for surgical services and also on the requirements for surgical standards, education and training, relevant public health issues and the workforce pipeline. The College has worked with the private health insurance

industry, and Medicare to provide reports to surgeons about key measures of performance relating to hospital admissions, complications and fee charges. The College meets frequently with the Australian Health Practitioner Regulation Agency, the Medical Board of Australia and the Medical Council of New Zealand on a range of issues and responds to requests for data or information.

To increase effective interactions with individual hospitals, the College has formed the Surgical Directors Section with a particular focus on the development of surgical leadership and the ability to influence organisations. The College aims to ensure the senior surgeons within hospitals have the leadership skills and access to appropriate surgical resources, position papers and policy to ensure improvements are achieved in surgical services and the culture of the health sector. Although the College does not have line management or employment-based authority in hospitals, RACS recognises its role and responsibility in setting the expectation of professional behaviour of fellows and trainees in their educational and clinical activities.

Within the BRIPS Action Plan, specific initiatives have been aimed at hospitals, with the College fostering a collaborative model with health departments and district health boards and many hospitals across Australia and New Zealand. Several formal agreements have been signed.

The College has a longstanding relationship with the Australian Indigenous Doctors' Association (AIDA). As part of the RACS Reconciliation Action Plan 2016–2017, RACS has committed to maintaining and enhancing its partnership with AIDA and developing at least two new partnerships with organisations working in its sphere of influence.

In New Zealand, the College has a longstanding relationship with Te Ohu Rata o Aotearoa - Māori Medical Practitioners Association (Te ORA). RACS supports Te ORA's annual Hui-a-Tau and the 2016 Pacific Region Indigenous Doctors Congress hosted by Te ORA. Te ORA is represented on the RACS Indigenous Health Committee, as well as on selection panels for scholarships offered to Māori medical students or junior doctors. As part of the RACS Māori Health Action Plan 2016–2018, RACS seeks to develop genuine partnerships with Māori organisations and Iwi (tribes). A Māori Health Steering Group, comprised primarily of Māori surgeons and Māori trainees, advises on activities required by the Māori Health Action Plan.

The RACS Indigenous Health Committee reports via Fellowship Services to the Professional Development and Standards Board. It oversees the implementation of RACS' position statement and strategic commitments in Indigenous health in Australia and New Zealand.

1.6.1 Team findings

The team heard from a wide range of stakeholders that the College interacts well with others in the health sector. There are multiple channels of communication between the College and jurisdictions. In contrast, some external stakeholders expressed views which may be summarised as a lack of clarity and transparency in relation to accountability, responsibility and control of key roles of the College, especially those which are shared with specialty societies.

An interface issue that came up several times is that the College undertakes a selection process into training which is separate to that of the recruitment into employment. The College advises hospitals of the trainees who have been 'allocated' to their hospital, and assesses the trainees but does not share referee reports with jurisdictions. This requires ongoing attention. This is also discussed under standard 7.1.

The BRIPS Action Plan has been received well. It has necessitated an increase in RACS' interactions with the health sector and will continue to do so for many years. At every site, most interviewed by the team were aware of many of the BRIPS initiatives, and the posters were visible. It was evident that the RACS-led initiative in surgery is having flow on effects into other areas of the hospitals.

The team could not state it any better than was expressed in the EAG report:

With the active support of all Fellows, the College and Specialty Societies can lead the way to a future in which there is no place for discrimination, bullying and sexual harassment in the practice of surgery. This will take courage, resources and a commitment to change. It will take enforcing the law and imposing sanctions as needed. It will take the College showing how to prevent and address discrimination, bullying and sexual harassment and how to hold people to account for their behaviour, working with the medical profession, employers and the healthcare sector more widely. Effective partnerships will be essential. It will take witnesses ending their silence and speaking out. To achieve the necessary fundamental cultural change, the College must also shine the light of independent scrutiny and greater transparency on its own assumptions and approaches. Critical self-reflection, fearless questioning of old habits and inherited practices, and a looser grip on tradition will be needed to shift the status quo.

An important recent initiative is the College's Diversity and Inclusion Plan (November 2016). This arises from the fourth goal in BRIPS which is to embrace diversity and foster gender equity.

The team met with members of the Women in Surgery Group. The group confirmed that there is not yet widespread acceptance that more flexibility in training and work is compatible with being a good surgeon. It is still a struggle to find examples of flexible training to offer as positive stories, and interruption of training is much more common than training part-time. The team heard varying accounts of where the problem lies with respect to the lack of part-time jobs, with the jurisdictions and the Specialty Training Board both being cited. The team does not agree with the view that trainees do not want or seek part-time posts but concurs with the Women in Surgery Group that the top priority is to establish a culture that fosters flexible training opportunities. This will require efforts by the College, Specialty Training Boards and jurisdictions. It is encouraging that flexible training is now a standing item on the Board of Surgical Education and Training agenda.

The Reconciliation Action Plan is another impressive initiative. The team met with Indigenous doctors from the RACS Indigenous Health Committee who confirmed that there has been a philosophical change, with Indigenous health now at the forefront of College business. The theme of Indigenous health has been part of RACS conferences. The College has demonstrated strong engagement with the two Indigenous doctors' organisations AIDA and Te Ora.

It was not yet clear to the team that either the Diversity and Inclusion Plan or the Reconciliation Action Plan had been adopted in full by the Specialty Training Boards or the Specialty Societies and Associations. The team recommends that the College continue maintaining its momentum on the implementation of the Reconciliation Action Plan, BRIPS and the Diversity and Inclusion Plan.

1.7 Continuous renewal

The accreditation standards are as follows:

- The education provider regularly reviews its structures and functions for and resource allocation to training and education functions to meet changing needs and evolving best practice.

RACS is an organisation based on the quality principles of continuous improvement, which recognises that it will always be evolving. The College regularly updates its strategic plan and business plan. The strategic plan is updated on a four-yearly cycle and the business plan annually. RACS is accredited within the ISO 9001 standard.

1.7.1 Team findings

There is ample evidence that the College addresses this standard. The College has made major changes in structure and function in each of the last two AMC accreditation cycles. In the current

cycle, step changes in direction have occurred with respect to surgical culture and use of technology. There is evidence from multiple sources that the BRIPS program is an excellent initiative and the culture of surgical training is changing. The College is commended on its leadership with the initiative. The College is well aware that several of its action plans 'are not universally embraced, requiring complex change management approaches.'

With so many initiatives underway, the College is encouraged to keep these efficient and aligned, both to maintain momentum, as well as to minimise change fatigue. Further, the initiatives need to be properly evaluated and reported upon. This is discussed in further detail under standard 6.

Commendations

- A The strong policy framework within which the College operates, including principle-based service agreements with Specialty Societies and Associations.
- B The College's contemporary and appropriate educational resources, in particular the Digital College initiative.
- C The Reconciliation Action Plan, and the Diversity and Inclusion Plan and progress made to date with regard to their implementation.
- D The enormous courage and leadership shown by the College in 2015 in establishing a broadly constituted Expert Advisory Group to undertake the substantial review of concerns relating to discrimination, bullying and sexual harassment. This resulted in the development and implementation of the Building Respect, Improving Patient Safety (BRIPS) program which is an excellent initiative and is evidencing a change in the culture of surgical training.

Conditions to satisfy accreditation standards

- 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)
- 2 RACS must develop and implement a stronger process for ongoing evaluation as to whether each of the specialty training programs remain consistent with the education and training policies of the College. (Standard 1.2)
- 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)
- 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)

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. (Standard 1.1.6)

2 The outcomes of specialist training and education

2.1 Educational purpose

The accreditation standards are as follows:

- The education provider has defined its educational purpose which includes setting and promoting high standards of training, education, assessment, professional and medical practice, and continuing professional development, within the context of its community responsibilities.
- The education provider's purpose addresses Aboriginal and Torres Strait Islander peoples of Australia and/or Māori of New Zealand and their health.
- In defining its educational purpose, the education provider has consulted internal and external stakeholders.

The RACS website contains information, policies and publications about the purpose of the College.

There are various documents/places that describe the overarching purpose of the College, including:

RACS Constitution	<p>The purpose of the College is to:</p> <ul style="list-style-type: none"> • advance education, training and research in the practice of surgery • determine and maintain professional standards for the practice of surgery in Australia and New Zealand • provide an environment promoting fellowship development and support; and • provide authoritative advice, information and opinion to other professional organisations, to governments and to the public.
RACS website	The College's purpose is to be the unifying force for surgery in Australia and New Zealand, with FRACS standing for excellence in surgical care.
RACS Business Plan 2016-17	<p>Statement of Purpose:</p> <p>The leading advocate for surgical standards, professionalism and surgical education in Australia and New Zealand.</p>
RACS Strategic Plan 2014-18	<p>RACS Purpose:</p> <p>Excellence in surgical practice and education.</p>
RACS Strategic Plan and Business Plan 2017-2018	<p>Vision:</p> <p>Leading surgical performance, professionalism and improving patient care.</p> <p>Mission:</p> <p>The leading advocate for surgical standards, education and professionalism in Australia and New Zealand.</p>
College's accreditation submission to AMC	The College's vision is to be 'the leading advocate for surgical standards, professionalism and surgical education in Australia and New Zealand.'

The College has a long history of setting and promoting high standards of training, education and assessment. The RACS Code of Conduct defines the professional behaviour for all surgeons and reflects the College's values. The College reviewed the Code in 2016 in consultation with the specialty societies and associations, as well as relevant RACS education sections, committees and boards.

There are nine RACS competencies adapted from Canadian Medical Education Directives for Specialists (CanMEDS) that apply across all specialties and these are well documented. More recently, the College has invested great time and energy on a culture change program, the Building Respect, Improving Patient Safety (BRIPS) program, which targets professional behaviours and practices. The BRIPS program is couched in a patient safety context.

The College recognises the disadvantage experienced by Indigenous peoples in Australia and New Zealand. As discussed under standard 1.6, the College has specific health action plans for Aboriginal and Torres Strait Islander peoples and Māori. The Reconciliation Action Plan 2016-2017 is certainly much broader in its focus.

The College displays a commitment to the needs of both Australian and New Zealand stakeholders and to regular communication through publications, the RACS website and social media.

The College's policy *External Co-opted Members on Committees and Boards* describes the role, responsibilities and selection criteria for external co-opted members (community representatives and honorary advisors) on its committees. Two community advisors sit as full members on the RACS Council and some of its major committees. In 2017, the College undertook an expression of interest process to recruit additional community representatives to College boards. A nominations committee is assisting the Specialty Training Boards and other committees appoint suitable community members. This is discussed further under standard 6.2.

2.1.1 Team findings

The team was impressed by the amount of positive feedback from multiple sources that the College sets and promotes high standards of training, education, assessment, professional and medical practice, and continuing professional development. There is evidence of focused work across the specialties to maintain and extend the high standards expected by the College and its members.

The team could not find sufficient evidence that these high standards are consistently applied within the context of RACS' community responsibilities. The College must define how its educational purpose connects to its community responsibilities. The team has made a number of recommendations under this standard and standard 6.2 that will assist the College to meet this requirement.

The College's commitment to continuing professional development is admirable and while the College's long-standing strength in clinical education and development is noted, this strength needs to be complemented by a similar focus on non-technical skills. The team is of the view that improvement in non-technical skills is vital and needs to be applied to existing fellows as well as to the specialty training programs. This is discussed further under standard 3.

The team was impressed with the College's willingness to be a strong leader in the culture and leadership change required across surgery and other medical professions, noting that culture change takes time and consistent focus.

The College has numerous versions of a vision statement or statement of purpose as shown in the table above. None of the statements provides a clear link to the breadth of RACS' community responsibilities, including providing services that the various populations and communities across Australia and New Zealand require.

Whilst the College states its commitment to Aboriginal and Torres Strait Islander peoples of Australia and Māori of New Zealand and their health, the team found that there is still opportunity

to strengthen action in this area significantly. In terms of education, the team found that cultural competence training needs to be built into teaching and education programs across all specialties and RACS' programs. Cultural competence should form part of training, education and continuing professional development. The current methods reported are not in line with contemporary expectations of cultural competence and this needs to be addressed as a priority. This is discussed further under standards 3.2 and 9.1. Current methods do not provide trainees with an understanding of the generational or disadvantage-related health issues that Indigenous peoples in Australia and New Zealand face, or the cultural support required as part of their care.

It is pleasing to see the beginnings of programs to support the selection of and support for Aboriginal and/or Torres Islander peoples, in a small number of specialties. More effort and commitment across the nine specialties are required. As detailed under standard 7.1, the team also noted that the RACS Māori Health Advisory Group had advised that it does not seek preferential selection of Māori candidates for the Surgical Education and Training (SET) program.

The College communicates well with its internal stakeholders and increasingly well with a narrow range of external stakeholders. Breadth and depth of external stakeholder engagement on the whole needs to be expanded. For this standard, the College needs to broaden and deepen its engagement with external stakeholders about connecting its educational purpose to its community responsibilities and the goals and objectives of surgical training. The College should also review its engagement strategy to ensure that external representatives are appropriately represented on College and associated committees.

2.2 Program outcomes

The accreditation standards are as follows:

- The education provider develops and maintains a set of program outcomes for each of its specialist medical programs, including any subspecialty programs that take account of community needs, and medical and health practice. The provider relates its training and education functions to the health care needs of the communities it serves.
- The program outcomes are based on the role of the specialty and/or field of specialty practice and the role of the specialist in the delivery of health care.

According to the College's accreditation submission, the Surgical Education and Training (SET) program is intended to produce an independent and competent specialist surgeon capable of providing the highest standard of safe, ethical and comprehensive care. The College reports that new fellows should be able to practise across the generality of their specialty, provide emergency care and hold the nine RACS competencies. The College also notes that many new fellows undertake post-fellowship training or experience.

As detailed under Standard 1, there are nine specialties within surgery and each of these has a single Specialty Training Board, except Orthopaedic Surgery and Plastic and Reconstructive Surgery, where there are separate Specialty Training Boards for Australia and New Zealand. Each Specialty Training Board has delegated authority from RACS to determine the program and graduate outcomes for its specialty.

The College monitors surgical workforce data. The College conducts a census of fellows every two years which provides feedback on workforce numbers and distribution. The Australian and New Zealand Surgical Workforce Projections to 2025 Report provides long-term national projection requirements of the surgical workforce. These reports serve as the basis for the College's efforts to ensure adequate growth of the surgical workforce to meet future population demands.

2.2.1 Team findings

The team findings for standard 2.2 are provided in combination with those of standard 2.3.

2.3 Graduate outcomes

The accreditation standards are as follows:

- The education provider has defined graduate outcomes for each of its specialist medical programs including any subspecialty programs. These outcomes are based on the field of specialty practice and the specialists' role in the delivery of health care and describe the attributes and competencies required by the specialist in this role. The education provider makes information on graduate outcomes publicly available.

The nine RACS competencies adapted from CanMEDS are articulated in the document, *Becoming a competent and proficient surgeon: Training Standards for the Nine RACS Competencies* (2012). These competencies are clearly defined and underpin the College's training, education and professional development programs, and are as follows:

- **Medical Expertise:** Medical Expertise relates to the acquisition, integrating and application of medical knowledge, clinical skills and professional attitudes in the provision of patient care.
- **Judgement – Clinical Decision Making:** Involves making informed and timely decisions regarding assessment, diagnosis, surgical management, follow-up, health maintenance and promotion.
- **Technical Expertise:** Technical expertise relates to safely and effectively performing surgical procedures conducted in the unit in which they are training.
- **Professionalism and Ethics:** Involves demonstrating commitment to patients, the community, and the profession through the ethical practice of surgery.
- **Health Advocacy:** Health Advocacy involves responding appropriately to the health needs and expectations of individual patients, families, carers and communities.
- **Communication:** All surgeons are required to be able to communicate effectively with patients, families, carers, colleagues and other staff.
- **Collaboration and Teamwork:** Involves developing a high level ability to work in a cooperative context to ensure that the surgical team has a shared understanding of the clinical situation and can complete tasks effectively.
- **Management and Leadership:** Involves leading the team and providing direction, demonstrating high standards of clinical practice and care, and being considerate about the needs of team members.
- **Scholar and Teacher:** As scholars and teachers, surgeons demonstrate a lifelong commitment to reflective learning, and the translation, application, dissemination and creation of medical knowledge.

The complete definitions of each of the nine surgical specialties are documented in the Guide to SET 2016 and are described under section 11 Surgical Specialties.

Each specialty has the responsibility for determining the graduate outcomes for its program which underpin the nine competencies.

2.3.1 Team findings

The College's strength is in the Specialty Training Boards and their expertise in outlining the requirements of their particular specialty. This arrangement has created a number of challenges however for RACS to meet this standard, as there are not clear program and graduate outcomes for each specialty and the outcomes that are available are not in a uniform style and therefore not easily comparable.

In its accreditation submission, the College notes that 'the RACS Surgical Education and Training Program produces independent surgeons who have specialty knowledge and skills, as well as

broad medical professional expertise'. Feedback from trainees and supervisors indicated that many new fellows consider they require some type of fellowship program to consolidate skills and confidence on the path to independent practice. The team reiterates the current lack of clarity around what a new fellow can and cannot do in terms of independent practice and the pressing need to clarify and communicate this. The team notes that the College plans to undertake a survey to evaluate preparedness for practice. It will be important to identify whether the issue is one of trainee competence or confidence, and what supports might be put in place to aid the transition to independent practice. This could include preparation of trainees to recognise their own CPD needs. The team also recommends that the College 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 SET program.

As noted above, the team draws the College's attention to the need under Standard 2.1 to relate the training and education functions to the health needs of the communities it serves. In particular, the College is encouraged to consider needs associated with Indigenous communities, rurality and areas with workforce challenges.

The team notes that a number of the specialties have curricula that are overdue for review and documenting outcomes is aligned with this review for a number of specialties. The College through the Specialty Training Boards must clearly articulate program and graduate outcomes for all specialties, which are publicly available and reflect community needs. The College will need to work with the Specialty Training Boards to agree on timeframes for ongoing curricula review and how the program and graduate outcomes are presented. The team also recommends that the College benchmark its training programs and graduate outcomes internationally.

The team received feedback from a number of senior fellows that the focus on safe working hours was diminishing the quality of graduates. This perception needs to be tested by the College and addressed as appropriate. There were also various reports from trainees that trainees are working hours additional to those recorded formally to bypass safe working hours requirements. Most of the trainees with whom the team met were in favour of additional hours to gain experience and practice. The team recommends that the College and Specialty Training Boards monitor this through the accreditation of training post process.

The College plans to survey new fellows five years post training to determine if their training was fit for purpose and meets community needs. The team agrees this will be a useful tool to guide curricula review leading to program and graduate outcomes. This is discussed further under standard 6.

Commendations

- E The College's commitment to producing surgeons who are viewed by supervisors, hospital administrators and other health professionals as being well-trained and surgically capable.

Conditions to satisfy accreditation standards

- 5 Define how the College's educational purpose connects to its community responsibilities. (Standard 2.1)
- 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)
- 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. (Standard 2.2 and 2.3)

Recommendations for improvement

- BB Benchmark the graduate outcomes of each of the surgical training programs internationally. (Standard 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. (Standard 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)

3 The specialist medical training and education framework

3.1 Curriculum framework

The accreditation standards are as follows:

- For each of its specialist medical programs, the education provider has a framework for the curriculum organised according to the defined program and graduate outcomes. The framework is publicly available.

The College introduced the RACS Surgical Education and Training (SET) program in 2007. The training programs are as follows:

- Cardiothoracic Surgery
- General Surgery
- Neurosurgery
- Orthopaedic Surgery – Australia
- Orthopaedic Surgery – New Zealand
- Otolaryngology Head and Neck Surgery
- Paediatric Surgery
- Plastic and Reconstructive Surgery – Australia
- Plastic and Reconstructive Surgery – New Zealand
- Urology
- Vascular Surgery.

As discussed under standard 2, the College has developed a competency framework, published under the title of Surgical Competence and Performance (2011). This document is complemented by *Becoming a Competent and Proficient Surgeon* (2012) which defines the nine competencies around which all specialties are expected to structure their training and assessment:

- Medical Expertise
- Judgement – Clinical Decision Making
- Technical Expertise
- Professionalism and Ethics
- Health Advocacy
- Communication
- Collaboration and Teamwork
- Management and Leadership
- Scholar and Teacher.

These competencies are demonstrated through clinical skills, patient care and professional judgement across five domains.

- Cognitive - Acquisition and use of knowledge to recognise and solve real-life problems.
- Integrative - Appraisal of investigative data against patient needs in clinical reasoning, manage complexity and uncertainty, application of scientific knowledge in practice.
- Psychomotor - Procedural knowledge, technical skill, manual dexterity, and adaptability.

- Relational - The ability to communicate effectively, accountability, works with others, consultative, resolving.
- Affective/moral - Self-awareness, ethical, critically reflective, responsible, healthy, safe.

In the RACS competency framework, progressive development through five stages of increasing complexity is described for each of the nine competencies. The stages are as follows:

- Pre-vocational - the behavioural markers that describe a level of performance which would be expected of a doctor applying for selection into surgical training.
- Novice - the behavioural markers that describe a trainee who has commenced surgical training and who has an aptitude for their surgical specialty.
- Intermediate - the behavioural markers that describe the performance of a surgical trainee who is clearly progressing but who still needs a reasonable amount of supervision, has some way to go before being regarded as competent, and thus ready for more independent surgical practice.
- Competent - the behavioural markers that describe the performance of a trainee nearing the end of their training program and who can be trusted to perform with a minimum of supervision unless the situation is complex.
- Proficient - the behavioural markers that describe the performance expected of a Fellow. They represent a maturity beyond the previous stage and a consolidation of the competencies that have been acquired during training, together with an increasing inventory of experience.

Each surgical specialty determines the required technical skills and expertise for its program and is expected to make these publicly available. It is noted that a number of specialties have initiated and are undergoing curricular review with plans to update as required.

Curriculum documents	Curriculum review timeline
Cardiothoracic Surgery Curriculum, August 2006	The Board of Cardiothoracic Surgery will be reviewing the curriculum in the coming 24 months. This review will assist with the development of clearer guidelines for competency-based training.
General Surgery Curriculum Subject Outlines, January 2015	The Board in General Surgery will move to competency-based training in 12 to 18 months.
Neurosurgery Curriculum – Syllabus Modules, January 2014	The Board of Neurosurgery has already introduced competency-based training. It introduced three levels of training with maximum time frames set at each level but flexibility to allow trainees to progress at different speeds.
Australian Orthopaedic Association SET Syllabus, 2011	The Australian Orthopaedic Association has commenced a progressive implementation of the revised curriculum. The competency-based training program, AOA 21 begins in Australia in 2018. The New Zealand Orthopaedic Association continues to utilise the Australian Orthopaedic Association SET Syllabus, from pre 2011.

Curriculum documents	Curriculum review timeline
Otolaryngology Head and Neck Surgery, Training Modules, February 2012	The curriculum is currently under review with the anticipated launch of the revised curriculum in February 2018.
SET in Paediatric Surgery Curriculum	The Board completed the formulation of a competency based curriculum in 2013. The Board will review this curriculum in the next 1-3 years.
Curriculum in Plastic and Reconstructive Surgery	The Australian Board of Plastic and Reconstructive Surgery has completed a curriculum review with drafts distributed to the specialty groups and external stakeholders for feedback (Australia and New Zealand) by end of 2017. Final documents will be published in 2018 for approval by the College. Implementation will take place in 2019. The New Zealand Board of Plastic and Reconstructive Surgery is collaborating with the Australian Board on the curriculum review and looking at competency-based outcomes.
Modular Curriculum Portfolio, Surgical Education and Training Urology, September 2013	Revision of the syllabus/curriculum is underway. In terms of the non-technical competencies, negotiations have commenced with other subspecialty groups (Orthopaedic Surgery) with a view to sharing a common curriculum.
Vascular Curriculum Modules	The Board of Vascular Surgery reported that a number of training modules need reviewing and this process has commenced. There has been progress on moving towards competency-based training. The expected levels of performance for each level of training have been developed.

The SET program has a defined structure combining aspects of time (rotations and duration of training) and competence (the progressive attainment of skills and expertise). Generally, each year of surgical training is comprised of six- to twelve-month clinical rotations (with three-month rotations for some specialties in the first year of training). The surgical specialties differ slightly in structure and in the time required to achieve independent practice, as shown in the following table:

		SET Program											
		PGY 1-4/5	1	2	3	4	5	6	7	8	9	10	11
JDocs													
Cardiothoracic Surgery		Expected duration of clinical training						Maximum time available to complete all requirements					
General Surgery commencing pre-2017		Expected duration of clinical training						Maximum time available to complete all requirements					
General Surgery commencing from 2017		Expected duration of clinical training				Maximum time available to complete all requirements							
Neurosurgery		Basic training 1-2 years		Intermediate training 3-4 years			Advanced training 1-3 years						
Orthopaedic Surgery Australia		Intro 1 year	Core 3 years		Transition 1 year		Maximum time available to complete all requirements						
Orthopaedic Surgery NZ		Expected duration of clinical training						Maximum time available to complete all requirements					
Otolaryngology Head and Neck Surgery		Expected duration of clinical training						Maximum time available to complete all requirements					
Paediatric Surgery		SET 1	Early SET	Mid SET			Senior SET	Maximum time available to complete all requirements					
Plastic and Reconstructive Surgery Australia		Expected duration of clinical training						Maximum time available to complete all requirements					
Plastic and Reconstructive Surgery New Zealand		Expected duration of clinical training						Maximum time available to complete all requirements					
Urology commencing pre-2016		Expected duration of clinical training						Maximum time available to complete all requirements					
Urology commencing from 2016		Expected duration of clinical training						Maximum time available to complete all requirements					
Vascular Surgery		Expected duration of clinical training						Maximum time available to complete all requirements					

There are several specialties which now emphasise expected standards of performance at particular stages, a move away from the definition of training by number of years. For example, neurosurgery and otolaryngology head and neck surgery are introducing minimum and

maximum periods of time in which competencies at each level must be achieved. General surgery has reduced the specified duration of training from five to four years and expects the competence of entry-level trainees will be evidenced by procedure-based assessments and other basic skills. The structure and framework for each specialty are found in the individual specialty regulations and in the RACS Guide to SET.

3.1.1 Team findings

There has been good progress made with the SET program since its introduction in 2007. The training, education and assessment programs of the College are well-respected locally, nationally and internationally. The fellowship of RACS is a designation sought after and valued by trainees and fellows. The College has defined its competency framework which is publicly available on the College's website. The Specialty Training Boards, with support from specialty societies and associations, create and deliver the curricula, which are also published either on the College or specialty society/association website. Although cumbersome, both the College and most Specialty Training Boards see benefit in this arrangement.

Standard and maximal times are set out for each specialty training program and differ between specialties. Maximal times in some specialties include time taken for research and other degrees (PhD etc.).

The team heard of concerns related to the length of training, including the time taken to gain entry into surgical training programs. The team agreed with a view expressed by some stakeholders outside the College that the time to train a surgeon is long, possibly too long. This has consequential effects: first, a lessening of the years in which surgeons may operate independently; second, being a deterrent to potential applicants; and finally, the effect on the workforce pipeline. The team commends the specialties of general surgery and urology for recently shortening training by a year, and the College for ensuring that competency-based training remains on the agenda.

For many years, the College has planned to introduce competency-based surgical education and training. However, the definition and understanding of what this actually means is variable, and it is not yet fully implemented. The team considers the College must better define what it means by 'competency-based training' and how 'time in training' and 'procedure numbers' complement specific observations of satisfactory performance in determining 'competence'. The establishment of College-wide definitions would promote progress on this initiative for all specialties and for those who have started the journey (Paediatric Surgery, Vascular Surgery).

The team encourages the College to look at further ways to increase the efficiency of training, such that 'competence' is achieved with fewer hours over a reduced time period. Time-based criteria have led to repeating significant portions of rotations and experiences. The team heard that Specialty Training Boards are able to use their discretion in accrediting a period of training for well-performing trainees even when they had not met the minimum number of weeks. However, the team considers the criteria for such decisions are not sufficiently explicit. Furthermore, trainees perceived that none of a six-month period would be granted if they exceeded the maximum weeks of leave. The College should continue to look at whether periods of less than the standard six months could 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.

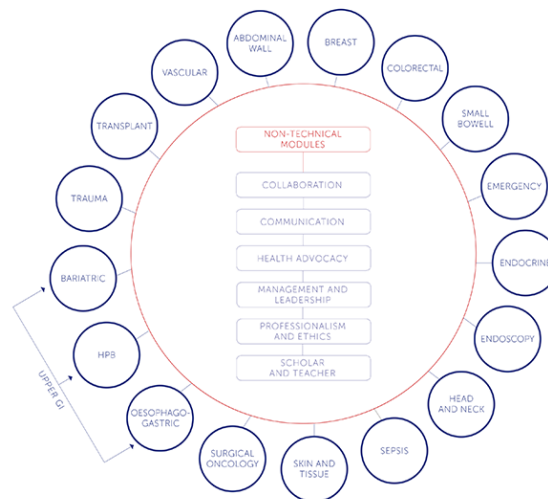
The curricula of the individual specialties were provided to the team as part of the assessment with further information submitted in response to questions asked by the team. Owing to the variety in the way curricula were presented, it proved a challenge for the team to compare each specialty with others, with the RACS competency framework, and with each of the AMC standards. Some curricula had not been revised since 2006. All had considerable detail on the technical competencies of the specialties expected at the completion of training, and most had a list of

graduate competencies in the non-technical domains. Few specialties had outlined non-technical competencies at each stage of training/SET level.

General Surgery was an example of a curriculum where the competency framework shows an explicit link between the non-technical and the specialty-specific standards for each topic that incorporates Judgement/Clinical Decision Making, Clinical Assessment, Investigations and Principles of Management, and Technical Expertise.

GENERAL SURGERY MODULES

→ TECHNICAL MODULES



The team agreed with stakeholders that all surgeons, regardless of specialty, should have a similar set of broad professional knowledge, skills and behaviours. It is not sufficient to assume that this will be brought forward from medical school or the early postgraduate period, or acquired from the healthcare environment. These aspects of surgery must be signalled as important by the Specialty Training Boards and reinforced and role modelled in the context of surgical training and practice.

The team accepts that a certain level of heterogeneity is inevitable, especially for the specialty-specific aspects. However, the team considers that the College, through the Specialty Training Boards, should develop more consistency in certain curricular aspects, such as:

- 1 a uniform and concise statement of program outcomes by specialty
- 2 defined graduate outcomes by specialty which map to the nine RACS competencies
- 3 how these (items 1 and 2) are portrayed publicly
- 4 clear learning outcomes at each stage of training which map to the graduate outcomes, thence the RACS competency framework, as well as to assessments
- 5 defined coverage of the subject areas in standard 3.2 below
- 6 greater concordance in the non-technical competencies across all surgical specialties.

With respect to the last point, the College might look to other specialist medical colleges. Some colleges have a number of different specialty programs yet only one professional qualities curriculum.

Finally, the team suggests that the College and the Specialty Training Boards address the issues raised in standard 2, i.e. confirming program and graduate outcomes of surgical training, as a necessary first step in alignment of surgical curricula.

3.2 The content of the curriculum

The accreditation standards are as follows:

- The curriculum content aligns with all of the specialist medical program and graduate outcomes.
- The curriculum includes the scientific foundations of the specialty to develop skills in evidence-based practice and the scholarly development and maintenance of specialist knowledge.
- The curriculum builds on communication, clinical, diagnostic, management and procedural skills to enable safe patient care.
- The curriculum prepares specialists to protect and advance the health and wellbeing of individuals through patient-centred and goal-orientated care. This practice advances the wellbeing of communities and populations, and demonstrates recognition of the shared role of the patient/carer in clinical decision-making.
- The curriculum prepares specialists for their ongoing roles as professionals and leaders.
- The curriculum prepares specialists to contribute to the effectiveness and efficiency of the health care 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 health settings within the Australian and/or New Zealand health systems.
- The curriculum prepares specialists for the role of teacher and supervisor of students, junior medical staff, trainees, and other health professionals.
- The curriculum includes formal learning about research methodology, critical appraisal of literature, scientific data and evidence-based practice, so that all trainees are research literate. The program encourages trainees to participate in research. Appropriate candidates can enter research training during specialist medical training and receive appropriate credit towards completion of specialist training.
- The curriculum develops a substantive understanding of Aboriginal and Torres Strait Islander health, history and cultures in Australia and Māori health, history and cultures in New Zealand as relevant to the specialty(s).
- The curriculum develops an understanding of the relationship between culture and health. Specialists are expected to be aware of their own cultural values and beliefs, and to be able to interact with people in a manner appropriate to that person's culture.
- Additional MCNZ criteria: Cultural Competence: The Training Program should demonstrate that the education provider has respect for cultural competence and identifies formal components of the training program that contribute to the cultural competence of trainees.

The SET framework emphasises self-directed learning aligned to supervised clinical work. The formal elements of the curriculum framework are outcome-focused as trainees demonstrate acquisition and performance of the nine RACS competencies. As detailed under standard 3.1, the standards of performance through SET, leading to progressive independence, are indicated in the document, *Becoming a competent and proficient surgeon (2012)* and *Surgical Competence and Performance (2011)*.

The program and graduate outcomes are discussed in further detail under standard 2 of this report. The curriculum underpins these outcomes and alignment is achieved using the nine RACS competencies as the framework. Each specialty determines the required technical skills and expertise for the relevant program.

Scientific and technical competencies

The Training Boards determine the specialty-specific technical requirements to practise as generalists in the specialty. The specialty curricula set the foundation for the scientific and technical knowledge required for practice in that specialty, along with the core professional competencies required of all surgeons.

The curriculum covers aspects of professionalism and technical expertise that prepare trainees to become surgeons and contribute to the healthcare system across a range of settings. All specialties train for the generalist outcomes of the specialty, with formal post-fellowship training and/or experiential sub-specialisation occurring in the early years of practice as a surgeon, after admission to fellowship.

Surgical training typically occurs across several hospitals and networks, across several states if training in Australia and, for some specialties, a trainee may train in both Australia and New Zealand. The College reports that this exposes trainees to a wide variety of patients across different populations. Exposure across language, education and socio-economic status levels can be discussed by supervisors and trainers. The College acknowledges that in a patient-centred approach, practice in a capital city tertiary referral hospital is not the same as practice in a major regional hospital, or practice in an outer-urban or provincial hospital.

Health Advocacy

The health advocacy competency expects trainees to identify and respond to the health needs and expectations of individual patients, families, carers and communities.

Surgical trainees work in multidisciplinary teams with a focus on patient-centred care. The clinical basis of SET, in which trainees combine supervised clinical practice with graduate learning, means that trainees work and train in the healthcare system. Components of clinical practice involve developing a working knowledge of this system.

Quality and safety in healthcare

Ensuring quality and safety in surgery is expected of trainees as part of the management and leadership competency. The specialty curricula contain references to quality and safety and are examined in some fellowship Examinations.

Since 2013, all applicants for surgical training must complete the Hand Hygiene Australia eLearning module, and from 2016 applicants must also complete the Operating with Respect eLearning module.

Professionals and leaders

As part of the professionalism competency, trainees are expected to demonstrate a commitment to patients, the community and the profession through the ethical practice of surgery.

In the management and leadership competency, trainees are expected to lead, provide direction, promote high standards, match resources to demand for services and show consideration for all members of staff. Leadership training is provided in learning modules, skills courses and assessments. The College has recently developed a Leadership in Everyday Practice course open to trainees, fellows and specialist international medical graduates. Two courses will be run in 2017.

Teacher and supervisor

In the scholar and teacher competency, trainees are expected to demonstrate a commitment to reflective learning, and the creation, dissemination, application and translation of medical knowledge. Trainees are encouraged to contribute as skills course instructors, teachers of their juniors, and by engaging with junior doctors seeking a career in surgery through the JDocs

Framework. Trainees can attend the Foundation Skills for Surgical Educators course and apply for membership of the Academy of Surgical Educators. Several trainees are enrolled in the master of surgical education program.

The collaboration and teamwork competency, expects trainees to work cooperatively with peers, other trainees and other health professionals to develop a shared picture of the clinical situation and facilitate appropriate task delegation, to ensure the delivery of safe, effective and efficient surgery.

Scientific foundations and research

Research is encouraged in all specialties. All surgical trainees undertake one or more research projects during SET. The research requirement may include (but is not limited to): presentation of a paper/poster display to a meeting for which abstracts are subject to review and selection; publication in a peer-reviewed journal; dissertation with a written review of a clinical problem, together with a critical literature review; period of full-time research; research higher degree at Masters level or above.

The College offers a Critical Literature Evaluation and Research (CLEAR) course in evidence-based medicine which is compulsory for some disciplines. This is described further under standard 4.2.

Culture and Health

As part of the health advocacy competency, trainees are expected to identify and respond to the health needs and expectations of individual patients, families, carers and communities.

The College provides resources to assist trainees, fellows and specialist international medical graduates to recognise their own and others' cultural values and beliefs. The College has developed an Intercultural Competence for Medical Specialists eLearning resource.

Aboriginal and Torres Strait Islander and Māori health

Aboriginal and Torres Strait Islander and Māori health and culture are primarily included as part of the health advocacy and communication competencies. The *Standards of Clinical Performance Guide* and *Becoming a Competent and Proficient Surgeon* state that trainees are expected to:

- provide care with compassion and respect for patient rights
- recognise that culture and beliefs affect patients and their expectations
- adapt patient care according to their concerns and expectations
- consistently deal with the challenges presented by different value systems
- adapt practices and care of patients from diverse backgrounds according to their culture and beliefs.

The College has developed an Australian Indigenous Health and Cultural Learning eLearning Module. The Board of Otolaryngology Head and Neck Surgery is currently developing a curriculum module specific to Aboriginal and Torres Strait Islander and Māori health. New Zealand trainees are encouraged to complete the Ministry of Health's online module, Foundation Course in Cultural Competency and to utilise the Medical Council of New Zealand's cultural competency resources.

3.2.1 Team findings

Trainees, supervisors and healthcare providers consider that the product of RACS training is a well-trained surgeon in the designated specialty. Those involved in training take pride in the training programs. Based on the documents presented, stakeholder interviews, the emphasis on attendance at courses and conferences, the suite of RACS courses, and the nature of the

Fellowship Examination, the team was in no doubt that the scientific and technical aspects of surgical training are very well covered by the College and the Specialty Training Boards.

As mentioned in standard 3.1 above, the team found considerable heterogeneity in other curricular aspects, such as whether material was covered at all, or in how well it aligned with graduate outcomes and assessments. The College with the Specialty Training Boards must show that all areas of the curriculum are important, through College-based or approved learning activities and assessments which map to relevant competencies.

The team has not reported on every strength and weakness in curricula content, but outlines several areas for enhancement. The team considers the College through the Specialty Training Boards must 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.

Curricula could be more explicit about how trainees learn to take into account the broader patient context. For example, this could include consideration of patient-family support and the patient's living situation. Another is how surgeons decide when it is best not to operate, and how this is communicated.

It was a perception of the team that the management of peri-operative comorbidities and complications are often delegated unnecessarily to medical or other consulting services. Management of common and straightforward comorbidities and complications in surgical patients should be specifically included in the curricula for all specialties.

At the site visits, the team heard that positive interprofessional communication needs continuing emphasis.

Progress has been made in the area of cultural competence but this is not yet sufficient to meet this standard. Often coverage of this aspect has been assumed from the basic medical degree curriculum or the employing hospital's orientation program, and it is not a formal element in every curriculum.

The Medical Council of New Zealand has a module on cultural competence that is required by some specialties but not others, despite cultural competence training being mandatory in New Zealand. The College's eLearning module on Australian Indigenous Health and Cultural Learning is not compulsory in all Australian curricula. Trainees reported to the team that cultural competence training is an area of deficiency in all specialty curricula. More work and attention will be required of each specialty in appropriately addressing cultural competence in its curriculum.

In addition, cultural competence with regard to Aboriginal and Torres Strait Islanders and/or Māori, needs to be an essential component in its own right in all curricula, and have ongoing emphasis. This includes an understanding of the determinants of the specific health needs of Aboriginal and Torres Strait Islanders and/or Māori.

In the wake of the expert advisory group recommendations regarding discrimination, bullying and sexual harassment, there have been several initiatives to facilitate both trainee and fellow learning in practice. Online modules are available and mandatory for fellows and should be available to all trainees. While the undertaking of courses is a good start, it is imperative that corresponding assessments (e.g. multi-source feedback) have specific enough criteria to enable the College and the Specialty Training Boards to use these in progression decisions.

3.3 Continuum of training, education and practice

The accreditation standards are as follows:

- There is evidence of purposeful curriculum design which demonstrates horizontal and vertical integration, and articulation with prior and subsequent phases of training and practice, including continuing professional development.
- The specialist medical program allows for recognition of prior learning and appropriate credit towards completion of the program.

A significant change since the last AMC assessment has been the development of the JDocs Framework. The JDocs Framework provides those interested in careers in procedural medicine with an opportunity to identify, develop and record the skills they require to enter specialty training. JDocs provides a comprehensive curriculum outline, and access to educational resources and self-assessment tools.

'Vertical' integration of the curriculum begins with JDocs, which aligns with the nine RACS competencies and uses key clinical tasks to articulate surgical skills early in trainees' careers and within the context of clinical practice. The need to support new surgical trainees by providing them with guidance on how to gain knowledge and skills that would readily integrate into surgical training was a significant driver in the development of JDocs.

The RACS continuing professional development program also uses this framework of competencies and outcomes. This means it is possible to map the curriculum from junior doctor to experienced independent consultant and throughout a surgical career.

The SET program was developed to encourage trainees to enroll directly in their preferred specialty, but within surgical training it is possible to move 'horizontally' from one specialty program to another, via the selection process. This does have drawbacks as transferring results in lost opportunity for the specialty who has trained the trainee for one to three years, and for doctors who were not selected during that period due to the number of posts available. It also may result in less than optimal numbers of surgeons graduating from the original specialty. The 2014 Review of the RACS SET Program noted that 90% of movement between specialties were from general surgery to other specialties. In 2015, approximately 42% of trainees who applied for another specialty were successful in transferring.

Specialty training programs have processes to acknowledge prior learning in another surgical specialty. A small number of fellows undertake training in a second specialty.

Recognition of Prior Learning

The College recognises that trainees entering SET may have gained prior medical training or experience comparable to components of the RACS SET program in terms of learning outcomes, competency outcomes and standards. The Recognition of Prior Learning (RPL) policy is available on the College's website. The policy is used in conjunction with the relevant specialty SET Program regulations. The outcome of assessment of RPL by training program is provided in the table below.

Training Program	Year	No. of applicants	No. accepted	No. rejected
Cardiothoracic	2013	2	0	2
	2014	3	1	2
	2015	1	0	1
General Surgery	2013	49	40	9
	2014	59	46	13
	2015	87	78	9

Training Program	Year	No. of applicants	No. accepted	No. rejected
Neurosurgery	2014	1	1	0
	2015	8	8	0
	2016	12	11	1
Otolaryngology Head and Neck Surgery	2014	2	1	1
	2015	0	0	0
	2016	1	1	0
Orthopaedic Surgery Australia	2013-15	4	0	4
Orthopaedic Surgery New Zealand	2013-15	1	0	1
Paediatric Surgery	2013	0	0	0
	2014	5	5	0
	2015	0	0	0
Plastic and Reconstructive Surgery (Australia)	2014	0	0	0
	2015	1	0	1
	2016	1	0	1
Plastic and Reconstructive Surgery (New Zealand)	2014-16	0	0	0
Urology	2014	1	1	0
Vascular	2014	2	2	0
	2015	1	1	0
	2016	0	0	0

3.3.1 Team findings

The team found evidence of purposeful curriculum design which demonstrates horizontal and vertical integration, and articulation with prior and subsequent phases of training and practice, including continuing professional development. The nine RACS competencies act as an integrating framework. For each specialty, training is clearly structured under years or stages of training. Trainees report the curriculum is clear to them.

There has been a recent and optional addition to prevocational training under the name of JDocs. This has been carefully designed to link with SET selection criteria and training. Thus JDocs provides structure and a framework for prevocational trainees wishing for a surgical career. RACS has been purposeful in leaving this as a voluntary and non-accredited program.

Some specialties require sign off on prevocational competencies (e.g. appendectomy in general surgery) and this is further discussed under standard 7. Some trainees and supervisors perceived that these prevocational requirements change at times with little warning.

However, as the team has indicated previously, horizontal integration between the technical and non-technical aspects of surgical training and between specialties is not yet sufficiently explicit. The Fellowship Examination could be enhanced as a horizontal integrating mechanism by inclusion of another column in the examination blueprint for non-technical aspects.

As noted under standard 2.3, the team heard that many trainees consider they are unprepared to work independently as a consultant surgeon and that a fellowship year is commonly sought. This highlights there may be difficulties in the articulation of SET and junior consultant practice. However, with the shortening of the length of training already implemented in a number of specialties, this sentiment of unpreparedness may worsen in coming years. The College plans to undertake a survey to evaluate preparedness for practice. It will be important for the College to identify whether the issue is one of trainee competence or confidence, and what supports might be put in place to aid the transition to independent practice. This could include preparation of trainees to recognise their own CPD needs.

3.4 Structure of the curriculum

The accreditation standards are as follows:

- The curriculum articulates what is expected of trainees at each stage of the specialist medical program.
- The duration of the specialist medical program relates to the optimal time required to achieve the program and graduate outcomes. The duration is able to be altered in a flexible manner according to the trainee's ability to achieve those outcomes.
- The specialist medical program allows for part-time, interrupted and other flexible forms of training.
- The specialist medical program provides flexibility for trainees to pursue studies of choice that promote breadth and diversity of experience, consistent with the defined outcomes.

The specialty curricula identify markers that demonstrate competence in the range of activities undertaken by trainees. They also identify assessment and examination tasks. Regulations specify barrier assessments to ensure trainees demonstrate required knowledge and skills before progressing to the next stage of training. Some specialties (for example, Neurosurgery, Otolaryngology Head and Neck Surgery, and Orthopaedic Surgery) specify minimum and maximum durations for stages of training. For example, in Orthopaedic Surgery the current training program is five years in duration, with a minimum training time of four years with flexibility allowed for trainees who require additional support or who demonstrate exceptional performance. There are differences in the duration of the program between specialties. The duration of each training program is determined by the individual Specialty Training Boards taking account of the specialty skills required, and estimated time needed to achieve competence.

The College is progressing more flexible approaches to the issue of the duration of training and taking steps to improve assessment by investigating entrustable professional activities (EPAs). Recent developments in this area are the key clinical tasks introduced in the JDocs Framework and the procedural skills and professional capabilities assessments used in selection to the training program in General Surgery. General Surgery is piloting some EPAs in 2017.

Surgical education and training remains significantly time-based and training in less than the usual time is rare. However, should a trainee come from another specialty, or have done significant other postgraduate medical training, then the program is able to allow for prior learning, especially with excellent performance at work.

Deferral, Interruption and Part-Time Training

Decisions to grant applications for deferral, interruption or part-time training are made by the relevant Specialty Training Board in accordance with specialty regulations, taking into consideration the reasons for the request, the trainee's progress to date and logistical considerations. Trainees in part-time and interrupted training in 2014, 2015 and 2017 are provided in the following table. Figures were not provided for 2016.

Year	Application	CAR	GEN	NEU	ORT	OTO	PAE	PLA	URO	VAS	Total
2014	Part-time	0	6	0	0	0	0	0	0	0	6
	Interrupted	2	40	1	2	10	1	6	3	5	70
2015	Part-time	0	3	0	0	0	0	0	0	0	3
	Interrupted	3	36	2	0	6	1	3	2	4	58
2017	Part-time	0	5	0	0	0	0	0	0	0	5
	Interrupted	2	33	4	5	4	4	5	4	2	63

3.4.1 Team findings

In most cases, the specialty curricula outline expectations by year or stage. Duration is outlined in 3.1. As has been stated, the technical competencies within each specialty are presented in detail, with less detail and much more variability between specialties in the non-technical competencies.

As discussed under standard 3.2, the team considers that the College must better define what it means by 'competency-based training' and how 'time in training' and 'procedure numbers' complement specific observations of satisfactory performance in determining 'competence'.

The College reports a low number of trainees undertaking part-time training or altered learning arrangements, with more being able to interrupt training. In its documentation to the team, the College reported only five trainees were currently in part-time training, all in General Surgery, but anecdotal reports suggest there are more. Of note, Paediatric Surgery advocates for improvement in training conditions for women surgeons. The team commends Paediatric Surgery for the flexible position about to be created at Gold Coast Hospital. The College has policies in place that permit such training, however trainees do not seem to be taking advantage of this option for a number of reasons. A number of reasons were presented to the team as to why there were so few part-time trainees. Among these were:

- jurisdictional requirements
- service demands
- small numbers of trainees in some specialties
- trainees did not want it
- Specialty Training Boards did not facilitate it
- a lack of role models
- curriculum demands, including the need to develop and retain 'muscle memory'; and training already long.

The team is of the view that trainees are aware they may request flexible or part-time training but are hesitant to make such a request, for one or more of the reasons listed.

The College in its 2016 Diversity and Inclusion Plan makes a commitment to 'increase the representation of women in the practice of surgery by removing barriers to participation and introducing flexible training models for any trainee or surgeon, irrespective of gender.' The team noted that flexible training is now a standing item on the Board of Surgical Education and Training agenda. Several other Specialty Training Boards have, or are considering, flexible training policies and models such as job-sharing or designating positions as part-time. The College's momentum to identify and remove overt and hidden barriers to flexible training must be maintained.

The New Zealand chair of the Board of Otolaryngology Head and Neck Surgery has developed a proposal to amend the current rules to make interruption more 'user-friendly'. The team considers this proposal should be shared with other surgical specialties.

Commendations

- | | |
|---|---|
| F | The progress that has been made with the Surgical Education and Training (SET) program since its introduction in 2007. |
| G | The formal surgical competency framework in the form of the nine RACS competencies for use across all surgical specialties. |
| H | Ongoing desire for improvement as indicated by a number of surgical specialties undertaking curriculum review, as well as the move by the College and some surgical |

specialties to introduce curricula based on competencies expected at each stage of training.

Conditions to satisfy accreditation standards

- 8 Enhance and align the non-technical competencies across all surgical specialties including a consideration of the broader patient context. (Standard 3.2)
- 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)
- 10 Document the management of peri-operative medical conditions and complications in the curricula of all specialty training programs. (Standard 3.2.3, 3.2.4 and 3.2.6)
- 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)
- 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'. (Standard 3.4.2)
- 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)

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)

4 Teaching and learning

4.1 Teaching and learning approach

The accreditation standards are as follows:

- The specialist medical program employs a range of teaching and learning approaches, mapped to the curriculum content to meet the program and graduate outcomes.

The College delivers surgical training through public and private hospitals in Australia and public hospitals in New Zealand. Clinical training in hospitals is structured at hospital, rotational, regional, national and/or bi-national levels.

A wide range of teaching and learning approaches is used across the surgical training programs. Work-based experiential learning and formal sessions in the clinical context are supplemented by online and printed/scheduled materials. Clinically-based learning is supervised by surgical specialists, cognisant of curriculum requirements, and in accordance with the College's hospital and training post accreditation requirements. In addition to independent self-directed learning, there are group activities and mandatory courses, workshops, simulation, eLearning, peer-to-peer learning, journal clubs, and study groups. There is an increasing use of web-based technology and simulation as a training tool. Each specialty training program follows a curriculum and recommends reference books and supplementary resources relevant to the specialty. Trainees also have access to the extensive RACS library.

The College supports the use of simulation in the training program. Several specialties have introduced simulation into their requirements as relevant to specialty practice. As part of the urology curriculum review, the Board of Urology is currently reviewing how simulation may be better incorporated into the curriculum. The College's head office has a well-equipped skills laboratory, as do other states/territories and New Zealand.

Some learning activities are compulsory for all trainees, for example, the Care of the Critically Ill Surgical Patient (CCrISP®) and Early Management of Severe Trauma (EMST) skills courses. The CCrISP® course equips trainees to recognise a deteriorating patient, to implement a structured management plan, and includes practising 'calling in' the consultant and 'handover' to intensive care staff. The EMST course teaches trainees how to approach the care of a trauma patient in the first one to two hours following injury. This course has been adapted from the Advanced Trauma Life Support® (ATLS™) program developed by the American College of Surgeons.

The Australia and New Zealand Surgical Skills Education and Training (ASSET) course is aimed at SET trainees and medical graduates who are postgraduate year (PGY) 2 or above. It is a mandatory requirement of training for all specialties except Neurosurgery.

Some activities are compulsory for particular specialties, for example: General Surgery Surgical Education and Assessment Modules (SEAM); Orthopaedic Surgery Bone School; Paediatric Surgery Critical Appraisal Tasks (CATS) and Directed Online Group Studies (DOGS); and some are optional, for example, SET Ready and Self-Assessment eLearning resources. The Specialty Training Boards conduct specialty-specific educational activities, including tutorials, trainee days, clinical workshops and courses, and practice fellowship examinations.

Some College courses relate more to non-technical skills. Examples are the Critical Literature Evaluation and Research (CLEAR) course taken by trainees in Neurosurgery, General Surgery, Orthopaedic Surgery, Paediatric Surgery and Urology. This course is designed to provide the trainee with tools to undertake critical appraisal of surgical literature and to assist in the conduct of clinical trials, which is further enhanced with the formation of the Clinical Trials Network of Australia and New Zealand, meant to allow for trainee-led trials. Another course is Training in Professional Skills (TIPS). The learning outcomes for this course relate to: effective patient-doctor communication in surgical practice; effective teamwork and collegial communication in surgical

practice; personal strengths and areas for improvement with respect to skills relevant to the above domains; and appropriate professional behaviours in the workplace.

Since 2013, all applicants for surgical training have completed the Hand Hygiene Australia eLearning module. From 2016, applicants must complete the Operating with Respect eLearning module. Operating with Respect is online evidence-based training module addressing discrimination, bullying and sexual harassment and is mandatory for trainees, fellows and specialist international medical graduates.

The College accredits courses and activities from external education providers, which meet its educational standards and criteria. The College accredits activities such as tertiary courses, short courses, workshops, and online courses. In order to be accredited, the educational activities must be aligned to, and address, one or more of the nine RACS competencies. Since 2013, more than 30 courses have been accredited. The standards and criteria for the accreditation of educational courses and activities are available on the College's website.

The College partners with the University of Melbourne to deliver a Master of Surgical Education program. This program was developed in 2011 and allows surgeons to gain formal skills in teaching and educational scholarship.

4.1.1 Team findings

The SET program employs a range of teaching and learning approaches. Most of the formal teaching and learning activities relate to knowledge or technical skills which are well articulated in most curricula.

On the other hand, there appear to be few formal learning activities targeted at non-technical (professional) skills (also discussed under standard 3). Among these courses are CLEAR, TIPS and the Operating with Respect eLearning module. CLEAR is only mandated for five surgical programs. Although the Operating with Respect module is mandatory for trainees, supervisors, and specialist international medical graduates, it does not feature in any of the specialty training regulations. Likewise, Orthopaedic Surgery is the only specialty in which TIPS is incorporated into the training regulations.

The team noted that several specialties are currently undergoing curriculum review. As part of the review process, curriculum maps should be developed to show the alignment of learning activities, and outcomes at each stage of training, including graduate outcomes. This includes outcomes for non-technical (professional) skills. The team also recommends that compulsory RACS courses should be reflected in curricula, regulations and other training documents to aid mapping efforts.

4.2 Teaching and learning methods

The accreditation standards are as follows:

- The training is practice-based, involving the trainees' personal participation in appropriate aspects of health service, including supervised direct patient care, where relevant.
- The specialist medical program includes appropriate adjuncts to learning in a clinical setting.
- The specialist medical program encourages trainee learning through a range of teaching and learning methods including, but not limited to: self-directed learning; peer-to-peer learning; role modelling; and working with interdisciplinary and interprofessional teams.
- The training and education process facilitates trainees' development of an increasing degree of independent responsibility as skills, knowledge and experience grow.

Clinical experience is fundamental to the SET program. Clinical rotations provide trainees with the breadth of experiences in specialty-specific contexts. Specialty Training Boards allocate trainees to rotations in surgical units that have been accredited as training posts. Allocation is

based on each trainee's stage of training, their learning needs and, where possible, on their preferences regarding case mix and geographic location. Supervisors and trainers are responsible for ensuring that each trainee receives the training and clinical experience that enable them to develop the necessary knowledge and skills to fulfil training requirements across the competencies. Specialty Training Boards monitor each trainee's logbook to ensure they are accessing a sufficient caseload and an appropriate case-mix. Complementing hospital-based learning is a variety of teaching and learning methods as mentioned under standard 4.1.

During each rotation, clinical experiences include:

- participation in ward rounds, handovers, multidisciplinary team meetings and outpatient clinics. The exception is NSW, which does not have traditional outpatient clinics
- participation in operating sessions where trainees develop technical skills and other competencies, such as teamwork and communication
- on-call duties to assess and manage patients with acute surgical problems
- participation in clinical audit and morbidity and mortality meeting review processes.

Supervisors assess trainees' performance against standards expected for each stage of training; as trainees' knowledge, skills and experience grow they are expected to manage increasingly complex clinical situations. At later stages of training, trainees are expected to take a greater proportion of cases as primary operator with less direct input from consultant supervisors, and to perform more complex procedures, usually with the supervising surgeon as assistant, providing supervision as required.

For example, the Board in General Surgery requires all trainees to complete 100 upper gastrointestinal endoscopies and 50 colonoscopies before applying to sit the Fellowship Examination. The Australian and New Zealand Conjoint Committees for the Recognition of Training in Gastrointestinal Endoscopy (CCRTGE) set the minimum training standards required prior to granting recognition of training in Upper Gastrointestinal Endoscopy, Colonoscopy and Endoscopic Retrograde Cholangio-Pancreatography (ERCP).

4.2.1 Team findings

For each surgical specialty, training is largely based in clinical practice, with responsibility for patient care graded by stage of training. Despite increasing clinical demands on trainees and supervisors, the College has managed to maintain apprenticeship-style learning which is closely overseen by trainers, supervisors and Specialty Training Boards. Each training post is accredited for patient case-mix, supervision, staffing levels, and working requirements for trainees and resources. Trainees must work within teams and with other health professional groups.

While clinically-based learning is largely opportunistic, the College provides several core courses and activities as outlined under standard 4.1.

Role modelling is an important teaching method. Trainees and members of some jurisdictions reported to the team that, while the Building Respect, Improving Patient Safety (BRIPS) program is leading to improvements, good role modelling is by no means universal. Furthermore, the relative lack of diversity in the senior surgical workforce as described under standard 1 means that trainees may not work with a diverse range of role models.

The team heard several concerns regarding the opportunities for trainees to obtain sufficient experience, not only to achieve basic competence, but to appreciate the natural history of a diverse range of cases. Some reasons for this were:

- reduced working hours for trainees (refer to standard 2.3)
- lack of outpatient services (NSW)

- lack of opportunity for endoscopy training in the general surgery program and aesthetic surgery in the plastic and reconstructive surgery program.

The College and Specialty Training Boards are using a range of methods to offset these deficiencies, predominantly through simulations and skills courses. Yet, the competence gained needs to match with performance in practice. The team recommends that the College find ways to enable general surgery trainees in New Zealand to meet their endoscopy requirements, for plastic and reconstructive surgery trainees to meet their aesthetic surgery requirement, and for all trainees in NSW to see patients at follow-up after surgery to learn about surgical outcomes.

Commendations

- I All specialty training programs are based firmly in relevant clinical practice with trainees experiencing a wide range of acute and elective cases.
- J The growing array of courses and resources with an increasing number of these available online, as well as the development of an appropriate suite of basic courses, such as Early Management of Severe Trauma (EMST), Care of the Critically Ill Surgical Patient (CCrISP), and Critical Literature Evaluation and Research (CLEAR).
- K The College's support for the increasing use of simulation in surgical training.

Conditions to satisfy accreditation standards

- 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)

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. (Standard 4.2.1)

5 Assessment of learning

5.1 Assessment approach

The accreditation standards are as follows:

- The education provider has a program of assessment aligned to the outcomes and curriculum of the specialist medical program which enables progressive judgements to be made about trainees' preparedness for specialist practice.
- The education provider clearly documents its assessment and completion requirements. All documents explaining these requirements are accessible to all staff, supervisors and trainees.
- The education provider has policies relating to special consideration in assessment.

The Surgical Education and Training (SET) program has a program of formative and summative assessments that includes workplace-based assessments, examination of technical and scientific knowledge from an early to mid-stage of training, and a final certification (fellowship) examination.

As discussed under the previous standards, the *Becoming a Competent and Proficient Surgeon* document outlines the expectations of trainees across the nine RACS competencies from prevocational through to novice, to intermediate, then to competent and to proficient.

Workplace-based assessments are the responsibility of each **Specialty Training Board**. The College has two key committees with oversight responsibility for the examinations. The **Surgical Science and Clinical Examinations Committee** is responsible for the General Surgical Science Examination (GSSE), the Clinical Examination (CE) and the written component of four Specialty-specific Surgical Science Examinations (SSSEs). The **Court of Examiners** has oversight of all Fellowship Examinations and viva components of four SSSEs.

A range of assessment-related policies and committees' terms of reference documents are publicly available on the College's website.

In accordance with the Assessment of Clinical Training policy, each surgical specialty uses assessments to guide learning and assess trainee performance to ensure it meets the designated standards at each stage of training. The regulations of each Specialty Training Board and the Guide to SET outline the number, type and frequency of assessments.

Over the past four years, the College has completed several reviews of its assessment program. In particular, in May 2016, RACS commissioned Cassandra Wannan to undertake a comprehensive review of all College assessments. This resulted in an extensive report, producing a total of 16 recommendations. These recommendations included seven recommendations relating to examination processes and nine recommendations regarding workplace-based assessments.

The College has a policy for special consideration in relation to the sitting of an examination. Trainees may apply for special consideration in cases where illness, bereavement or other serious matters beyond their control, have the potential to affect their examination results. The College's policy on reasonable adjustments for disability outlines the criteria and processes for accommodating the needs of a candidate where a disability may affect their ability to participate in the examination. The College also has a policy for the consideration of religious observance.

The committee chair or senior examiner of the relevant specialty Court of Examiners will review and determine adjustment to assessment protocols. Applications for special consideration are assessed by the relevant committee or specialty Court of Examiners. Applications for religious observance are considered by the College Board, committee or other body that administers the assessment activity.

5.1.1 Team findings

The team commends the College on its comprehensive suite of assessments administered by dedicated fellows supported by both the Specialty Training Boards and the College's Education Staff. Information regarding the College's assessments is comprehensive and readily accessible.

As discussed under standard 3, the training document *Becoming a Competent and Proficient Surgeon* clearly outlines the increasing expectations of trainees as they progress through training.

5.2 Assessment methods

The accreditation standards are as follows:

- The assessment program contains a range of methods that are fit for purpose and include assessment of trainee performance in the workplace.
- The education provider has a blueprint to guide assessment through each stage of the specialist medical program.
- The education provider uses valid methods of standard setting for determining passing scores.

Surgical trainees are assessed throughout the training program by a combination of examinations and workplace-based assessments.

Examinations

Examinations comprise both written and practical 'clinical' formats, and the topics examined are either generic to all surgical trainees or specialty-specific. All nine specialties have a suite of examinations with much commonality but also some significant differences as listed in the table below.

Generic Surgical Science Examination (GSSE)	Compulsory for all prevocational applicants for surgical training.
Clinical Examination (CE)	Compulsory for all surgical specialties except Orthopaedic Surgery (Australia) and Neurosurgery.
Specialty Specific Surgical Science Examination (SSE)	Neurosurgery SSE replaced with a neuroanatomy examination which must be passed prior to entry to surgical training. General Surgery SSE replaced by a summative on-line module assessment. The other seven specialties undertake an SSE.
Fellowship Examination	Similar format undertaken by all nine specialties.

Generic Surgical Science Examination

The Generic Surgical Science Examination (GSSE) assesses the candidate's knowledge, understanding and application of anatomy, physiology and pathology in health and disease. Trainees previously completed the examination within the first two years of training. From 2014, this examination was made available to prevocational doctors – a major change since the inception of the SET program in 2007. From 2016, the GSSE is compulsory for all prevocational applicants for surgical training and must be passed prior to being eligible for selection into the program. The examination pass rate is variable: 85% in 2011; 60% in 2015. The examination results are not used quantitatively in selection.

Clinical Examination

The Clinical Examination (CE) is a practical examination, testing candidates' clinical application of the basic sciences early in surgical training. The examination is an objective structured clinical examination comprising 16 five-minute stations. Candidates are assessed as they undertake four questions or activities for each of the four station types: physical examination; communication; history taking; and procedure. The examination must be passed within the first two years of training. Trainees are permitted a maximum of four attempts. The examination pass rate is high but there is conflicting evidence regarding correlation with the outcomes of other assessments.

Specialty Specific Surgical Science Examination

Seven of the specialties currently have a specialty-specific examination to assess trainees' knowledge of surgical sciences and principles specific to their specialty. The Specialty Specific Surgical Science Examination (SSE) must be completed in accordance with the specialty requirements:

- Orthopaedic Surgery - Orthopaedic Principles and Basic Science Examination (OPBS)
- Plastic and Reconstructive Surgery - Plastic and Reconstructive Surgical Sciences and Principles Examination (PRSSP)
- Paediatric Surgery – Paediatric Anatomy & Embryology (PAE) Examination and the Paediatric Pathophysiology (PPP) Examination
- Otolaryngology Head and Neck Surgery, Urology and Vascular Surgery – Surgical Science Specialty Specific (SSE) Examination.

Neurosurgery and General Surgery have a variation as noted in the above table.

Fellowship Examination

The Fellowship Examination assesses the candidate's knowledge, clinical skills, judgment and decision making and professional competencies, in order to ensure that they are safe and competent to practise as surgeons. For all specialties except Vascular Surgery, the Fellowship Examination comprises two written components and five clinical/viva components. Vascular Surgery has one written and six clinical components.

The Fellowship Examination is very much the flagship of RACS' assessment program. The information session for new examiners is conducted in a very professional manner by dedicated leaders from the Court of Examiners. New examiners must observe before examining and examiner performance is assessed. This is also discussed under standard 8.1.

Material is selected for inclusion in the examination at an annual workshop, in February, and involves blueprinting against the curriculum.

The Fellowship Examination is comprehensive with seven separate examinations which might include written assessments, imaging, pathology and structured oral examinations. The "expanded closed marking system (ECMS)" appears fit for purpose and provides the Court of Examiners with the necessary information to make a determination on borderline candidates. For each examination, candidates are scored between 1 and 4 where 4 is excellent, 3 is a pass, 2 borderline and 1 a clear fail. The passing score for the Fellowship Examination is 21 – that is an average of 3 across all seven examinations. The team observed that it was very difficult to score 4 and in fact was mostly discouraged by the leading examiners. For each of the seven examinations there are two examiners scoring independently with a consensus mark reached at the end. For some sections of the examination there will be an observer (usually a first-time examiner) scoring as well. Those scoring 19 or 20 are further discussed by the full Court of Examiners but generally the advice of the chair of the relevant specialty Court is followed.

The Fellowship Examination exhibits good reliability. The pass rate is approximately 70-80% across all specialties. The eventual pass rate (within 5 years) is 97%.

Standard Setting

The College's procedures for standard setting for the CE and the GSSE and specialty SSE, as well as reports and presentations are available on the RACS website. The College collaborates with the Australian Centre for Educational Research (ACER) in the development of standard setting. The standard setting methods for each of the GSSE, CE and Fellowship Examination appear to be appropriate with a sound evidence base. The specialty-specific SSE is variable with three disciplines using the much respected modified Angoff method but some others using a fixed cut-off mark based on historical precedent – which would not allow for examinations that vary in difficulty. A detailed explanation of the standard setting for the Orthopaedic Principles and Basic Science Examination is provided on the RACS website in a document authored by the Orthopaedic Surgery Senior Examiners in both Australia and New Zealand. The methods of standard setting are detailed in the table below as provided in the College's accreditation submission.

Generic Surgical Science Examination	Rasch model scaling
Clinical Examination	Borderline regression
Specialty Specific Surgical Science Examination (Urology, Otolaryngology Head and Neck Surgery, Vascular Surgery)	Modified Angoff
Cardiothoracic Surgical Sciences and Principles Examination	Predetermined 75 per cent cut score
SEAM module multiple-choice questions	Predetermined 80 per cent cut score
Neurosurgery Neuroanatomy Examination	Predetermined 70 per cent cut score
Orthopaedic Principles and Basic Science Examination	Predetermined 70 per cent cut score
Paediatric Anatomy & Embryology Examination	Specialty experts. The anatomy component is assessed by two examiners, similar to the Fellowship Exam.
Paediatric Pathophysiology Examination	Predetermined 65 per cent cut score
Plastic and Reconstructive Surgical Science and Principles Examination	Predetermined 75 per cent cut score
Fellowship Examination	Expanded close marking system; consensus scoring. Specialty experts and predetermined pass mark outlined in marking policy clause 3.16 of Conduct of the Fellowship Examination policy.

Workplace-based Assessments

Work-based assessments (WBAs) include mid-term and end-of-term assessments, Direct Observation of Procedural Skills (DOPS) reports, Mini-Clinical Examinations (Mini-CEX) reports and logbooks. These are largely at the discretion of each of the Specialty Training Boards (the requirements for Orthopaedic Surgery in Australia and New Zealand differ). The table below is adapted from the College's accreditation submission and demonstrates some variation in the extent to which WBAs have been adopted across the surgical specialties.

Assessment type	Surgical Specialty
In-training Assessments (ITA) (mid-term and end-of-term assessments)	All surgical specialties
Direct Observation of Procedural Skills (DOPS)	Cardiothoracic Surgery, General Surgery, Orthopaedic Surgery New Zealand, Otolaryngology Head and Neck Surgery, Paediatric Surgery, Plastic and Reconstructive Surgery, Urology, Vascular Surgery
Mini-Clinical Evaluation Exercise (Mini-CEX)	General Surgery, Orthopaedic Surgery, Otolaryngology Head and Neck Surgery, Paediatric Surgery, Plastic and Reconstructive Surgery, Urology, Vascular Surgery
Multi-Source feedback (MSF)	Paediatric Surgery (On request: Orthopaedic Surgery, Otolaryngology Head and Neck Surgery, Plastic and Reconstructive Surgery, Vascular Surgery, Urology)
Entrustable Professional Activities (EPAs)	General Surgery (piloting in 2017)

In-training Assessments (ITAs)

During training, trainees will complete In-training Assessments (ITAs), also known as mid-term assessments and end-of-term assessments. ITAs are used both formatively and summatively by all specialties. Mid-term ITAs provide opportunities to guide learning activities and for early identification and support of trainees in difficulty. End-of-term assessments provide opportunities to review a trainee's performance over an entire rotation and to identify goals for subsequent rotations. End-of-term assessments also have summative functions, as failure to meet identified standards can result in trainees being placed on structured remediation programs, such as a performance management plan or on probation. Ongoing poor performance may lead to dismissal from the training program.

The Surgical Supervisor and the Specialty Training Board are responsible for the in-training evaluation of trainees. There is some variation between specialties in the forms used for the in-training assessment.

Surgical DOPS and Mini-CEX

Surgical Direct Observation of Procedural Skills (DOPS) is a method of assessing the trainee's competence in performing diagnostic and interventional procedures during surgical practice. The assessment involves an assessor observing the trainee perform an operative procedure within the workplace.

The Mini-Clinical Evaluation Exercise (Mini-CEX) assesses competencies essential to the provision of good clinical care. The assessment involves an assessor observing the trainee interact with a patient in an unrehearsed clinical encounter in the workplace.

There is considerable variation in the use of these forms. Forms used vary between the specialties. Orthopaedic Surgery (Australia) uses forms with AOA branding.

Multi-source feedback (MSF)

Multi-Source Feedback (MSF) is a questionnaire-based assessment that includes self-evaluation and feedback on observable behaviours from colleagues (peers and referring physicians), co-workers (nurses, pharmacists, psychologists etc.) and patients. The MSF is a mandatory assessment component only for Paediatric Surgery but is an option for four other specialties in the event of under-performance as detailed in the above table.

Logbooks

All trainees are required to complete logbooks. Logbooks are used to record each procedure undertaken by the trainee and their level of involvement in the procedure (for example, primary operator, assistant, etc.). The Surgical Supervisor and Specialty Training Board review logbooks at regular intervals. The College has developed an online Morbidity and Audit Logbook Tool (MALT) which will be available to fellows, trainees, and international medical graduates, and for prevocational doctors as a component of JDocs registration.

Entrustable Professional Activities (EPA)

Entrustable Professional Activities (EPAs) are a relatively new innovation for the College. Recent developments include the key clinical tasks introduced in the JDocs Framework and the procedural skills and professional capabilities assessments used in selection to General Surgery training. General Surgery is piloting some EPAs in 2017.

5.2.1 Team findings

The team commends the College on the careful moderation and blueprinting of the Fellowship Examination which serves to integrate standards across specialties and satisfy external stakeholders of the adequacy of surgical training. As discussed under standard 3, the Fellowship Examination could be enhanced as a horizontal integrating mechanism by inclusion of another column in the examination blueprint for non-technical aspects.

The team commends the College on the commissioning of the 2016 'Review of Assessments' by Cassandra Wannan. However, the team was unable to find an overall College-wide approach to the findings of the review report. In meetings with the chairs of the Specialty Training Board, there did not appear to be an awareness of the recommendations or even the existence of the report. A College response (negative or positive) to each of the report's recommendations is required.

The team supports the move of the GSSE from early in the SET program to being a prerequisite for entry into the SET program from 2017. This allows trainees to begin training with the necessary scientific background and concentrate on their specialty rather than being distracted by generalities in their early training years. However, only approximately 25% of applicants are successful in gaining entry to the program. Although some of the 75% of unsuccessful applicants may achieve entry subsequently, for most of these doctors, the GSSE is unlikely to significantly assist them in their ultimate career path. The College should look at strategies to reduce the time and financial burden for those candidates who are not selected for entry into surgical training. For example, the College may explore implementation of an 'early short-listing' so that only those with a reasonable probability of entry into training based on their CV and references are subject to the GSSE.

The CE did not receive widespread support from the trainees that were interviewed by the team. Many felt this was a 'leftover' from the previous training program structure where all specialties began their training in General Surgery. If it is to be retained, many trainees thought it should be more specific for their specialty.

Although considerable effort has been expended by the College and the Specialty Training Boards in undertaking standard setting of the GSSE, Clinical and Fellowship Examinations, the report of

the 2016 Review of Assessments is notably critical of the standard setting process of those SSEs that continue to use 'cut-off' scores. Specific criticism of the Orthopaedic Principles and Basic Science Examination standard setting is noted in the review report. The rigor of standard setting applied to other College examinations (and several of the SSEs) needs to be applied to all SSEs.

The College has begun the electronic delivery of examinations rather than paper-based. As experienced by other specialist medical colleges in the same transition, this demands the highest level of reliability of the IT platform given the high-stakes nature of the examinations and the unsolvable difficulties in the event of a technological failure. The AMC will be interested in updates from the College on progress in this area.

The team also recommends that behaviour-related reporting (i.e. descriptive of the key features) rather than simple scoring should be adopted by all specialties in their various DOPS and Mini-CEX as recommended in the 2016 Review of Assessments Report.

The team commends the College's progress with the implementation of EPAs and the plans to pilot with General Surgery. This is likely to fill a need at the level of service delivery as well as complementing work-based assessments. The team recommends that the College undertakes early evaluation of EPAs to allow any implementation difficulties to be rectified in a timely manner.

5.3 Performance feedback

The accreditation standards are as follows:

- The education provider facilitates regular and timely feedback to trainees on performance to guide learning.
- The education provider informs its supervisors of the assessment performance of the trainees for whom they are responsible.
- The education provider has processes for early identification of trainees who are not meeting the outcomes of the specialist medical program and implements appropriate measures in response.
- The education provider has procedures to inform employers and, where appropriate, the regulators, where patient safety concerns arise in assessment.

Feedback

In addition to the feedback supervisors and trainers give to trainees in clinical settings, feedback on examination performance is provided within the timeframes stipulated in the conduct of the examination policies.

The College has policies regarding feedback to unsuccessful candidates with opportunities for remediation. For the examinations taken early in training and the specialty-specific examinations, written feedback is provided to all unsuccessful candidates by the RACS Examinations Department. This is used as a basis for discussion with their supervisor.

Unsuccessful performance in the Fellowship Examination is defined separately and a suitable process specified. The senior examiner's feedback report is provided to the candidate following an unsuccessful attempt. This feedback is used as a basis for discussion between trainees and their supervisors to assist with the review and planning of training and/or examination preparation for a subsequent attempt.

If a candidate has been identified as a poor performer, defined by a total score of 14 or less (that is, more than six below the pass standard of 21), he or she will be interviewed by the relevant Specialty Training Board to address concerns and implement a remedial plan.

Patient safety

There is also a documented process for managing concerns regarding patient safety that become apparent in the course of an assessment. If the candidate is considered a risk to patient safety (not related to a defined score), the Specialty Training Board will be notified within two days. The Board will then consult with the candidate's supervisor, and may seek information from the hospital. If the Board agrees there are concerns for patient safety, it will recommend to the chair of the Board of Surgical Education and Training that the candidate be reported to the Australian Health Practitioner Regulation Agency (APHRA) or the Medical Council of New Zealand.

Trainee in difficulty and early identification of the under-performing trainee

The Specialty Training Boards have policies and processes to identify and support trainees who experience difficulties during their training. In-training assessments provide an opportunity to identify trainees whose performance is not satisfactory for their level of training. Such trainees may be placed on a performance management plan (description varies between specialties), or they may be placed on probation (typically for six months). During this time, trainee performance is reviewed regularly, with constructive feedback and support provided by surgical supervisors.

The College has developed the Keeping Trainees on Track (KTOT) course to assist supervisors and trainers with the early detection of trainees in difficulty. The course is available face-to-face or as an eLearning module. An online resource, Trainees in Difficulty, provides further useful information for supervisors.

Probation

Each Specialty Training Board has provision for periods of probation to assist trainees who are under-performing. During the probationary period, surgical supervisors regularly review trainees' performance and trainees are provided with feedback and support. Supervisors complete the required probationary forms, which trainees submit to their Specialty Training Board.

Dismissal from surgical training

The Dismissal from Surgical Training policy outlines the process, criteria and responsibilities for dismissal from the training program. Among the reasons for dismissal are: exceeding the maximum number of attempts at examinations (usually four); not completing examinations within the specified time-frame; or three unsatisfactory In-training Assessments (ITAs).

5.3.1 Team findings

The trainees who were interviewed by the team indicated that performance feedback to trainees appears is generally constructive and useful.

The KTOT program, which assists supervisors and trainers in the early detection of trainees in difficulty, is commendable, as are policies around remediation and probation of under-performing trainees.

The absence of routine MSF as a component of the ITAs was of concern to the team. Only Paediatric Surgery currently accomplishes this for all trainees. While some Specialty Training Board chairs were concerned regarding the organisational load that routine MSF would entail, there appears to be general agreement that this would be a valuable formative and summative assessment for trainees. This is particularly of relevance to the College given the Building Respect, Improving Patient Safety (BRIPS) action plan. In the opinion of the team, feedback from colleagues, co-workers and patients would appear to be of critical relevance to BRIPS for the trainee. The increased workload for supervisors of training is an issue but structures could be put in place to manage this. For example, were the College to stipulate a maximum number of trainees per supervisor of training (therefore multiple supervisors at large sites), as is the case at some

colleges, each supervisor would therefore not have an excessive workload were MSFs to be introduced. The team recommends that the Specialty Training Boards continue to explore the use of MSF for all trainees at set points throughout training.

5.4 Assessment quality

The accreditation standards are as follows:

- The education provider regularly reviews the quality, consistency and fairness of assessment methods, their educational impact and their feasibility. The provider introduces new methods where required.
- The education provider maintains comparability in the scope and application of the assessment practices and standards across its training sites.

Training of assessors and examiners

The College has developed several resources for supervisors and trainers to ensure consistency in work-based and clinical assessments. These include the Supervisors and Trainers for SET (SATSET), Keeping Trainees on Track and the mandatory Foundation Skills for Surgical Educators courses which cover methods, tools and skills to facilitate supervision, training and assessment in the training program. This is discussed in further detail under standard 8.1.

The College goes to significant lengths to prepare examiners for the examinations with the objective of maintaining assessment standards and consistency. Mandatory training for new examiners for the Fellowship Examination is directed at the concepts of standards, standard setting, reliability and validity, as well as specific processes within the examination.

Monitoring examination pass rates

The RACS Activities Report provides comprehensive detail of examination pass rates including breakdowns by year, discipline, gender, region, number of attempts and trainee versus specialist international medical graduate. The RACS Examination Department monitors functions and reports to the Board of Surgical Education and Training. Explanation is sought for unexpected variation.

Monitoring examiner performance

Examiner performance is closely scrutinised with the use of 'heat maps' in the Fellowship Examination in an attempt to identify anomalies in scoring. Scoring by observers (examiners from different specialties) also assists in assessment of inter-rater reliability. Observers provide structured feedback on the validity of examination content, alignment to the syllabus, examiner performance and the taxonomy level employed.

Monitoring question performance

Questions in the GSSE are assessed (with the assistance of the Australian Council for Educational Research) with respect to reliability. The specialty Courts of Examiners meet annually to 'blueprint' forthcoming Fellowship Examinations by determining the allocation of examination content with regard to the specialty training curriculum, the RACS competencies and the taxonomy. This process is based on the consensus of experts, knowledge of clinical settings and work-based requirements and is supported by the collective knowledge, experience, expertise and qualifications (including educational qualifications) of the fellowship.

Quality control between assessments

The 2016 Review of Assessment Report provides cross correlations between the various assessments. Reliability was generally high with the possible exception of the Clinical Examination.

5.4.1 Team findings

As discussed under standard 5.1, the commissioning of the 2016 Review of Assessments by Cassandra Wannan was commendable. Much of the report is very positive, particularly in reference to the Fellowship Examination. The report also identifies many areas identified for possible improvement. There is considerable valuable information in the body of the report and a total of 16 recommendations (seven pertaining to examinations and nine to work-based assessments). While the College must decide whether it would be appropriate to adopt all recommendations, each merits either a plan for implementation (if not implemented already), an alternative strategy to address the issue, or a rationale for rejection.

The team notes that the review report considers that essay-type examinations are widely-regarded as poorly performing in terms of reliability. Where essay-type questions are still being used, it is the view of the team that the College should consider whether they could be replaced with short-answer type questions (rather than MCQs as suggested in the report).

Commendations

- L The overall conduct of the Fellowship Examination including its careful moderation and blueprinting which serves to integrate standards across surgical specialties and satisfy external stakeholders of the adequacy of surgical training.
- M The commissioning of the 2016 Review of Assessments by Cassandra Wannan.
- N The Keeping Trainees on Track program which assists supervisors and trainers in the early detection of trainees in difficulty.

Conditions to satisfy accreditation standards

- 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. (Standard 5.2 and 5.4)
- 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)

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)

6 Monitoring and evaluation

6.1 Monitoring

The accreditation standards are as follows:

- The education provider regularly reviews its training and education programs. Its review processes address curriculum content, teaching and learning, supervision, assessment and trainee progress.
- Supervisors contribute to monitoring and to program development. The education provider systematically seeks, analyses and uses supervisor feedback in the monitoring process.
- Trainees contribute to monitoring and to program development. The education provider systematically seeks, analyses and uses their confidential feedback on the quality of supervision, training and clinical experience in the monitoring process. Trainee feedback is specifically sought on proposed changes to the specialist medical program to ensure that existing trainees are not unfairly disadvantaged by such changes.

Both the College and the Specialty Training Boards use a variety of methods for monitoring the surgical training programs. The College collects and publishes a significant amount of data about its activities, including the Annual Activities Report which is a comprehensive and valuable summary. There is regular monitoring of all of the key aspects of the training programs, including course delivery, examinations, professionalism, attrition and fellow and trainee satisfaction.

The College has several formal means of monitoring its programs and the satisfaction of key stakeholders with regard to surgical education and training. These include:

- six-monthly end of rotation Royal Australasian College of Surgeons Trainees' Association (RACSTA) survey, which is now being compiled as five-yearly data to protect trainee anonymity and encourage a higher response rate and more robust feedback
- six-monthly Specialist Training Program (STP)-funded training posts end-of-rotation survey
- two-yearly Fellows' survey
- curriculum review through the Specialty Training Boards.

Supervisors contribute to monitoring and program development through the Specialty Training Boards. In some of the larger specialties this input occurs through regional subcommittees. Curriculum review is an ongoing activity for the College which is discussed in further detail under standard 3.

There is also regular consideration and review of aspects of the selection process and selection tools. Additionally, all courses delivered by the College are evaluated, with evaluation reports reviewed for potential improvements. The Specialty Training Boards regularly monitor the progress of trainees and the quality of trainee supervision through a variety of mechanisms.

In 2015, the College showed courage and leadership by forming the independent Expert Advisory Group (EAG) to undertake the substantial review of concerns relating to discrimination, bullying and sexual harassment. This involved a substantial commitment of resources and openness to a very public critique of the College's inner workings and culture. The College supported the EAG by providing a background paper, briefing paper, surveys of hundreds of fellows, trainees, specialist international medical graduates and over 300 hospitals, as well as facilitation of online discussions. This was clearly a mammoth effort by the College. As previously discussed, the work of the EAG resulted in the Building Respect, Improving Patient Safety (BRIPS) Action Plan.

6.1.1 Team findings

The College has a commendable approach to monitoring, with significant systems in place for both the collection of data and monitoring of programs from internal stakeholders. The team

found a strong commitment to not only the collection of data but its use in the ongoing assessment of many aspects of the SET program. The Annual Activities Report published by the College highlights the breadth and depth of monitoring that occurs and covers its work in education and assessment, as well as providing details on the surgical workforce. The team commends the College for the ongoing publication of this report which is a useful way of providing feedback to a range of internal and external stakeholders.

Given the amount of data tracked across the College programs, the team considers this could be better used to inform and support any major changes to the SET program. An overall plan with a commitment to cycle through all aspects of the program and review and renew it in that timeframe would assist in managing such a large and complex system. The team considers the College would benefit from, and should develop, an overarching framework for monitoring and evaluation.

The team found considerable optimism, particularly amongst fellows, about the early impact of BRIPS on surgical culture, as well as the potential for improving the community view of surgeons and the College following on from the negative publicity in 2015. The team also found enthusiasm and support amongst trainees for BRIPS, though they reported a more mixed view about whether the entrenched culture of bullying and sexism was changing as quickly as the College believes. Trainees expressed the view that bad behaviour is recognised by many within the profession, but that trainees feel the onus is still on them to speak up and call it out. Many trainees still view taking this step highly risky to their career prospects. The team found a large gap between what senior surgeons (and College staff) believe about the risks to a trainee's career from speaking up and trainees' assessment of that risk.

Across the board, there is a view that BRIPS has put the key issues on the table, enabling discussion of good and bad behaviour and raising expectations. However, the team found a strong view that the College must assiduously continue to implement the action plan if it hopes to achieve the necessary and ongoing culture change.

The College currently relies on the Specialty Training Boards to capture the views of supervisors, through representatives who are board members. While this is useful, the development of a more direct, first-hand means of collecting input would be beneficial for both the College and supervisors. The team considers the College needs to establish methods to seek confidential feedback from supervisors of training, taking better advantage of their in-depth knowledge to better contribute to the monitoring and development of the training program.

In terms of trainee feedback, the College is conscious of the importance of hearing from trainees, but is also aware of the challenge of doing this effectively. The RACSTA survey now has a higher response rate than in past years, though it is still below 50%. STP-funded training posts have less than a 20% response rate on end-of-rotation surveys. Additionally, many trainees the team spoke with admitted that they do not give full and frank responses out of fear that their demographic data (particularly for those in smaller specialty training programs) would identify them. The team heard repeatedly that it is too risky to give honest feedback about the quality of supervision after a particular rotation. Trainees provided the team with specific examples of when trainees had been identified based on their feedback. There is also a lack of confidence that the feedback given via methods such as the centralised complaints hotline run through RACSTA will be used to initiate change. The team recommends that the College, 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.

Though challenging, the College will need to work closely with trainees and RACSTA to identify and understand the barriers to giving robust feedback and to develop approaches to improving this key issue. The team considers the College must make a clear and public commitment to developing and implementing completely confidential and safe processes for obtaining—and acting on—regular, systematic feedback from trainees on the quality of supervision, training and clinical experience.

6.2 Evaluation

The accreditation standards are as follows:

- The education provider develops standards against which its program and graduate outcomes are evaluated. These program and graduate outcomes incorporate the needs of both graduates and stakeholders and reflect community needs, and medical and health practice.
- The education provider collects, maintains and analyses both qualitative and quantitative data on its program and graduate outcomes.
- Stakeholders contribute to evaluation of program and graduate outcomes.

The nine RACS competencies describe the key characteristics of practice required for surgeons. Together with the recently revised RACS Code of Conduct, which defines the professional standards for all fellows, these form the standards against which the College's program and graduate outcomes are evaluated.

There is a variety of tools which enable trainees to understand and assess themselves against the expected standards, including The Surgical Competence and Performance Guide, Becoming a Competent and Proficient Surgeon and the JDocs Framework which identifies performance standards for prevocational doctors.

The College undertakes a wide variety of evaluation activities of its training and education programs. The range of evaluation reports and reviews undertaken in the past five years, include:

- Annual Scientific Congress evaluation report (2016)
- Fellowship Examination written hurdle requirements (2015)
- Leaving surgical training (2016)
- Predictive utility of selection tools (2016)
- Review of Assessments (2016)
- Selection diversity: gender bias in SET applicant outcomes (2016)
- SET evaluation – quantitative (2013)
- SET evaluation – mixed methods (2013).

The 2016 Leaving Surgical Training study was initiated due to what was felt to be an unacceptably high rate of trainees failing to complete the SET program; women were disproportionately represented in this group. The themes emerging from this study include inflexible training, discrimination, bullying and sexual harassment, as well as the complexity of work or the sense of it being the 'wrong' career choice. The issue of the inflexibility of training related not only to timing (inability to train less than full-time) but importantly it reflected the need for trainees to move, often interstate, for training and sometimes several times during the program.

The College was frank in its accreditation submission to the AMC in acknowledging the very limited exposure it has to hearing the views and perspectives of external stakeholders. The College noted the lack of regular, formal stakeholder evaluation from external groups, such as patients or hospital and surgical directors. This gap has made it particularly challenging for the College to adequately understand or integrate the views of the broader medical and non-medical communities.

6.2.1 Team findings

The College should be commended for its resources which aim to define the professional standards and competence of surgeons and trainees. Working across nine surgical specialties with their associated Specialty Training Boards makes it potentially a significant challenge to

clarify and codify the program and graduate outcomes for all surgeons. When speaking with trainees and supervisors, most indicated that upon completion of the training—plus a fellowship year—the surgical training program produces surgeons who are able to practise independently. However, as discussed under standard 2, because there are not clear program and graduate outcomes for each specialty it is difficult for the College to accurately measure program or graduate outcomes. This is a key task for the College to set its mind to in the near future.

As discussed under standard 3, the College plans to undertake a survey of new fellows to evaluate their preparedness for practice. The team commends this initiative and recommends that the College consider what supports might be put in place to aid their transition to independent practice.

The evaluation activities undertaken in recent years have been largely independent studies and surveys, looking at discrete areas of the curriculum or the program. While each piece contributes to a broader understanding of the strengths and weaknesses of the College's activities, there is currently no overarching framework or approach to evaluation. The team commends the intent but considers there is a need for a more systematic and coordinated approach which will produce more useful information.

The team commends the College for its plans to introduce an annual survey in 2017 of those trainees who leave surgery without completing the program. Based on the results of the initial survey, the team believes there will be potentially very valuable insights gained from this. Developing concrete actions in response to the survey data and themes will be important for change and for building confidence amongst trainees that the College listens to and responds proactively to criticism.

The initial survey was commissioned by RACS in 2015 to better understand why some trainees left the program, as part of the work of the RACS EAG into bullying, discrimination and sexual harassment. The study was conducted by independent researchers in the same year the EAG was established. It surveyed and interviewed trainees who had withdrawn from surgical training between 2008 and 2015. The research found inflexibility in the specialty training programs, surgery being the wrong career choice (including for lifestyle reasons), and poor supervision were also significant factors in trainees' decision to leave, as well as concerns about the culture of surgical training. Lack of academic success was ruled out as a factor, with about 80% of research participants continuing to work or train in medicine, almost all in other medical specialties.

The College is currently disadvantaged in its ability to ensure that program and graduate outcomes reflect broader community needs and priorities by its largely inward focus. Stakeholder representation is still almost exclusively internally based, that is, surgeons or trainees with only very limited external input. There is minimal crossover or attempts to elicit feedback from non-surgical medical or nursing professionals, hospitals, state health departments, health administrators, or health consumer groups. Also, there is little to no input from the community to help build the picture of what today's surgeon should look like from a broader, non-surgical perspective.

The team commends the College on its placement of a small number of external representatives on some of its major committees and applauds its commitment to requiring an external member on all boards from 2017. This needs to be seen as only one element of inviting the consumer and community perspective into the work of the College.

The team considers that the College would benefit from several changes. The first would be to increase the external representation on boards and committees, viewing this as a valuable opportunity to benefit from ongoing interdisciplinary and cross-sector perspectives and input into College decisions as detailed under Standard 2.1. This representation would ideally include both non-surgical health experts as well as those with a strong track record of representing the

consumer or community perspective. The second change is to establish a routine and systematic approach to external stakeholder consultations.

The team commends the Board of Paediatric Surgery for its leadership in being the first Specialty Training Board to invite a community representative to become a member. Both the community representative and the Board spoke very highly of this initiative. Members of the College noted the difficulty of finding adequately skilled consumer and community members to take up places within its governance structure. However, the team considers that with an appropriately supported and resourced approach to the recruitment, selection and support of these members, this challenge could be addressed.

There has been little external community consultation, despite good opportunities, such as through the recent revision of the RACS Code of Conduct. This may have been achieved through consumer organisations such as the Heart Foundation, Cancer Australia, etc. The team received feedback about the College's lack of formal consultation processes, particularly when considering major changes to the SET program. Several different groups mentioned not only the lack of consultation but also the lack of warning to those affected. The team strongly encourages the College to consider opportunities for seeking broad community and external stakeholder input. The team is confident that a commitment to this kind of consultation and contribution by external stakeholders will enhance and increase the speed of cultural change that the College is hoping to see across the SET program.

6.3 Feedback, reporting and action

The accreditation standards are as follows:

- The education provider reports the results of monitoring and evaluation through its governance and administrative structures.
- The education provider makes evaluation results available to stakeholders with an interest in program and graduate outcomes, and considers their views in continuous renewal of its program(s).
- The education provider manages concerns about, or risks to, the quality of any aspect of its training and education programs effectively and in a timely manner.

The majority of the College's reporting of monitoring and evaluation activities, and changes and proposed actions, occur through its governance structures as described under standard 1. Monitoring and evaluation reports are usually submitted to the initiating board or committee and also may be submitted to committees responsible for the activities under review, where these differ from the initiation committee. The College's approach to disseminating evaluation information varies, depending on the activities being reported. Major research findings are often presented at national and international conferences or shared among other medical education groups. The EAG findings were published widely, including in the media, on social media and in journals.

The College records strategic and key operational risks to its training and education programs in the RACS Risk Register. The College addresses concerns about the quality of its training programs through its governance and administrative structures. Actions and resources are identified and prioritised while project management plans are put into place.

6.3.1 Team findings

The team commends the College on its worthy goal (#3) from the BRIPS Action Plan to 'increase transparency, independent scrutiny and external accountability' in College activities. To achieve this will require a commitment to cultural change and leadership in addressing issues of discrimination, bullying and sexual harassment. But it will also demand an organised approach to inviting consultation, feedback and collaboration to improve the surgical training program.

One important element of this is the development of a broad reporting structure which shares relevant information and increases the transparency of decision-making processes.

The College notes that its cyclical review and renewal of programs is informed by stakeholder representation on boards and committees (Standard 6.3.2). The team would see this as but one way to hear and report back to stakeholders. As previously noted, one of the limitations of this is that currently the College's governance structure is almost completely comprised of internal stakeholders and while they can provide a very in-depth and detailed knowledge, this is not the only input/output required.

The team did not find it clear as to how the data collected from the ongoing monitoring and evaluation is systematically fed back into the decision-making mechanisms of the College. This is particularly important when addressing concerns about, or risks to, the quality of any aspect of the College's training. While the team applauds the College's actions in undertaking the EAG review, the feedback from trainees and RACSTA suggests that the College was receiving reports of widespread bullying, discrimination and, to a lesser extent, sexual harassment for years before action was taken. If the College's commitment to cultural change is to be believed—by trainees and the wider community—there is an urgent need for it to show an unambiguous link between its monitoring, evaluation and action.

If the College intends to develop a broader, more consultative approach to monitoring and evaluation, it will be critical that it simultaneously builds a transparent and broad reporting structure to match. The team considers that the College must 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.

Commendations

- O The significant systems in place for the collection of data from internal stakeholders to monitor programs.
- P As a result of the findings from the 2016 Leaving Surgical Training study, the College's plans to introduce an annual survey in 2017 of those trainees who leave the training program prior to completion.

Conditions to satisfy accreditation standards

- 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)
- 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)
- 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)
- 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. (Standard 6.1.3 and 8.1.3)
- 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)

- 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)
- 23 Develop and implement an action plan in response to the 2016 Leaving Surgical Training study. (Standard 6.2)

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)

7 Trainees

7.1 Admission policy and selection

The accreditation standards are as follows:

- The education provider has clear, documented selection policies and principles that can be implemented and sustained in practice. The policies and principles support merit-based selection, can be consistently applied and prevent discrimination and bias.
- The processes for selection into the specialist medical program:
 - use the published criteria and weightings (if relevant) based on the education provider's selection principles
 - are evaluated with respect to validity, reliability and feasibility
 - are transparent, rigorous and fair
 - are capable of standing up to external scrutiny
 - include a process for formal review of decisions in relation to selection which is outlined to candidates prior to the selection process.
- The education provider supports increased recruitment and selection of Aboriginal and Torres Strait Islander and/or Māori trainees.
- The education provider publishes the mandatory requirements of the specialist medical program, such as periods of rural training, and/or for rotation through a range of training sites so that trainees are aware of these requirements prior to selection. The criteria and process for seeking exemption from such requirements are made clear.
- The education provider monitors the consistent application of selection policies across training sites and/or regions.

Trainees are selected into one of nine surgical specialties by 13 different selection processes. There are 13 processes given that General Surgery, Orthopaedic Surgery, Otolaryngology Head and Neck Surgery, and Plastic and Reconstructive Surgery have separate selection processes for each of Australia and New Zealand. The administration of selection may be through the College (five programs) or through the relevant specialty society and association (eight programs).

Although eligible for selection after the intern year, applicants are on average at PGY4 to PGY6 before they enter the SET program, therefore, the period of prevocational training now averages approximately 5.5 years: that is, the intern year and another 4.5 years before surgical training commences. Most of the 4.5 years is usually spent in 'non-accredited' service surgical resident then registrar positions. During the prevocational years, the JDocs Framework is available to the aspiring surgeon but as yet is not a pre-requisite for entry into surgical training. However, as of 2017, the Generic Surgical Science Examination (GSSE) has become a pre-requisite for selection to any of the nine specialties, in addition to completion of the Hand Hygiene and Let's Operate with Respect modules.

Each Specialty Training Board has responsibility for developing its own regulations for selection. These must be within the guiding principles set by the College and as outlined in the policy document, 2014 Selection to Surgical Education and Training, which gives consideration to the relevant AMC and MCNZ accreditation standards and the Brennan report. There is a strong emphasis on fairness and transparency.

Curriculum vitae (CV), applicant-nominated structured referee reports and multi-station interviews are used by all disciplines, but the details and weighting of the individual elements differ. Varying detail of CV scoring is provided for each of the specialties but for most specialties each section of the CV is assessed subjectively rather than providing a points rating for a given

achievement. There are some specialties (e.g. Cardiothoracic Surgery) that provide specific detail as to how many points are awarded for each specific achievement.

All applicants are made aware of the appeals mechanism as described under standard 1.3 should they consider that there has been an error in the selection process.

The number of trainees selected into the programs relates directly to the number of training positions available to each of the 13 selecting panels. Employing hospitals are not involved in the selection process. Successful applicants are recommended to hospitals but there is no obligation for that hospital to employ them. If the hospital declines to accept a recommended trainee, this does not affect accreditation of that hospital's training post.

The number of trainees by specialty who entered the SET program in Australia and New Zealand (2013–15), as detailed in the College's accreditation submission, is provided below.

		CAR	GEN	NEU	ORT	OHN	PAE	PLA	URO	VAS	Total
AUS	2013	5	105	6	35	19	6	12	16	13	217
	2014	7	60	9	58	13	4	12	0	8	171
	2015	7	83	11	51	9	5	17	24	8	215
NZ	2013	1	13	1	9	2	0	3	3	1	33
	2014	0	9	1	9	5	2	4	0	0	30
	2015	1	11	0	9	2	2	4	5	2	36

The number of both applicants and trainees selected for the SET program are published in the annual RACS Activities Report. Inspection of the 2015 data reveals that there were 1003 applicants for the program of which only 281 (28%) were female. The greatest discrepancy was in Orthopaedic Surgery where only 13% of applicants were female. In total, 25% of applicants succeeded in gaining entry to the program with similar proportions of male and female applicants being successful. Neurosurgery had the lowest application success rate (19%) and Orthopaedic Surgery the highest (32%).

The College's Education, Development and Research Department monitors and reviews the selection process at the end of each selection round. The Department reviews the processes and tools used as well as the reports on selection outcomes by specialty. Recommendations will be made to the surgical specialty to address any concerns. Each specialty also reviews its selection processes and tools. Some have a designated committee and/or staff member to undertake detailed analyses of selection tools; some use external experts to review selection tools and processes.

Otolaryngology Head and Neck Surgery has a specific policy of reserving the greater of 10% of posts or one post for an Aboriginal and Torres Strait Islander trainee who meets the 'minimum standard for appointment as defined by the Board'. Cardiothoracic Training Board approved a similar policy in February 2017. Such a policy is not in use by the other seven surgical specialties in Australia. In New Zealand, the RACS Māori Health Advisory Group has advised that it does not seek affirmative action in the selection of Māori candidates.

Information about compulsory rotations is said to be readily available to trainees but not easily found in the selection area of the College's website. The specifics of the rotations are not made available to trainees such that it would not be possible to apply specifically for a set of hospitals in the same state (in those specialties having interstate or international rotations). The College reports that applicants apply knowing that the program is a national one.

7.1.1 Team findings

As in all specialist medical colleges, there is considerable interest in the selection process from all those involved, as well as a desire to select the most suitable applicants whilst maintaining transparency and fairness. It was not clear to the team whether the object of the selection process is to select the most suitable trainee for year 1 of the training program, or the future consultant surgeon. This difference is important as greater prevocational experience will impact more on the former than the latter. Similarly, it was not clearly defined as to whether the selection objective was selecting the best surgical trainee or selecting the surgical workforce that could best meet the surgical needs of Australia and New Zealand. Again, there are important differences in these two objectives. Rurality, Indigenous status and diversity are all attributes that make essential contributions to the surgical workforce but might be overlooked in selecting the best 'surgeon'. It is recommended that the objectives of the selection process are both clear and consistent for each of the 13 selection processes.

Given that SET programs are mostly five to seven years in length, and applicants are currently at an average of PGY4 to PGY6 before they enter the program, the new fellow will be on average 10 years postgraduate. With the addition of research leave, parental leave, part-time training and an (often expected) overseas fellowship, it is quite plausible for a new fellow to be 15-20 years postgraduate before entering specialist practice. This seemingly long process may discourage many with an interest in surgery from applying for surgical training and is inefficient. An extended time in prevocational surgery may allow the SET 1 trainee to perform more procedures independently and therefore be attractive to selection committees but is unlikely to have a significant impact on the final product of surgical training. The College should consider setting an upper limit on the number of years of prevocational experience that can advantage an applicant in selection. This will become increasingly important as the prevocational space becomes more crowded with a higher number of medical graduates looking to pursue a specialist career.

There is considerable variation across the specialties regarding the extent to which details are publicised regarding how many selection points are awarded for specific achievements on the curriculum vitae. Most specialties are clear as to broad category point allocation and also as to what within those categories is deserving of recognition, but few are specific as to how many points would be awarded for each defined achievement e.g. a peer-reviewed first author paper. Such detail would assist applicants and improve the consistency and transparency of the selection process. It is of course appropriate that the allocation of points varies among specialties however this allocation information should be publicly available.

The team also heard at site visits that the selection criteria often changes without sufficient notification or consultation with trainees, and in some cases resulting in entire degrees no longer being scored in the CV, where they are no longer considered relevant to that specialty. Subsequent changes to selection criteria should first undergo evaluation and consultation with all stakeholders with an appropriate amount of lead time prior to implementation. The rationale for all proposed changes should also be clearly communicated at the time they are declared. This requires ongoing attention by the College and the Specialty Training Boards.

Assessing the prevocational performance of applicants as part of the selection process was of concern to almost all fellows involved with trainees. Considerable variation exists not only in technical ability but also in professional qualities – the latter being particularly relevant in a specialty challenged by accusations of workplace bullying and harassment. There is a general agreement that the current process of referee reports does not function well. As with referee reports across all the specialist medical colleges, the referee perceives an expectation that the applicant must be awarded maximum scores (or close to) on all categories. This seems to occur regardless of the number or nature of the questions being asked and almost regardless of how many referees are used. As these references are the only means by which prevocational performance is applied to selection, lack of appropriate discrimination is a problem. For the smaller selection panels, this is less of a problem with all applicants being reasonably 'known' to

the panels but this in itself may lack fairness and transparency. At least one specialty selection panel uses telephone references which is an acceptable form of reference but must be done in an open and transparent manner. Some training boards are using Entrustable Professional Activities (EPA) style assessments of prevocational skills acquisition.

College members interviewed by the team were of the view that the Brennan report prevented anything other than individual referee reports being used to assess prevocational performance and were essentially at a loss as to how the 'true' prevocational performance could be applied to selection in a fair and transparent manner. One fellow suggested that surgeons, senior trainees and senior nurses might provide a collective appraisal of the prevocational applicant via a 'multi-source' process. For the larger programs, the multi-source panel could 'rank' applicants, thereby providing the discrimination needed to reliably influence the selection outcome. This suggestion seems worthy of exploration given the widespread dissatisfaction with the current process.

Critical in the selection process for a surgical training program is the inherent ability of the applicant to perform technical procedures which require some aptitude in surgical dexterity. The team heard from many fellows who are frustrated at the lack of surgical ability in some of the trainees selected. Information on surgical ability could influence selection by more effective prevocational referencing and/or measures of inherent technical dexterity. The latter has been explored in North America and may have a future role in selection for surgical training programs in Australia and New Zealand.

Given the relatively uniformly high-scoring referee reports, discrimination relies on other elements of the selection process including academic record, research achievements and interview. The team heard from almost all fellows that, although some research participation is desirable, it should probably not be a key discriminator for selection to surgical training programs.

As discussed under standard 1.6, an issue that was raised on a number of occasions was that the College undertakes a selection process into training which is separate to that of recruitment into employment. The College advises hospitals of the trainees who have been 'allocated' to their hospital but does not share referee reports.

The team was disappointed to learn that only two specialties (Otolaryngology Head and Neck Surgery and Cardiothoracic Surgery) has a process to assist in the recruitment of Aboriginal and Torres Strait Islander trainees. With increasing numbers of Indigenous medical graduates, it is essential that specialist medical training programs have processes to assist in the selection, training and ongoing support of Aboriginal and Torres Strait Islander doctors. It was disappointing to hear from a number of Specialty Training Board representatives that selection should be based solely on a concept of "merit" which appears to be purely clinical/technical. There was a lack of agreement that there could also be merit in selecting an applicant who would better meet critical community needs. Similarly, there do not appear to be any strategies to increase intake of surgical trainees from a rural background, even though this is known to be the single strategy most likely to address the maldistribution of the medical workforce.

In the description of the process for supporting the selection of an Aboriginal and Torres Strait Islander trainee, Otolaryngology Head and Neck Surgery refers to 'reaching the minimum standard for selection'. This standard needs to be accurately and publicly defined for all nine specialties such that it is not the subjective impression of the selection panel but a prospectively defined clear standard for entry into surgical training.

The minimum application criteria are mostly clearly specified. As discussed under standard 5, the team supports the moving of the GSSE to the prevocational space and therefore becoming an essential application criterion. Trainees interviewed thought that study and preparation for the examination was valuable but became a distraction from their specialty once training had commenced. The problem created by moving this examination is that only 25% of applicants for surgical training are successful, meaning that 75% of those making a considerable professional,

emotional and financial investment in the GSSE do so with little long-term benefit for most alternative careers. The College is therefore encouraged to devise strategies to reduce the burden on applicants not selected into surgical training.

It is clear from the College's Annual Activities Report that there is a relative lack of female applicants to surgical training. Women constitute on average 25% of applicants but the number is much lower for Orthopaedic Surgery (15%) and higher for Paediatric Surgery (40%). Fellows interviewed by the team largely ascribed the overall lack of female applicants to perceived gender differences in 'medical interests'. Few had considered the possibility that structures within the surgical training programs (e.g. a perceived lack of part-time training opportunities) might disincentivise female applicants. The team was pleased to read in the Diversity and Inclusion Plan of the intention to explore both the real and perceived impediments to diversity of applicants for the training programs. The planned survey of final year medical students, and PGY1 and PGY2 doctors may be key to learning why current applicants are predominantly male. The team recommends that the College promote and monitor its Diversity and Inclusion Plan through the College and all Specialty Training Boards to ensure there are no structural impediments to a diversity of applicants for the training programs, and applicants selected into each program, as well as participation in the practice of surgery.

7.2 Trainee participation in education provider governance

The accreditation standards are as follows:

- The education provider has formal processes and structures that facilitate and support the involvement of trainees in the governance of their training.

The RACS Trainees' Association (RACSTA) was established in 2007 and advocates for trainees within the College. The chair of RACSTA is a voting member of RACS Council. RACSTA has representation from each training region and each of the nine specialties. The RACSTA Board reports directly to the College Education Board.

As described in their terms of reference, 'RACSTA was established to provide leadership and strategic direction for the Trainees' Association and to facilitate its goals and objectives.' Core among their main roles are advocacy for trainee issues to the College, as well as acting as the liaison between the College and trainees. They have a board that is comprised of 13 specialty representatives, including 8 regional representatives, College council representatives nominated by Council, and a number of co-opted members. All registered trainees of RACS are eligible to vote and stand for election to RACSTA, including those who are on interrupted training, with the exception of those who are suspended, on probation or under review by their Specialty Training Board. RACSTA board members are elected by the trainee body via the regional networks and Specialty Trainee Groups.

The chair of RACSTA is elected by secret ballot at a board meeting, and all board members have an equal vote. The chair remains in the role for one year with the option for re-election for an additional year, while terms for other board positions are similarly between one to two years depending on the specific role. Succession planning is in-built into the structure, which ensures that the immediate past chair continues to serve on the executive for an additional year to facilitate the transition.

The RACSTA Board engages in meetings, teleconferences, and workshops as required, but holds at least two face-to-face meetings per year, and all proceedings are recorded in minutes and reported to the RACS Council and to the Trainees' Association.

Trainee representatives are also members of each Specialty Training Board and many key RACS committees also include trainee members. In addition, some of the surgical specialties have their own trainee associations.

In 2015, a RACSTA executive officer was appointed to provide additional support to the RACSTA Board. The College provides funding for RACSTA's staff support and activities, including the

significant undertaking of the development of the Morbidity Audit and Logbook Tool (MALT) Offline app, which has been largely a trainee-driven initiative.

As discussed under standard 6, RACSTA, in 2011, introduced an end-of-term survey to seek confidential feedback from trainees. De-identified survey results are reported to the Board of Surgical Education and Training and the Specialty Training Boards.

Trainees can also report their concerns or seek assistance via the RACSTA generic email address. A RACSTA board member will contact the trainee by phone, particularly if an issue requires action or intervention. RACSTA filters trainees' concerns and opinions through to RACS and the training boards via reporting mechanisms and representation at relevant meetings.

7.2.1 Team findings

RACSTA is an effective organisation, well supported by the College fellows and staff. Trainee involvement with RACSTA is commendable as all have extensive clinical and training commitments alongside their involvement in this important body which advocates effectively on behalf of trainees.

RACSTA is to be commended for its commitment to the rolling five-year analysis of the bi-annual trainee survey. It will be important that this survey is conducted in a manner that allows trainees to comment freely without fear of subsequent retribution by a consultant surgeon, a supervisor of training or training board.

RACSTA is to be commended for its contribution to the Building Respect, Improving Patient Safety (BRIPS) program – in its design, the validation of its delivery, and ongoing monitoring and quality improvement efforts.

Although there is trainee representation on Council, the team considers that a single trainee among 28 or so fellows may lack effectiveness. Although there is a trainee on each of the Specialty Training Boards, this trainee may feel compromised in raising training difficulties – particularly in the smaller disciplines.

Many trainees feel that they are somewhat restricted in any criticism of training or trainers for fear of ramifications on workplace-based assessments or future training. While the team sees no ready solution to this problem, it does highlight the importance of effecting change through RACSTA representation. Not all trainees seemed to be aware of this avenue for addressing their concerns in a less direct manner.

The team heard that some of the regional training committees do not include trainee representation. As this is a forum in which many significant discussions take place regarding rostering and movement between rotations, trainees consider it is important that there is adequate representation and input into these discussions. This is an area for further consideration by the specialties. The otolaryngology head and neck surgery training board reports that regional trainee representation is inappropriate as discussions include commentary on peers' and colleagues' performance.

7.3 Communication with trainees

The accreditation standards are as follows:

- The education provider has mechanisms to inform trainees in a timely manner about the activities of its decision-making structures, in addition to communication from the trainee organisation or trainee representatives.
- The education provider provides clear and easily accessible information about the specialist medical program(s), costs and requirements, and any proposed changes.
- The education provider provides timely and correct information to trainees about their training status to facilitate their progress through training requirements.

Responsibility for what, when and how information is communicated is stipulated in RACS policy and specialty regulations. Most communication to trainees is delivered by the Specialty Training Boards and general information is provided on the RACS or Specialty Society/Association website. Increasing use is made of social media including Facebook and Twitter. There is a weekly e-newsletter (Fax Mentis) and a monthly publication (Surgical News). RACSTA also has an increasing noticeable presence in being the liaison between the College and trainees, with regular newsletters and independent social networking accounts.

RACS is responsible for providing information to trainees on the overall surgical education and training program and policies, including selection, examinations, information on skills courses, and program costs. The Specialty Training Boards inform trainees about their status in and progression through the program, the requirements of the program, and any program changes or issues affecting training.

7.3.1 Team findings

In feedback to the team, trainees generally felt communication to be at a satisfactory level through the various publications and personal email. The website provides a resource for both trainees and prospective applicants to the training program. Emphasising the presence and role of RACSTA as a liaison body would also assist in bolstering communication pathways.

During the site visits, trainees and specialist international medical graduates consistently reported concerns with the high costs of training and assessment fees. The team recommends that the College and the Specialty Societies/Associations ensure transparency in setting and reviewing fees for training, assessments and training courses, while also seeking to contain the costs of training.

7.4 Trainee wellbeing

The accreditation standards are as follows:

- The education provider promotes strategies to enable a supportive learning environment.
- The education provider collaborates with other stakeholders, especially employers, to identify and support trainees who are experiencing personal and/or professional difficulties that may affect their training. It publishes information on the services available.

Over recent years, issues of discrimination, bullying and sexual harassment affecting RACS trainees have been well publicised in the media. As previously reported, the College responded with the establishment of the EAG which reported in 2015. Recommendations from the EAG Report via the BRIPS Action Plan have either been implemented or are in the process of implementation. A key element of the action plan is cultural change in the workplace, and this will be an ongoing process.

RACS has engaged Converge International to establish a 'Surgeons Support Service' for trainees experiencing personal, emotional or workplace difficulties. Converge International report twice yearly to the College regarding the service and it appears to be well received by trainees.

The guidelines for the accreditation of training posts address trainee welfare issues as well as training. This is discussed under standard 8.2.

Supervisors play a key role in identifying trainees who are experiencing personal or professional difficulties. Contact with RACSTA, via an executive member, is also an option for a trainee with personal and/or professional difficulties. RACSTA may assist directly, but also may direct the trainee to appropriate support, whether this is the Surgeons Support Service, hospital, supervisor, GP, or training board.

7.4.1 Team findings

Most trainees were very pleased to be undertaking surgical training and very conscious of the intense commitment needed to attain their career objectives in surgery. The team heard from trainees that they were well aware before application of the expectations of the surgical training program. The trainees informed the team that had they not been prepared or able to make the necessary personal commitment, they would have pursued a different medical career.

Most trainees are accepting of rotations within their region including rural rotations. However interstate and international rotations can cause particular hardship. This is more particularly so for trainees with partners who have reduced mobility or children dependent on relatives for child-minding. It is the view of the team that interstate and international rotations should only occur if they are an absolute necessity for breadth of training. This should never be the case in the larger regions but may be necessary for the small specialties in the smaller regions where there may be only one training site. In that latter event, the program for interstate and/or international rotations should be clearly specified on commencement of training. The College must adhere to mandatory minimum notice periods for any rotations (including rural rotations within a region) that require a change in domicile. This is also discussed under standard 8.2.

As discussed under previous standards, trainees reported to the team that, while BRIPS program is leading to improvements, the culture of bullying, harassment and sexual harassment may not be changing quickly. It is important that the College continue to maintain its momentum with the BRIPS program.

7.5 Resolution of training problems and disputes

The accreditation standards are as follows:

- The education provider supports trainees in addressing problems with training supervision and requirements, and other professional issues. The education provider's processes are transparent and timely, and safe and confidential for trainees.
- The education provider has clear impartial pathways for timely resolution of professional and/or training-related disputes between trainees and supervisors or trainees and the education provider.

The College manages complaints about bullying and harassment. Issues raised by trainees in relation to training supervision and requirements are generally managed in the first instance by Specialty Training Boards. The regulations stipulate how each of the boards conducts the process, and there are RACS guidelines to assist boards in meeting natural justice requirements, Natural Justice – Guidelines for Decision Makers.

If the issue is not resolved by the Specialty Training Board, the matter is referred to the Censor-in-Chief Review Committee, comprising the censor-in-chief and two members of the Education Board Executive. This committee can ask the Specialty Training Board to reconsider the original decision but does not appear to have the power to overrule a Specialty Training Board decision. If the trainee remains dissatisfied with the decision, a formal Appeals Committee is convened to manage the decision.

7.5.1 Team findings

It is obviously critically important that trainees can provide constructive criticism of their training program in order that this valuable feedback contributes to ongoing development of the educational programs. It is also absolutely critical that any negative comments from a trainee do not negatively affect their progress in the training program. Even a perception that this could happen is likely to curtail important constructive feedback. Other than possibly in General Surgery, it is extremely difficult for a trainee not to be readily identified by virtue of the comment made – particularly if in reference to deficiencies of a training post. It will be important for the College and the Specialty Training Boards to work together to ensure there are processes in place

that enable trainees to raise issues and resolve disputes during training without jeopardising their ongoing participation in the training program. The RACSTA five-year rolling survey and the training post accreditation process give some opportunity for some de-identification but further progress is essential.

Commendations

- Q The commitment of the RACS Trainees' Association (RACSTA) in implementing a rolling five-year survey of the trainee experience, and by advocating on behalf of trainees.
- R The College's clear commitment to trainee participation in governance by dedicating both human and financial resources to ensure the RACS Trainees' Association (RACSTA) is well supported.
- S The specialties of Otolaryngology Head and Neck Surgery and Cardiothoracic Surgery that reserve a place for an Aboriginal and Torres Strait Islander applicant who reaches the minimum standard for selection.

Conditions to satisfy accreditation standards

- 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)
- 25 Clearly document and make publicly available the standard of entry into each surgical training program. (Standard 7.1)
- 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)
- 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)
- 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. (Standard 7.3.2 and 10.4.1)
- 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)

Recommendations for improvement

- 00 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)

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

8.1 Supervisory and educational roles

The accreditation standards are as follows:

- The education provider ensures that there is an effective system of clinical supervision to support trainees to achieve the program and graduate outcomes.
- The education provider has defined the responsibilities of hospital and community practitioners who contribute to the delivery of the specialist medical program and the responsibilities of the education provider to these practitioners. It communicates its program and graduate outcomes to these practitioners.
- The education provider selects supervisors who have demonstrated appropriate capability for this role. It facilitates the training, support and professional development of supervisors.
- The education provider routinely evaluates supervisor effectiveness including feedback from trainees.
- The education provider selects assessors in written, oral and performance-based assessments who have demonstrated appropriate capabilities for this role. It provides training, support and professional development opportunities relevant to this educational role.
- The education provider routinely evaluates the effectiveness of its assessors including feedback from trainees.

Supervisor of training role

The College has well-defined principles of supervision, including the eligibility criteria for, and the duties to be performed by, a supervisor. Each Specialty Training Board provides further specification of a supervisor's duties through its training regulations. Some specialties have developed position descriptions and supervisor handbooks. The College does not set supervisor to trainee ratios but assesses whether an institution can support the number of training posts.

Supervisors are responsible for: coordinating the management, education, and training of trainees; conducting performance assessments; monitoring operative experience and reviewing operative logbook summaries; and managing issues of unsatisfactory trainee performance. Supervisors are the liaison between trainees and hospital authorities on matters related to training. Supervisors also liaise with the Specialty Training Boards regarding trainee and training matters.

Appointment and tenure

Supervisors must be fellows of RACS and meet the criteria set down in the Surgical Supervisors Policy. Some Specialty Training Boards also require membership of the specialty society or association. Each Specialty Training Board determines the appointment process and term of appointment for their specialty. The term of appointment is usually three years, with supervisors eligible for reappointment. The maximum period that a Specialty Training Board can allow a supervisor to serve is nine years. In extraordinary circumstances, the College censor-in-chief may approve an extension for a supervisor.

The Surgical Supervisors Policy documents the mandatory and recommended training required of all supervisors and trainers. As a minimum, supervisors and trainers are required to complete the Supervisors and Trainers for SET (SAT-SET) and Keeping Trainees on Track (KTOT) courses. Supervisors and surgeons who teach and train SET trainees are now required to complete the Foundations Skills for Surgical Educators (FSSE) or equivalent, and undertake advanced training

in discrimination, bullying and sexual harassment. The College has scheduled eighty FSSE courses for 2017.

Supervisors are required to undertake professional development activities relevant to the role. The College's website contains a number of resources for those involved in education and training. A number of the surgical specialties also conduct workshops and training days specifically for supervisors.

As discussed, the College's Academy of Surgical Educators (ASE) has more than 700 members and promotes formal training of fellows involved in the education and training of trainees.

Feedback on supervisor performance

The College collects feedback from trainees on supervisor performance via a number of means including the RACS Trainees' Association (RACSTA), surveys conducted by the Specialty Training Boards, and the post reaccreditation process. Feedback is also gathered via the complaints hotline which specifically addresses discrimination, bullying and sexual harassment and breaches of the RACS Code of Conduct. The College does not collect specific named feedback attributed to a trainee about a supervisor within a post. The College reports that trainees remain reluctant to be named.

The College is in the process of developing supervision standards which will provide a baseline against which supervision will be assessed and remediation plans can be developed. This initiative is a key focus for the College in 2017 and stems from the Building Respect, Improving Patient Safety (BRIPS) Action Plan. A process for review of supervisor performance will be implemented in 2018.

Assessors

Membership of the Court of Examiners is by application, seconded by a RACS fellow. New fellowship examiners are selected in consultation with members of the court. Members must be a RACS fellow and compliant with a College-approved continuing professional development program. In selecting new examiners, the specialty court considers the geographical and teaching hospital representation and subspecialty mix to ensure diversity and broad representation. Examiners usually serve for nine years, and their appointment is reviewed every second year.

The College has a mandatory one-day training course for fellowship examiners. The training covers the concepts of examination standards, standard setting, reliability and validity. Once appointed, all new examiners must attend a College Fellowship Examination to observe examiner performance and the examination process. This was also discussed under standard 5.

There is no application process for clinical examiners. Prior to each examination, an expression of interest is circulated to identify interested fellows. The College has developed a clinical examiner training course which was made available to examiners in June 2017.

Evaluation of assessors and feedback from trainees

The College conducts a voluntary post-examination survey of the candidates which includes feedback on examiner performance. The College uses a range of other methods to evaluate examiner performance and these are described under standard 5.

Mentors

Following an unsuccessful trial of a facilitated mentoring program, the College has developed a mentoring webpage which provides a guide, tools and templates to develop and support an effective mentoring relationship.

8.1.1 Team findings

The College has a dedicated paid and pro-bono workforce providing high-quality surgical training. The team generally found that supervisors and trainers feel well supported by the College.

Some supervisors reported to the team that the requirements of the supervisor role are becoming more onerous each year, making pro-bono work increasing difficult. The College acknowledges that balancing training and development commitments in a volunteer workforce is a major challenge for supervision. The College reports that a constant constraint of the SET program is the provision of adequate paid and protected time to allow supervisors to fulfil their educational role. When competing with service provision, the lack of time devoted to training impacts on the supervisor's ability to provide high-quality assessment and feedback, particularly for trainees experiencing difficulties.

Training requirements, including the roles for supervisors and trainers, are clearly articulated and easy to access. The College provides clear direction about mandatory training requirements for supervisors. The newly developed College courses, KTOT, Operating with Respect (OWR) and FSSE, have a high uptake by supervisors. Supervisors reported to the team that these courses are of high quality and relevant. The assessment team was also given the opportunity to observe the FSSE course. The introduction of mandatory training for clinical examiners is noted as a positive step for the College.

The College does not currently mandate cultural safety training for supervisors, trainers and assessors, with the assumption made that this occurs within the hospital setting. The team recommends that the College mandate training and include this requirement as part of accreditation standards for training posts.

The team found that there is a range of data collected from trainees regarding training posts. However, unless specific concerns are raised, none of these methods provide feedback in relation to a specific supervisor or trainer. The College acknowledges that further work is required to improve the quality of supervision, and identify and remediate underperforming supervisors. Data quality in relation to trainee feedback about supervisors was consistently raised as an issue. Trainees are reluctant to provide feedback, and reported concerns regarding de-identification processes. The College will need to continue to work towards providing an environment where trainees are able to provide feedback without fear of consequences.

The team commends the work of the College in developing supervision standards and a process for reviewing supervisor performance. The team recommends that the College in conjunction with the Specialty Training Boards finalise the supervision standards and process for reviewing performance and implement across all specialty training programs.

8.2 Training sites and posts

The accreditation standards are as follows:

- The education provider has a clear process and criteria to assess, accredit and monitor facilities and posts as training sites. The education provider:
 - applies its published accreditation criteria when assessing, accrediting and monitoring training sites
 - makes publicly available the accreditation criteria and the accreditation procedures
 - is transparent and consistent in applying the accreditation process.
- The education provider's criteria for accreditation of training sites link to the outcomes of the specialist medical program and:
 - promote the health, welfare and interests of trainees

- ensure trainees receive the supervision and opportunities to develop the appropriate knowledge and skills to deliver high-quality and safe patient care, in a culturally safe manner
- support training and education opportunities in diverse settings aligned to the curriculum requirements including rural and regional locations, and settings which provide experience of the provisions of health care to Aboriginal and Torres Strait Islander peoples in Australia and/or Māori in New Zealand
- ensure trainees have access to educational resources, including information communication technology applications, required to facilitate their learning in the clinical environment.
- The education provider works with jurisdictions, as well as the private health system, to effectively use the capacity of the health care system for work-based training, and to give trainees experience of the breadth of the discipline.
- The education provider actively engages with other education providers to support common accreditation approaches and sharing of relevant information.

The College has clearly defined standards for the accreditation of hospital posts entitled Accreditation of Hospitals and Posts for Surgical Education and Training. The College accredits individual posts within hospitals, and not the hospital as a whole.

In 2016, the College reviewed its accreditation standards to incorporate the BRIPS Action Plan. The College introduced a requirement for hospitals to demonstrate that they 'build and maintain a culture of respect for patients and staff.' The College is engaging with hospitals, hospital networks and jurisdictions to ensure this standard will be met. As discussed under standard 1, a number of formal agreements and memoranda of understanding have been signed.

The accreditation criteria are based around eight core educational, clinical and governance standards. The accreditation standards cover: building and maintaining a culture of respect for patients and staff; education facilities and systems required; quality of education and learning; surgical supervisors and staff; support services and flexibility for trainees; clinical load and theatre sessions; equipment and clinical support services; clinical governance, quality and safety.

Each Specialty Training Board has a published process for accrediting a training post in that specialty, which is compliant with the RACS Training Post Accreditation and Administration Policy. The accreditation team (sometimes referred to as an inspection team which is effectively a subcommittee of the Specialty Training Board) will make a recommendation on the suitability of the post for training purposes.

The accreditation team usually comprises two to three fellows of the relevant specialty who are involved in training. Usually team members will be from outside the jurisdiction in which the post under review is located. The Board in General Surgery also includes a trainee representative in the accreditation process.

The accreditation team reviews the hospital's accreditation submission, meets with hospital administration, members of the unit and current trainees. The team considers whether the post provides the experience necessary for a trainee, based on likely operative experience, the breadth of procedures undertaken in the unit, the equipment available to ensure the unit can perform the procedures indicated in its submission, the infrastructure available to support a trainee (library, study facilities, access to examination leave, etc.) and the level of supervision a trainee would receive.

The draft report prepared by the accreditation team is made available to the hospital prior to finalisation. The accreditation recommendation is presented to the Specialty Training Board for approval. The Specialty Training Board decides on the accreditation period, and whether there should be any further inspections during the accreditation period. While five years is the usual accreditation period, a board may accredit a post for a shorter period.

The Specialty Training Board may re-inspect posts where it identifies – through complaints, trainee surveys, trainee underperformance, etc. – that there may be a diminution of standards. Issues that may result in a post review include significant change in staff, proven complaints of discrimination, bullying and sexual harassment, changes of accreditation by another organisation, and change of service provision by the hospital.

The College acknowledges the benefits of training in the private sector, including exposure of trainees to procedures predominantly conducted in that sector. The College accredits 73 Australian Department of Health Specialist Training Program (STP) posts. Posts are predominantly in the public sector, however the College is encouraging private sector hospitals to seek accreditation. This initiative has had limited success, which the College considers is due to the different expectations of private patients. It is also essential that trainees receive experience as the primary operator with appropriate supervision. Such opportunities can be limited in private hospitals.

Accrediting posts in rural areas depends somewhat on the organisation of specialist services by health jurisdictions: suitable units exist in medium-sized cities, but trainees rotating in from a metropolitan-based program usually fill the training positions. The College reports that because there are more trainees in General Surgery and Orthopaedic Surgery, these programs are organised on a regional basis, and this enables the operation of training posts in rural areas. It is possible within these programs to have more non-metropolitan training, however, other specialties are city-based due to the need for highly specialised equipment (for example, Neurosurgery).

The College reports that all trainees gain experience in the provision of health care to Aboriginal and Torres Strait Islander patients in the major teaching hospitals. Some Specialty Training Boards have introduced initiatives that address Indigenous health in rural communities. For example, members of the Board of Otolaryngology Head and Neck Surgery, and its supervisors and trainees, undertake regular outreach clinics to remote Indigenous communities.

The College has included jurisdictional representatives on accreditation teams with the full rights and duties exercised by surgeon-members of the team. Jurisdictional representatives have also been invited to be members of the Specialty Training Boards, the Board of Surgical Education and Training, and the Education Board.

The Australian and New Zealand College of Anaesthetists (ANZCA) and RACS provide representation on each other's councils to facilitate communication on high-level issues of education, and this includes strategic discussion on accreditation. The College has participated in workshops organised by the Council of Presidents of Medical Colleges and the Health Workforce Principal Committee regarding collaboration on accreditation. Currently, the College does not share information from its accreditation process with other colleges, and does not collaborate with them on joint accreditations, nor share findings about common criteria.

8.2.1 Team findings

The team considers that the College accreditation standards and processes are fit for purpose and are driving positive changes within workplaces. The accreditation process is rigorous, transparent and clearly defined. Information regarding the accreditation process is easily accessible.

The College has eight accreditation standards, the first of which concerns respectful and safe working and educational environments. Hospital executives at various sites visited by the team commented on the efforts of the College in operating with respect. They reported that this has translated to conversations with medical staff about appropriate behaviour within the workplace. Trainees have reported feeling that consultants are taking more interest in their psychological health. The team recommends that each Specialty Training Board, with the support of the College, must maintain momentum with the BRIPS action plan, by promoting the program and the positive

participation of all fellows and trainees, including supporting all surgeons to “call out” bad behaviour in work and training.

As discussed under standard 2, the team heard reports during site visits that trainees are working hours additional to those recorded formally in order to bypass safe working hours requirements. The team also heard that some trainees are often expected to work a one in two on-call roster, with fatigue a potential issue. The team recommends that the College and Specialty Training Boards continue to closely monitor working hours through the accreditation process.

Cultural competency training is inconsistent across specialties and between Australia and New Zealand as covered under standard 3.2. The College’s Australian and New Zealand cultural competency training frameworks have been developed independently. Cultural safety and Indigenous health is not currently specified within training curricula, and is not assessed. The efforts of the Indigenous Health Committee to ensure that meaningful cultural competence training is rolled out across the College is commended. The team recommends that the College include in their accreditation standards a requirement that training sites demonstrate a commitment to Aboriginal and Torres Strait Islander and/or Māori cultural competence.

The Board of Otolaryngology Head and Neck Surgery fully supports training and education opportunities in diverse settings aligned to the curriculum requirements, including rural and regional locations, and settings which provide experience of the provisions of health care to Aboriginal and Torres Strait Islander peoples in Australia and/or Māori in New Zealand. Trainees in Otolaryngology Head and Neck Surgery undertake outreach visits to sites that provide health care to Aboriginal and Torres Strait Islander peoples. These outreach clinics include: Deadly Ears Program – Queensland; Kimberley Region Outreach Clinics – Western Australia; Yatala Outreach Clinic – South Australia. The team commends this program of visits as an area of strength which it recommends other specialty training programs may also wish to consider.

The team considers that the lack of access to flexible training has a significant impact on the welfare of trainees. While the team noted that College policies and the College executive are supportive of part-time and flexible training, there is a disconnect in terms of trainees accessing this training. Flexible training is not currently role modelled by the College, and is reported by some trainees and supervisors to be perceived as substandard training. This issue is further discussed under standard 3.4.

The team heard considerable feedback in relation to the impact of interstate and international rotations on trainee welfare. Such rotations are disruptive to the usual support networks and to caring roles. Trainees reported loss of benefits such as sick leave and other accrued leave when transferring between jurisdictions. Trainees also reported inadequate notification periods ahead of interstate and international rotations. The team recommends that the College develop a policy that is adhered to by all Specialty Training Boards that minimises the number of interstate/international rotations and stipulates a minimum advanced notice period prior to commencement of rotations. The team encourages the College to develop a practice whereby trainees are given a plan for their rotations at the commencement of their training program. The College is also encouraged to work with the jurisdictions to assist in preventing the loss of employment benefits when trainees transfer between jurisdictions.

The great majority of trainees have limited exposure to rural and regional training locations. The team recommends that the College further explore how it can expand the training programs in rural and regional locations.

The team considers further collaboration amongst the Specialty Training Boards to support common accreditation processes and share relevant information is required. The team notes the College’s contribution to the Health Workforce Principal Committee’s Accreditation of Specialist Medical Training Sites Project. As detailed under the notes to the accreditation standards, the AMC endorses the work on developing tools to support consistent approaches to accreditation.

The College is encouraged to map the RACS accreditation standards against the accreditation domains outlined in the Accreditation of Specialist Medical Training Sites Project Final Report.

Commendations

- T The College's dedicated, high-quality, paid and pro-bono workforce that is committed to training.
- U The large scale implementation of the Foundation Skills for Surgical Educators (FSSE) and Operating with Respect (OWR) courses as part of the Building Respect, Improving Patient Safety (BRIPS) program.

Conditions to satisfy accreditation standards

- 30 Mandate cultural safety training for all supervisors, clinical trainers and assessors. (Standard 8.1.3, 8.1.5 and 8.2.2)
- 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)
- 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)
- 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 Maori cultural competence. (Standard 8.2.2)

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)

9 Continuing professional development, further training and remediation

9.1 Continuing professional development

The accreditation standards are as follows:

- The education provider publishes its requirements for the continuing professional development (CPD) of specialists practising in its specialty(s).
- The education provider determines its requirements in consultation with stakeholders and designs its requirements to meet Medical Board of Australia and Medical Council of New Zealand requirements.
- The education provider's CPD requirements define the required participation in activities that maintain, develop, update and enhance the knowledge, skills and performance required for safe and appropriate contemporary practice in the relevant specialty(s), including for cultural competence, professionalism and ethics.
- The education provider requires participants to select CPD activities relevant to their learning needs, based on their current and intended scope of practice within the specialty(s). The education provider requires specialists to complete a cycle of planning and self-evaluation of learning goals and achievements.
- The education provider provides a CPD program(s) and a range of educational activities that are available to all specialists in the specialty(s).
- The education provider's criteria for assessing and crediting educational and scholarly activities for the purposes of its CPD program(s) are based on educational quality. The criteria for assessing and crediting practice-reflective elements are based on the governance, implementation and evaluation of these activities.
- The education provider provides a system for participants to document their CPD activity. It gives guidance to participants on the records to be retained and the retention period.
- The education provider monitors participation in its CPD program(s) and regularly audits CPD program participant records. It counsels participants who fail to meet CPD cycle requirements and takes appropriate action.
- Additional MCNZ criteria: Continuing professional development – to meet MCNZ requirements for recertification.

RACS established its continuing professional development (CPD) program in 1994. Its most recent iteration was published in 2016 for use from 2017.

The Professional Standards Board oversees the CPD program which is revised every three years. The program is published on the RACS website as well as being available in hard copy.

Participation in CPD is mandatory for all RACS fellows and there was 100% compliance by those participating in the CPD program in 2014. At the time of the accreditation submission, the College indicated that the 2015 CPD year was being finalised and is on track to again reach 100% compliance.

If a fellow does not participate, they are referred to the College's Professional Conduct Committee for review and possible sanction, including loss of fellowship. Since 2013, three fellows have had their fellowship removed for failing to meet CPD requirements, with RACS notifying the Australian Health Practitioner Regulation Agency (AHPRA) about these terminations.

Fellows are required to select a type of practice that best reflects their work. As it is important that fellows maintain the same standards of surgical care regardless of hours worked, the

requirement is the same for fellows working in full- and part-time practice. Fellows must ensure that the majority of their CPD activities relate to their specific scope of practice.

The changes to 2017 CPD program are largely related to the implementation of recommendations of the EAG into discrimination, bullying and sexual harassment, and to ensure the program is aligned with the standards articulated by the Medical Board of Australia and the Medical Council of New Zealand. New features of the CPD program are that all active fellows must participate in one reflective practice activity annually, which for 2017 is the RACS Operating with Respect (OWR) eLearning module, and that fellows in non-operating (i.e. consulting-only) practice are required to undertake a peer review audit of their practice each year. The College advises that in the long term it is anticipated that participants will use multi-source feedback to inform their learning plan and subsequent educational activities.

The CPD program requirements are outlined in the 2017 handbook as follows:

Type of Practice	Annual Requirement
Operative practice in hospitals or day surgery units	<ul style="list-style-type: none"> Undertake a peer reviewed Surgical Audit and participate in Australian and New Zealand Audit of Surgical Mortality (ANZASM) where available Accrue at least 10 points in Clinical Governance & Quality Improvement Accrue at least 50 points in Maintenance of Knowledge & Skills Participate in at least one activity in Reflective Practice
Operative procedures in rooms only	<ul style="list-style-type: none"> Undertake a peer reviewed Surgical Audit and participate in ANZASM where available Accrue at least 50 points in Maintenance of Knowledge & Skills Participate in at least one activity in Reflective Practice
Operative practice as a locum only	<ul style="list-style-type: none"> Undertake a peer reviewed Surgical Audit and participate in ANZASM where available Note: If a peer reviewed audit is not available, maintain a logbook of surgical procedures in MALT and present this to the Locum Evaluation and Peer Review Committee Accrue at least 50 points in Maintenance of Knowledge & Skills Participate in at least one activity in Reflective Practice
Clinical consulting practice only	<ul style="list-style-type: none"> Undertake a peer reviewed Audit of Practice Accrue at least 50 points in Maintenance of Knowledge & Skills Participate in at least one activity in Reflective Practice
Surgical assisting or other non-consulting practice	<ul style="list-style-type: none"> Accrue at least 30 points in Maintenance of Knowledge & Skills Participate in at least one activity in Reflective Practice

There are four CPD program categories as detailed below:

Category 1 - Surgical audit and peer review

All surgeons in operative or clinical consulting practice are required to participate in an audit each year and submit the audit for peer review. Fellows can participate in a range of audits including: focused audit; group audit (including clinical unit audit); selected audit from surgical practice; total/practice workload audit and peer review of reports (non-operative fellows). The College provides a surgical audit and peer review guide on its website.

Category 2 - Clinical governance and quality improvement

The clinical governance framework includes elements that take place in a continuous quality improvement environment such as clinical audit, clinical effectiveness, clinical risk management,

organisational and staff development, patient and carer experience and information management.

Clinical governance activities generally attract 1 point per hour and can include: hospital or clinical meetings that focus on improvements in clinical care; activities related to organisation or review of surgical services; completion of Australian and New Zealand Audit of Surgical Mortality (ANZASM) surgical case form; participation in annual individual and/or department performance review.

Category 3 - Maintenance of knowledge and skills

Surgeons must maintain their skills, knowledge and competence which includes developments in their area of practice, as well as advances in clinical and medical science. Fellows are required to attend activities that span the range of the College's nine competencies.

Attendance at meetings/seminars/workshops/courses attracts 1 point per hour and includes: scientific meetings; courses/workshops that focus on technical competencies and professional practice/non-technical competencies; and participation in a Masters/Diploma/Certificate course at tertiary institutions. Other activities in Category 3 that attract 1 point per hour include: general teaching activities to trainees, undergraduates, health professionals – including grand rounds, multi-disciplinary meetings and clinical teaching rounds; supervision of surgical trainees; and acting as an examiner for the College, AMC, universities or other recognised educational institutions.

Category 4 - Reflective practice

Fellows are required to participate in education that promotes self-reflection and champions respectful behaviour. This includes embracing diversity, fostering gender equity, increasing transparency and being open to independent scrutiny and external accountability. As described above, fellows must complete the OWR eLearning module before the end of 2017; and complete at least one activity from reflective practice each year, from 2018 onwards. Other Category 4 activities that focus on a review of professional practice across a range of College competencies include: development of a structured learning plan including self-reflection; participation in a structured mentoring program; and recipient of a structured practice visit by a peer with evaluation and action plan.

The College has also developed a range of resources to support fellows to meet the requirements of Category 4, including the online Learning Plan which is available through the RACS Portfolio. Fellows can also choose to develop their own learning plan.

The College offers a comprehensive program of professional development activities across the surgical competencies. These include generic, non-technical competencies of communication, collaboration and teamwork, judgment and decision making, professionalism, health advocacy, management and leadership, and scholarship and teaching. Programs are provided in a range of learning modes including workshops, forums, webinars, seminars, blended learning, residential workshops and online learning.

The College offers activities that address cultural competence, professionalism and ethics. The Network for Indigenous Cultural and Health Education (NICHE) portal is available to all Australian specialists. The College reports that work is continuing on developing a wide range of modules that aim to improve cultural understanding and awareness.

All activities offered by the College – and an increasing number delivered by external providers – are assessed for educational validity, appropriateness and relevance before they are 'CPD-approved'. The College approves approximately 350 activities each year, with attendance data automatically populated into a participant's CPD online record.

The number of participants in the CPD program by category and by region, as provided in the College's accreditation submission, are given in the tables below.

Participants by category	Number of participants
RACS CPD program	5119
Non Fellow RACS CPD program	95
External CPD programs:	1271
<i>Australian Orthopaedic Association</i>	797
<i>New Zealand Orthopaedic Association</i>	228
<i>Royal Australian College of General Practitioners</i>	13
<i>Australasian College for Emergency Medicine</i>	2
<i>Royal Australian and New Zealand College of Ophthalmologists</i>	227
<i>Royal Australian and New Zealand College of Obstetricians and Gynaecologists</i>	1
<i>Royal College of Physicians and Surgeons of Canada</i>	3
Total number of participants	6485

Participants by region	Number of participants
RACS CPD participants based in Australia	5283
RACS CPD participants based in New Zealand	860
RACS CPD participants based overseas	342
Total number of participants	6485

As detailed above, approximately 1000 RACS fellows participate in alternative CPD programs which have been recognised and approved by the College with 80% of these participants undertaking the separate CPD program of either the Australian Orthopaedic Association (AOA) or the New Zealand Orthopaedic Association (NZOA). While compliance with the NZOA CPD program is reported to be 100% this is not the case for the AOA CPD program. The team was advised that 26 out of 1600 fellows are neither participating in the RACS nor the AOA programs and will therefore be reported to the RACS Professional Conduct Committee.

Each year 7% of RACS participants are randomly subject to a full audit of their CPD participation.

9.1.1 Team findings

The team found that there is near universal support for, and uptake of, the RACS CPD program. It noted the regular update of the program every three years and considers that the consultation process internally and with external bodies such as the Medical Council of New Zealand and the Medical Board of Australia is comprehensive.

The team commends the College for using the CPD program as the means by which mandatory training and greater awareness of discrimination, bullying and sexual harassment has been brought into the ongoing professional lives of all fellows.

Also well regarded by the team is the introduction of the self-reflection component through the Reflective Practice category which all surgeons regardless of their type of practice must undertake. It was noted that it is intended to enable reflection on topics such as diversity, gender equity, increasing transparency and openness to independent scrutiny, and external accountability. The team also recommends that this list, which it understood to be suggestions and not a limited list, should nevertheless be expanded to include cultural competence as an area of reflection.

The team was advised that the College has formed a CPD Audit Working Group, which it felt was a necessary step, especially with its particular focus on the breadth of the surgeon's individual practice and the inclusion of a more robust feedback loop. The AMC looks forward to updates on progress.

The team spent considerable time with representatives of the Australian and New Zealand Society for Vascular Surgery (ANZSVS) who have developed the Australian Vascular Audit. It is compulsory for surgeons who are members of the ANZSVS but is also available to non-members who practise vascular surgery. It covers four areas of vascular practice: carotid surgery; lower limb arterial bypass surgery; access surgery for renal dialysis; and aortic surgery. In discussion with the team, and in its accreditation submission to the AMC, the ANZSVS argued the College (and indeed the AMC) should mandate the ANZSVS audit for all vascular surgeons, not just those who are members of the Society.

This argument has not found favour with the College for several reasons and it is hoped that the recently formed RACS CPD Audit Working Group will, in its deliberations, enter into dialogue with the ANZSVS on this matter. In its feedback to the draft accreditation report, the College indicated that a meeting with ANZSVS will be arranged.

As detailed above, 26 Orthopaedic fellows are non-compliant in CPD and will be reported to the RACS Professional Conduct Committee. The team recommends that the College and the Australian Orthopaedic Association (AOA) continue to share data to ensure those surgeons enrolled in the AOA CPD program are compliant. The College reported to the team that it is committed to ensuring there is 100% compliance of Australian Orthopaedic surgeons in either the AOA or RACS CPD programs.

9.2 Further training of individual specialists

The accreditation standard is as follows:

- The education provider has processes to respond to requests for further training of individual specialists in its specialty(s).

The College has developed policy and processes to respond to further training of individual specialists on request from a variety of sources such as hospitals, specialty societies and individual surgeons. The focus is particularly on technical skill deficiencies of an individual but there is also a mechanism for reviewing clinical standards for both individuals and clinical units. The processes are outlined in the RACS Reskilling and Re-entry Program Guidelines and the RACS Clinical Standards Review policy available on the College's website.

For fellows returning to active practice, or an element of clinical practice, following a period of absence, the fellows must first contact the College's Executive Director of Surgical Affairs (EDSA). The EDSA in discussion with the relevant Specialty Society President reviews the reskilling and re-entry request to determine if a structured reskilling and re-entry program is required. Consideration is given to adverse events, complaints, or restrictions on practice imposed by regulators; length of time away from clinical practice; and results of a review of current practice, if this has been undertaken. If reskilling is considered appropriate, the EDSA appoints an appropriate supervisor to coordinate a clinical attachment.

A structured re-skilling and re-entry program will include the following elements: goals; achievement of expected competencies; clear competencies to be achieved; allocated time for regular feedback to the fellow; performance assessment based on the Specialty Training Board's training assessment reports.

The fellow undergoing retraining must maintain a logbook of surgical procedures using the appropriate data set recommended in the Surgical Audit and Peer Review Guide.

At the completion of the reskilling and re-entry program, the supervisor prepares a report for the EDSA on the program, including the extent to which the goals of the program have been achieved.

9.2.1 Team findings

The team is satisfied that the College has addressed this standard. The team considers that the College could further explore its own role in identifying the poorly performing fellow, for example through CPD returns, and offer further training to those so identified.

9.3 Remediation

The accreditation standards are as follows:

- The education provider has processes to respond to requests for remediation of specialists in its specialty(s) who have been identified as underperforming in a particular area.

In contrast to standard 9.2 where the focus is on remedying a deficiency in technical skills, the College regards remediation as applying to situations where there is a departure from acceptable practice in non-technical skills and behaviours, and it has linked this standard to the College's complaints management processes.

The improvement of complaints handling is described as a major pillar of the Building Respect, Improving Patient Safety (BRIPS) Action Plan which has been referred to throughout the report.

9.3.1 Team findings

While, understandably, the focus on the College's accreditation submission for this standard has been on responding to complaints regarding discrimination, bullying and sexual harassment, the team has noted that formal processes exist to assist requests for further training or remediation of individual surgeons, whether self-referred or referred by others, which can address all or some of the nine key competencies of a surgeon. The team regarded this as a strength of the College's program.

Commendations

- V The CPD program is the means by which mandatory training and greater awareness of discrimination, bullying and sexual harassment has been brought into the ongoing professional lives of all fellows.
- W The promotion of the importance of self-reflection through the addition of a Reflective Practice category with all participants required to undertake at least one such activity per year.
- X Reducing the burden of reporting for fellows by organising for providers of RACS CPD activities to report attendances to the College which is updated directly onto each fellow's online CPD profile.

Conditions to satisfy accreditation standards

Nil

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 surgeon's 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)

10 Assessment of specialist international medical graduates

10.1 Assessment framework

The accreditation standards are as follows:

- The education provider's process for assessment of specialist international medical graduates is designed to satisfy the guidelines of the Medical Board of Australia (MBA) and the Medical Council of New Zealand (MCNZ).
- The education provider bases its assessment of the comparability of specialist international medical graduates to an Australian- or New Zealand- trained specialist in the same field of practice on the specialist medical program outcomes.
- The education provider documents and publishes the requirements and procedures for all phases of the assessment process, such as paper-based assessment, interview, supervision, examination and appeals.
- Additional MCNZ criteria: Recognition and Assessment of International Medical Graduates (IMGs) applying for registration in a vocational scope of practice.

The processes for assessment of specialist international medical graduate (SIMG) surgeons differ significantly between Australia and New Zealand, and will be treated separately within this section of the report.

In Australia, the College undertakes all specialist international medical graduate assessments and decision making, advising the MBA at the stage of eligibility for award of fellowship.¹

Conversely, in New Zealand, the College assesses details of the specialist international medical graduate's qualifications, training and experience so that it can provide that information to the MCNZ, to enable the MCNZ to make the decision about vocational registration. The MCNZ specifies that fellowship is not necessary for vocational registration and cannot be required as a pre-requisite for vocational registration of specialist international medical graduates in New Zealand.

Australia

RACS' policy for assessment of SIMG surgeons in Australia is described in an overarching policy, Specialist Assessment of International Medical Graduates in Australia. The College has a comprehensive range of policies relating to its processes for the assessment of specialist international medical graduate surgeons in Australia. These are publicly available on the College website.

The SIMG assessment process assesses the comparability of specialist international medical graduates (by comparing their training and the examinations undertaken) with those of an Australian-/New Zealand-trained surgeon holding FRACS in that specialty.

Initial assessment, either as a preliminary assessment of the documentation supplied or by interview by a panel (after invitation to an interview), assesses the SIMG surgeon as either substantially comparable (SC), partially comparable (PC), or not comparable (NC) to a locally-trained surgeon in that branch of surgery. Those judged SC will be asked to undergo a period of level 4 supervised clinical assessment (MBA definition¹), those judged PC will be asked to undergo an initial period of level 3 clinical assessment (followed by level 4) and pass the RACS fellowship examination.

The Australian interview panels have a representative(s) of the Specialty Training Board in the specialty in which the SIMG is being assessed, along with a representative of the RACS Board of

¹ Medical Board of Australia, "Guidelines: Supervised practice for international medical graduates", January 2016

Surgical Education and Training (BSET) and a jurisdictional representative. The recommendations of the panel are forwarded to BSET or its executive and there is a process described for those occasions when consensus cannot be reached. While there is a very well-defined process for assessing the comparability of the specialist surgical training and the exit examination of the SIMG, there is far less clarity in assessment of subsequent experience as outlined in the MBA guidelines. For example, if an SIMG's specialist training program is of lesser duration to the College program, the College must consider the training and any experience completed after training to determine comparability"².

Those SIMGs assessed as SC or PC then undertake assessments as requested, and the College has relevant policies. When all assessments are successfully completed, the MBA is notified accordingly.

Recent initiatives in College's SIMG assessment include the establishment of the International Medical Graduates Committee and expansion of the role of Clinical Director IMG Assessments and Support. The International Medical Graduates Committee met for the first time in 2017 and its duties include development and review of IMG assessment tools, oversight of the assessment process to ensure consistency, and providing recommendations to BSET for changes to the IMG assessment process. As noted under standard 1, membership of this committee includes representatives from all Specialty Training Boards, two international medical graduates who have completed the pathway, and a community representative. The role of the Clinical Director IMG Assessments and Support includes monitoring of progress and support of SIMGs.

These two recent initiatives have come about in part in response to feedback from the Expert Advisory Group (EAG) about negative perceptions of the IMG assessment pathway by applicants, and in part to achieve greater consistency in SIMG assessment across the College.

New Zealand

The College's process for the assessment of SIMGs' qualifications, training and experience so that it may provide advice to the MCNZ on eligibility for vocational registration is described in the policy, Vocational Assessment of International Medical Graduates in New Zealand. The memorandum of understanding between the College's New Zealand Board and the MCNZ describes the responsibilities and understanding of each party. The New Zealand Board delegates the assessment tasks to the New Zealand Censor's Committee. The assessments requested by the MCNZ consist of preliminary assessment on the documentation and final assessment at interview of the SIMG's qualifications, training and experience to inform the MCNZ's decision on vocational registration.

The interview panel consists of the New Zealand Censor, New Zealand chair or nominee of the relevant Specialty Training Committee/Board, one or more New Zealand chairs or nominees in another specialty and the RACS New Zealand manager or nominee. The various aspects of qualifications, training and experience are assessed as equivalent, as satisfactory, or neither "equivalent to" nor "as satisfactory as"³, and overall the SIMG is assessed as suitable for recommendation for one of the following: the supervision pathway (similar to substantially comparable in Australia); the assessment pathway (similar to partially comparable in Australia); or not equivalent. The SIMG assessments are subject to approval by the New Zealand Board, but the final decision rests with the MCNZ.

Those on the supervision pathway will provide supervision reports directly to the MCNZ. Those on the assessment pathway will have their assessment overseen by RACS, who will advise the MCNZ when it is successfully completed, according to RACS policy.

² Medical Board of Australia, "Guidelines: Good practice guidelines for the specialist international medical graduate assessment process", 2 November 2015

³ This wording reflects that of the governing Act of Parliament, (New Zealand) Health Practitioners Competence Assurance Act 2003

The College then assesses eligibility for fellowship for New Zealand SIMG surgeons as a completely separate process once vocational registration has been attained, and uses similar processes to that used for SIMG assessment in Australia. This means that for New Zealand SIMGs, there is a two-stage process and the same or similar information has to be provided twice, often years apart and significant extra cost is incurred. As fellowship is not essential for practice as a specialist surgeon in New Zealand, this has the potential unintended consequence of increasing the number of non-FRACS surgeons in New Zealand, currently approximately 13% of all vocationally registered (specialist) surgeons.

10.1.1 Team findings

RACS has a suite of policies covering all aspects of SIMG surgeon assessment in Australia and New Zealand.

Australia

The outcomes of assessment of SIMGs in Australia vary among the specialties, and for some specialties, it is rare for any SIMGs to be considered substantially comparable (SC), while for other specialties a significant proportion are considered SC. The full analysis of outcomes by specialty is detailed under standard 10.2. As all specialties follow the same overarching policies, the variation in outcomes of assessment by specialty is more likely to be a result of the application of the policy, rather than the policy per se. The most likely source of that variation is undue focus on the comparability of the training and examination process the SIMG has undertaken to the exclusion of the mitigating effect of subsequent experience. While the policies do place emphasis on the SIMG sitting a comparable examination, it states that one of the criteria for SC assessment is that the SIMGs do not need to pass an exit examination 'if the quantity, depth and scope of surgical practice in the specialty is of sufficiently high standard as to waive the need to sit the Fellowship Examination'.

For that reason, RACS could make its policies adhere to the MBA guidelines by making them more specific, changing the methods of assessing comparability, or ensuring more uniform and appropriate interpretation of the role of 'training and any experience completed after training' in SIMG assessments. This would help ensure that both training and post-training experience are appropriately considered in assessment of comparability, and not in any way suggest that vocational experience and examination completion should each be independently comparable (without considering the additional impact of post-training experience and further training in mitigating any deficiencies in initial training and examinations).

The published policies on all aspects of SIMG assessment compare the SIMG with a locally-trained surgeon and the RACS training program, and adhere to the MBA guidelines.

Discussion of the RACS appeals process is provided under standard 1.3 of this report. While there are many requests for reconsideration of SIMG assessment decisions, there are very few appeals. Despite this, there was significant negative feedback provided by SIMGs in AMC surveys and in meetings with the team. Common themes raised include: the focus of the assessment on initial training and which does not take into account post-training experience, such that almost all applicants in some subspecialties received a decision of '2 years' supervised practice and the examination no matter what their qualifications, training and experience; and a perceived lack of clarity in the standards SIMGs were judged against;

The recent initiatives of the establishment of the International Medical Graduates Committee and the expanded role of Clinical Director IMG Assessments and Support should improve SIMG assessment by overseeing the process, recommending improvements, and ensuring more uniform application of the MBA guidelines. These initiatives also have the potential to improve support for SIMGs, especially those who are struggling with the process. The team recommends that the College proceed with its plans to provide greater support for SIMG surgeons working towards specialist/vocational registration particularly.

New Zealand

The RACS policies for assessment of SIMGs in New Zealand in order to provide advice to MCNZ meet the MCNZ guidelines.

The team heard during site visits that the separation of fellowship assessment from assessment for vocational registration has had the unintended consequence of an increasing the number of vocationally registered non-FRACS surgeons in New Zealand. This has a flow-on effect on the specialist surgical workforce available for supervision and other College activities in New Zealand that require fellowship, unless RACS takes steps to either make it more attractive for this group to seek fellowship, or to allow such surgeons to take a wider role in RACS activities in New Zealand. The College may consider how it could better support surgeons without a FRACS in New Zealand who are vocationally registered.

10.2 Assessment methods

The accreditation standards are as follows:

- The methods of assessment of specialist international medical graduates are fit for purpose.
- The education provider has procedures to inform employers, and where appropriate the regulators, where patient safety concerns arise in assessment.

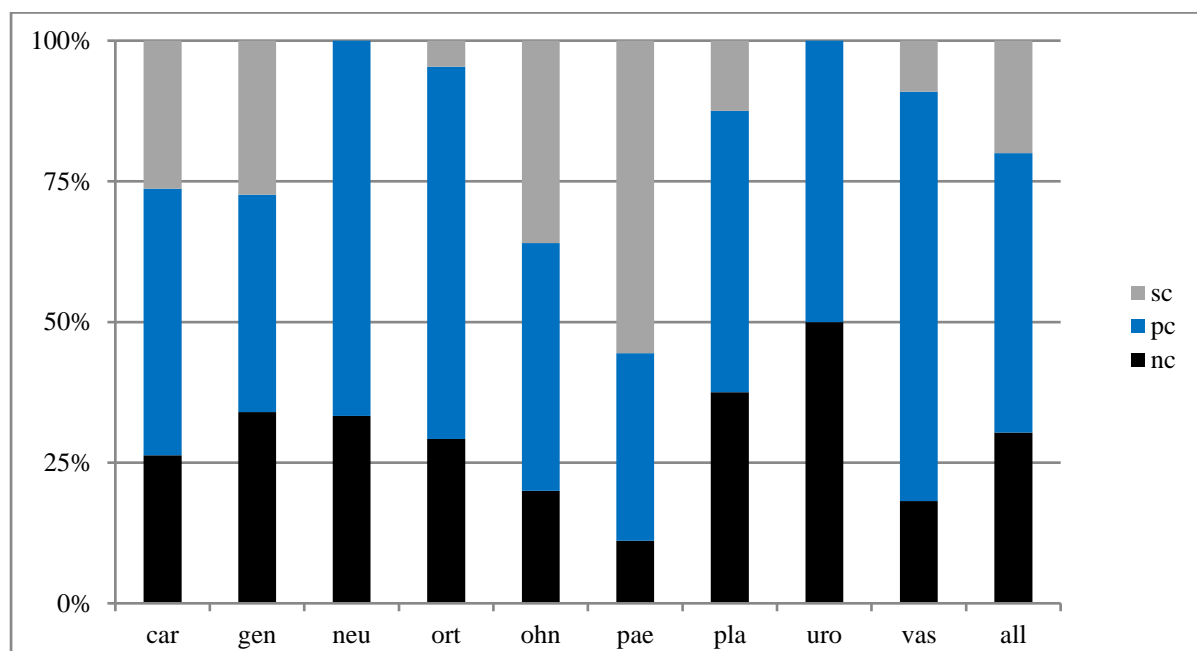
The assessment methods include assessment of comparability of the documentation supplied, followed by interview, and then clinical assessment, which may include participation in specified skills courses, activities including professional development activities and if partially comparable (PC), the fellowship examination in the relevant specialty. There is no non-examination assessment available for SIMGs assessed as PC.

Australia

The following table is a summary by specialty of the outcomes of 270 IMG applications (including the actual numbers and the percentage of SIMGs assessed in each specialty) from 2010-2015, as provided in the College's accreditation submission to AMC.

	CAR	GEN	NEU	ORT	OHN	PAE	PLA	URO	VAS	Total
NC	5	36	3	19	5	1	6	5	2	82
	26%	34%	33%	29%	22%	10%	35%	42%	15%	30%
PC	9	41	6	43	11	3	8	5	8	134
	47%	39%	67%	66%	48%	30%	47%	42%	62%	50%
SC	5	29	0	3	9	5	2	0	1	54
	26%	27%	0	5%	39%	50%	12%	0	8%	20%
For those that don't add to 100%, there are still a few in progress										

The information presented in the table above is shown below in graphical format.



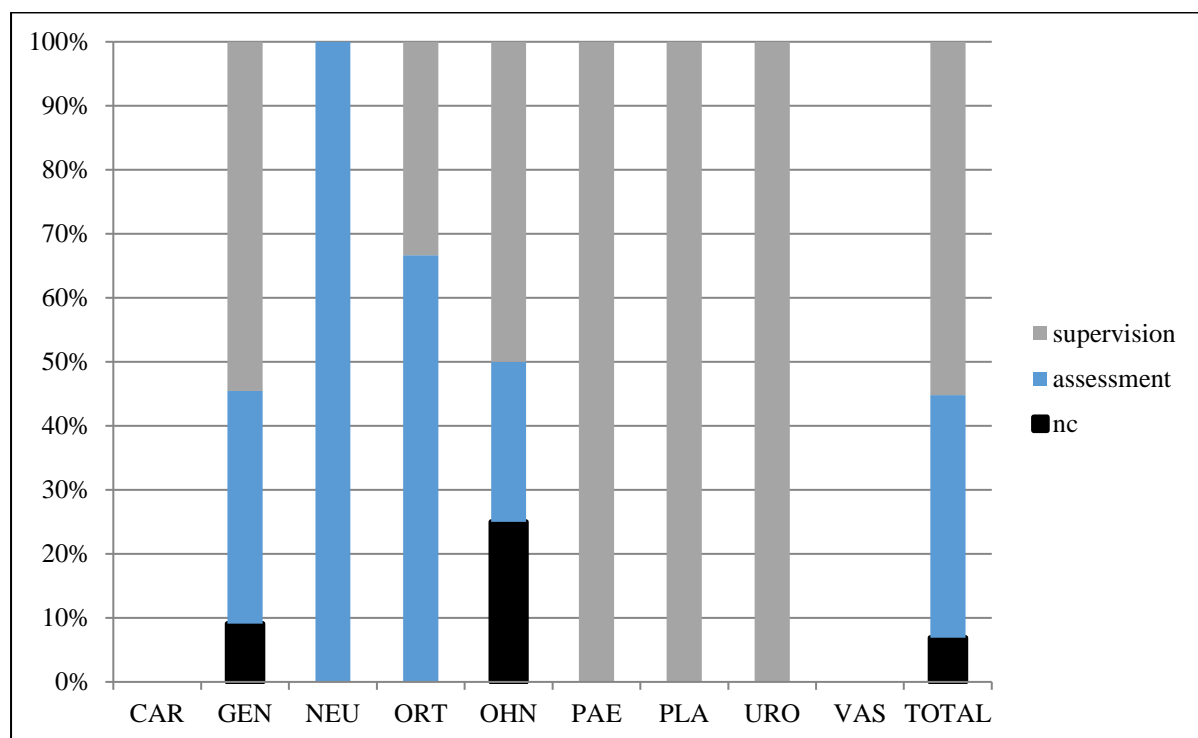
SIMG applicants in Australia come from 28 countries, although the top three countries (United Kingdom, India and South Africa) accounted for 52% of all applicants in 2016, as noted in the RACS Activities Report 2016. (In Australia in 2016, 70% of all applicants for specialist assessment by specialist medical colleges came from those three countries).

New Zealand

The following table is a summary by specialty of the outcomes of interviews of 29 IMG applicants (including the actual numbers and the percentage of SIMGs assessed in each specialty) for 2015 and 2016, as provided in the RACS Activities Reports 2015 and 2016. The 2015 and 2016 data have been combined by the AMC.

MCNZ	CAR	GEN	NEU	ORT	OHN	PAE	PLA	URO	VAS	Total
NC	0	1	0	0	1	0	0	0	0	2
	0	9%	0	0	25%	0	0	0	0	7%
Assessment (PC)	0	4	2	4	1	0	0	0	0	11
	0	36%	100%	67%	25%	0	0	0	0	38%
Supervision (SC)	0	6	0	2	2	2	2	2	0	16
	0	55%	0	33%	50%	100%	100%	100%	0	55%

The information presented in the table above is shown below in graphical format.



The data provided in the activities table for the last two years indicate a significant number (55%) are assessed as supervision pathway (equivalent to substantially comparable in Australia), with 38% being assessed as assessment pathway (equivalent to partially comparable) and the balance (7%) not equivalent. The numbers are too small to make too much of a comparison between specialties, but there does appear to be less specialty-to-specialty variation than in Australia.

Australia and New Zealand

In the event that serious concerns are raised concerning SIMG misconduct or patient safety, the College has developed procedures to inform employers. These procedures are described in the Fellowship Examination Eligibility and Exam Performance Review and IMG Misconduct policies available on the College’s website.

As part of the regular three-monthly performance review, the clinical supervisors and/or the Specialty Training Board are responsible for identifying any issues of underperformance or safety. Underperformance will result in a meeting between the international medical graduate and the supervisor/Specialty Training Board, leading to the development of a performance management plan. If a subsequent period of underperformance is identified a formal interview is held to reassess comparability.

10.2.1 Team findings

Australia

For the comparability assessment in Australia, there is considerable variation among specialties with some (Neurosurgery, Orthopaedic Surgery, Urology and Vascular Surgery) consistently finding fewer than 10% of applicants are substantially comparable to a locally-trained surgeon (detailed in the table above). While it is possible that this is affected by the inherent variability of small numbers applying in the specialties, not including the large specialty of Orthopaedic Surgery, the outcomes are consistent year by year and indicate variation in the process of comparability assessment, probably due to inadequate allowance for the mitigating effect of post-training experience, as noted above.

There is considerable reliance on the fellowship examination in the relevant specialty as the external assessment for SIMGs assessed as partially comparable, with no non-examination external assessment available. The team recommends that other assessments, such as externally provided workplace-based assessments, or the MCNZ vocational practice assessment should be developed to replace the Fellowship Examination for selected specialist international medical graduates.

The team heard negative feedback from SIMGs about the behaviour of a few of the fellows conducting the assessment interviews, with the SIMGs feeling that the interviewers were looking to 'fail' them, and were not treating them with the respect they felt they deserved as fellow specialists. The team also heard unverifiable statements from SIMGs of expressions of improper attitudes from fellows outside of the assessment process regarding the likelihood of individual SIMGs being accepted into the surgical fraternity. This behaviour would appear to be at odds with the RACS Building Respect, Improving Patient Safety (BRIPS), as detailed under standard 1.6.

New Zealand

There is less variation between specialties in assessment advice provided to the MCNZ indicating that the assessment methods for comparability are likely fit for purpose (although again there are issues with small numbers of applicants in the smaller specialties).

Australia and New Zealand

The IMG department described the processes for notifying employers, and where appropriate, the regulators, where patient safety concerns arise in assessment, which are appropriate.

10.3 Assessment decision

The accreditation standards are as follows:

- The education provider makes an assessment decision in line with the requirements of the assessment pathway.
- The education provider grants exemption or credit to specialist international medical graduates towards completion of requirements based on the specialist medical program outcomes.
- The education provider clearly documents any additional requirements such as peer review, supervised practice, assessment or formal examination and timelines for completing them.
- The education provider communicates the assessment outcomes to the applicant and the registration authority in a timely manner.

Australia

According to RACS policy, those assessed as substantially comparable are asked to undergo clinical assessment of up to 12 months duration, and to take part in professional development activities and specified skills course and activities. Those assessed as partially comparable are asked to undertake: clinical assessment for a period of up to 24 months; the fellowship examination; and professional development activities and specified skills course and activities. Those requirements are specified in communications with the SIMGs. It may be identified during clinical supervision that an international medical graduate is performing better than expected or an exceptional level. Supervisors can recommend a reduction in periods of supervision and/or waiving of other requirements, including the fellowship examination. The Specialty Training Board considers these recommendations.

New Zealand

The College's advice to MCNZ on vocational registration is completed on the agreed documentation (RGR5). The College must communicate its advice to MCNZ within three to four months of receipt of the application, if the SIMG is already in New Zealand. MCNZ then communicates its assessment decision directly to the SIMG.

10.3.1 Team findings

Australia

The policy covering assessment decisions for both pathways (substantially comparable (SC) and partially comparable (PC)) adhere to the MBA guidelines. The policies take into account the SIMG's specialist medical program outcomes, although some specialties do not take advantage of the fact that the Fellowship Examination requirements can be waived (see above).

As noted under 10.1.1, a number of SIMGs commented to the team on a lack of clarity in the basis for the assessment decision and that it did not appropriately take account of previous training and experience.

Although the additional requirements are documented in letters to the SIMGs, some reported to the team that the advice provided was not clear.

The College reports the agreed key performance indicators of the assessment processes to the MBA, which publishes them. In 2016, RACS was the only College that did not meet the requirements for the maximum duration of period of practice recommended for SC SIMGs: the standard is 12 months or less, and two RACS SIMGs assessed as SC (17% of total) were asked to undertake clinical practice of 18 months or longer. It took RACS greater than 28 days to notify five SIMGs (10% of those interviewed) of the interview outcome. These specific instances highlight times when RACS has not met the requirements of the pathway, or timeliness of notification of the SIMG of the outcome of the assessment

New Zealand

RACS advice to the MCNZ meets the requirements of the MCNZ, including that fellowship cannot be recommended as a requirement for gaining vocational registration.

10.4 Communication with specialist international medical graduate applicants

The accreditation standards are as follows:

- The education provider provides clear and easily accessible information about the assessment requirements and fees, and any proposed changes to them.
- The education provider provides timely and correct information to specialist international medical graduates about their progress through the assessment process.

Australia and New Zealand

All of the policies relevant to IMG assessment are published on the RACS website, in a specific IMG site, along with information to assist SIMGs with the assessment process and links to appropriate documentation, information and resources.

10.4.1 Team findings

Australia

While information available on the website describes the processes by which the assessment judgements are made, some SIMGs find it difficult to use this information to gain some indication of their likely outcomes, especially those who are less likely to be found substantially comparable

(SC). The amount of information available on the website may also be confusing to those SIMGs. The team recommends that the College make information available to future applicants that may allow them to assess the likelihood of their application achieving SC or partially comparable status prior to them making a substantial financial payment that historical evidence might suggest is unlikely to succeed.

There was a significant amount of negative feedback from SIMGs assessed by RACS about the total fees they are charged for their assessment. The team recommends that the College consider this along with trainee fees as discussed under standard 7.3 of this report.

There was also a significant amount of negative feedback about the lack of access to resources, such as examination revision courses, to assist SIMGs to successfully complete the SIMG assessment process. The team recommends that the College provide access to educational resources for SIMGs in the SIMG assessment process, such as examination revision courses, and other resources that are accessible to trainees. This is particularly important for those practising in rural and regional areas. While it's not the College's responsibility to find a supervised post for the SIMG, difficulty in obtaining a supervised post was consistently noted as an issue by SIMGs in the AMC survey and meetings with the team.

In relation to supervision, the team heard feedback from some SIMGs regarding the expense incurred for the period of oversight, in addition to the sporadic and intermittent nature of the supervision provided, particularly for those working in areas of need. It is important that the College ensures that supervisors are fully aware of their role and prepared for it.

New Zealand

This is dealt with by MCNZ itself.

Commendations

- Y The recent formation of the College's International Medical Graduates Committee and the expanded role of the Clinical Director of IMG assessment along with the College's plans to increase support for specialist international medical graduate surgeons.
- Z The quality of the advice provided to the Medical Council of New Zealand (MCNZ) on eligibility for vocational registration, which satisfies the MCNZ guidelines and embodies the principle that fellowship cannot be recommended as a pre-requisite for vocational registration by MCNZ.

Conditions to satisfy accreditation standards

- 34 All College and Specialty Training Board specialist international medical graduate 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)
- 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)

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)

11 Surgical Training Programs

Cardiothoracic Surgery

The Board of Cardiothoracic Surgery is responsible for the SET program in Cardiothoracic Surgery in Australia and New Zealand, reporting to the College's Board of Surgical Education and Training.

Cardiothoracic surgery is the medical specialty devoted to the surgical management of intrathoracic diseases and abnormalities. The cardiothoracic surgeon may perform surgical procedures that involve the lungs, heart, and/or the great vessels. The Cardiothoracic Surgery program provides trainees with clinical and operative experience, to enable them to manage both cardiac and thoracic conditions that relate to the specialty, including becoming familiar with the techniques related to the discipline.

As of 2016, there were 39 trainees (33 in Australia and 6 in New Zealand) in Cardiothoracic Surgery training.

The Cardiothoracic Surgery program is usually taken sequentially over a six-year period: SET 1 to SET 6 require satisfactory completion of six-month terms; and SET 2 to 6 require five years of satisfactory operative experience.

There is a minimum of 12 rotations and trainees may only stay in one institution for a maximum of two years. The specific program and assessment requirements are outlined in the RACS Guide to SET booklet and the SET Program Regulations.

New Cardiothoracic Surgery SET program regulations came into effect at the beginning of the 2017 training year.

Team findings

The team acknowledges the tragic death of Dr Patrick Pritzwald-Stegmann FRACS, cardiothoracic surgeon, during the course of this accreditation review, and the significant impact his death has had on his family, patients, cardiothoracic surgery colleagues, the RACS community and the health sector.

Cardiothoracic surgery is one of the smaller specialties in surgery. There are a number of advantages and disadvantages associated with the small size from the perspective of the trainees and supervisors.

Some of the advantages include familiarity between fellows and trainees and a high level of support and encouragement provided to trainees as they progress through the program. Some of the disadvantages include: the impact of the smaller group when a trainee is not performing well or a placement is not progressing well; and the burden of the travel requirements in order to fulfil the 12 placements. This is evidenced by the low response rates to the AMC trainee survey and feedback to the team from trainees regarding difficulties in reporting issues with placements due to the genuine fear of being identified and of retribution. Refer to standards 6.1 and 7.4 for further discussion of this issue.

The Board of Cardiothoracic Surgery reports a positive, supportive and constructive relationship with the College. The Board enjoys its position within the College and the benefits this brings including educational advice from RACS and support for the secretariat. The Board does not see any need or benefit in a more separate arrangement, such as those in place for the larger specialties.

Trainees and supervisors reported to the team generally high satisfaction with Cardiothoracic Surgery training and education. Cardiothoracic Surgery fellows are considered well trained and competent.

The Board expressed support for the Building Respect, Improving Patient Safety (BRIPS) program and the need for culture change within surgery, including Cardiothoracic Surgery. The team received feedback from trainees and supervisors about the strong need for change to be balanced with training in providing and receiving constructive criticism to ensure that high training standards are met.

The team was particularly pleased to see some evidence of flexible training being supported by the Board of Cardiothoracic Surgery, noting that this is in the context of a lack of flexible training options with the RACS specialty training program across all specialties. The team strongly encourages the Board of Cardiothoracic Surgery to actively pursue flexible training options for its trainees. Refer to standard 3.4 for further discussion of this issue.

The Board of Cardiothoracic Surgery was able to evidence acceleration through the standard timing of the SET program under a competency-based assessment framework. While the team commends the Board of Cardiothoracic Surgery on progress in this area, the Board is encouraged to undertake further work to ensure a robust competency-based assessment framework is in place, along with associated monitoring and evaluation processes.

Cardiothoracic Surgery is one of only two surgical specialties (Otolaryngology Head and Neck Surgery being the second) that is actively recruiting Aboriginal and/or Torres Islander trainees. The Board of Cardiothoracic Surgery approved a policy for selection of Aboriginal and/or Torres Islander trainees in February 2017. The team was particularly impressed with the commitment of the Board of Cardiothoracic Surgery to actively increase the number of Aboriginal and/or Torres Strait Islander trainees.

The team noted feedback that Cardiothoracic Surgery training is over-subscribed and there is resistance from trainees about specialist international medical graduates entering Australia and New Zealand and competing for a small number of consultant posts.

There are several areas for improvement for Cardiothoracic Surgery that also apply more broadly to the College and surgical specialties, as articulated under the relevant accreditation standards. The issues raised by and with trainees, supervisors and the Board of Cardiothoracic Surgery relate to: difficulty in differentiating between candidates in the selection process; safe working hours, including the perceived need for more hours to gain experience and competence, versus the same or less hours for work-life balance and safe practice; lack of cultural competence in the curriculum; the need for new fellows to undertake a fellowship or be mentored by a senior consultant in their early post-fellowship years; loss of entitlements when rotating between jurisdictions or countries; the need to review the curriculum and fully articulate program and graduate outcomes; and the need to review that appropriate facilities and educational resources are available to trainees to support self-learning activities as well as structured educational programs.

General Surgery

The SET program in General Surgery operates in Australia and New Zealand and is administered in each country respectively by General Surgeons Australia (GSA) and by the New Zealand Association of General Surgeons (NZAGS). As per the service agreements between GSA and RACS and NZAGS and RACS, these Societies provide administrative support to the Board in General Surgery (BiGS) which is the overseer of the SET program in General Surgery, and reports directly to the Board of Surgical Education and Training and the RACS Council.

General Surgery is a specialty within the discipline of surgery. The general surgeon is a surgical specialist engaged in the comprehensive care of surgical patients involving the Breast and Endocrine Systems, Trauma, Hepatobiliary, Colorectal, Upper Gastrointestinal and Surgical Oncology.

As of 2016, there were 433 trainees (374 in Australia and 59 in New Zealand) in General Surgery training.

The SET program in General Surgery is structured over a four-year curriculum: SET 2-5 in which trainees are required to satisfactorily complete 8 six-month terms in posts accredited by the Board in General Surgery. Trainees who commenced training prior to 2016 were required to complete 10 rotations. The program and assessment requirements are outlined in the RACS Guide to SET booklet and the SET Program Regulations.

Team findings

General Surgery is the largest of the surgical specialties and many of the strengths and areas for development are common to all specialties, however magnified due to the size of the discipline.

General Surgery has a dedicated pro-bono senior surgical workforce which is effectively managing a large number of trainees and this is a significant strength.

The team considers there appears to be a satisfactory working relationship between GSA and the College. However, GSA expressed concerns that there is unnecessary duplication of data between the Societies and the College, giving rise to some inaccuracies and incorrect reporting of data by the College, for example the trainee data in the Activities Report. Refer to standard 1.2 for further discussion of this issue.

There appear to be significant challenges in the communication and links between NZAGS and various Departments within the College in Australia. The team received feedback that there is limited communication from the College Departments to NZAGS and the specific issues raised include: the timeliness of communication; ability to provide feedback on policy changes; and an inability to contribute to decisions that directly affect the Societies. NZAGS is concerned that it is not able to access the information required to operate the training program, due to privacy concerns of RACS. NZAGS also has concerns about the possibility of legal challenge and is seeking indemnification by RACS for the training-related activities undertaken by NZAGS.

NZAGS states that its interaction with the RACS decision-making educational bodies is limited and that the College communicates directly with fellows, but not with the Association Executive or administrative staff. The team considers that this is an area for further development between the College and NZAGS.

In relation to the representation of specialties on the RACS Board of Surgical Education and Training (i.e. comprising the chair of each Specialty Training Board), the team heard from the BiGS that it considers this 'senate style' representation to be unrepresentative, with much smaller specialties having equal representation to the larger specialties.

In discussion with the team, General Surgery raised concerns about a lack of involvement in the development of College initiatives such as the one-day Bullying Discrimination and Sexual Harassment course, which it considered could be more effective. The BRIPS program is also a source of concern to General Surgery and these mandatory programs are considered to have significant workforce implications if all supervisors and trainers in General Surgery are required to participate. The team notes there are concerns about the lack of appropriate stakeholder engagement and buy-in in their development/implementation which is also impacting on the perceived effectiveness of these programs. The team considers there is action required by the College to improve local engagement and ownership of these programs. Refer to standard 1.2 for further discussion of this issue.

The General Surgery curriculum is regularly reviewed and contemporary. A major review of the curriculum occurs every three years. The review process includes elected surgeons considering the curriculum, reflecting on current practice and recent developments, and determining what is necessary for trainees. The team commends this regular review of the curriculum.

The BiGS was not able to provide clear graduate outcome statements, however it is in the process of defining program outcomes through entrustable professional activities and procedural-based assessments. The team considers this is an important initiative and the AMC will be interested to

receive updates on the progress of this activity. Refer to standards 3.4 and 5.2 for further discussion of this issue.

The BiGS advised that there is no specific training program that meets the needs of surgeons working in rural areas. Regarding the development of a curriculum to specifically train rural general surgeons, it is noted that while the curriculum for General Surgery encompasses colorectal, hepatobiliary, upper GI and breast surgery, it does not cover those parts of other specialties (such as Otolaryngology, Head and Neck Surgery and Urology) that are considered appropriate, and often essential, for a rural general surgeon given the urgency of the presentations and geographical limitations regarding alternative treatment options. Those who met with the team considered that the required skills would be learnt on the job. The team considers it might disincentivise rural practice if it is known that there are additional skills required of the rural general surgeon upon taking up such a role. The BiGS should consider the inclusion in the curriculum of all skills required of both a general and rural general surgeon.

The team commends the BiGS for the time, effort and consideration put into the examination processes. The team notes the significant work that has been undertaken to ensure that assessments are fair and align with the curriculum.

The efficiency in the delivery of the CPD program is considered a strength, and was commended by those fellows who met with the team.

Selection into the SET program in General Surgery is described as merit-based, and as such there is no quota system for Indigenous doctors or doctors with a rural background. As discussed under standard 7.1, this will require action.

As discussed under standard 7, it is recommended that the College develop a selection process that will enable the applicant's prevocational performance (such as surgical skills or behavioural issues) to be taken into consideration. For a large discipline such as General Surgery, there is currently a high level of dependence on the 'applicant-nominated' referees which is considered to be problematic in terms of identifying possible professional or behavioural issues. The BiGS considers that a method such as 360 degree (multi-source) feedback would not be a practical alternative with too many trainees for a single supervisor to coordinate this feedback. The team notes that multi-source feedback has been found to be a valuable tool by other specialist medical colleges.

The team considers that gender equity in General Surgery would be improved by a training structure that makes it easier for a parent with significant family responsibility to participate. The team heard varied reports on the rotation experience of trainees. In general, the trainees in larger jurisdictions reported to have sufficient training posts to enable them to rotate within a hub in the state, whereas smaller jurisdictions require more significant movement of trainees to experience the full training experience. In contrast to the smaller disciplines, the team considers that rotations to distant locations might not always be required to achieve sufficient diversity in training in General Surgery.

The team heard that the regional committees try to meet individual trainee needs (for example family) in relation to their training rotations. Specific direction from the College in the form of principle-based policy from which General Surgery regulations can be developed, is likely to encourage those with a family contemplating General Surgery but currently uncertain about the manageability of distant rotations. The team considers that training credit for periods less than six months on a pro-rata basis is needed for those taking parental leave during a training period. Part-time training should be readily achievable in General Surgery, particularly given the larger numbers of trainees than other disciplines. The team considers that this issue requires attention. This discriminates against a parent with significant family responsibilities contemplating general surgical training. Refer to standard 3.4 for further discussion of this issue.

The team heard that some general surgeons (for example, those with an interest in breast surgery) are not participating in general surgery after-hours rosters. It is a key workforce

requirement that a sufficient quantity of general surgeons fulfil the general surgery after-hours roster requirements of a typical hospital in Australia or New Zealand. Many general surgeons focus on specific areas of practice, such as breast surgery, which makes them unsuitable for general surgery on-call rosters. The team notes that this is something that likely needs consideration by hospital administration in terms of ensuring general surgeons maintain their general skills.

Neurosurgery

The administration and management of the SET program in Neurosurgery is delegated to the Neurosurgical Society of Australasia (NSA) in accordance with the Service Agreement. The SET program in Neurosurgery operates in Australia, New Zealand and Singapore. The Board of Neurosurgery has dual reporting roles and represents both the College and the NSA on all matters relating to the training program.

Neurosurgery provides for the operative and non-operative management of disorders that affect the central, peripheral and autonomic nervous system, including their supportive structures and vascular supply. This includes prevention, diagnosis, evaluation, treatment, critical care and rehabilitation as well as the operative and non-operative management of pain. Neurosurgery encompasses disorders of the brain, meninges, skull and their blood supply including the extracranial carotid and vertebral arteries, disorders of the pituitary gland, disorders of the spinal cord, meninges and spine, including cranial and peripheral nerves.

As of 2016, there were 46 trainees (41 in Australia and 5 in New Zealand) in Neurosurgery training.

The Neurosurgery training program is structured on a three-level sequential curriculum over a minimum of five years and a maximum of nine years: Basic Neurosurgical Training (1-2 years); Intermediate Neurosurgical Training (3-4 years); and Advanced Neurosurgical Training (1-3 years).

Trainees must rotate through a minimum of four training units during their SET program. This will often include two different jurisdictions. The specific program and assessment requirements are outlined in the RACS Guide to SET booklet and the SET Program Regulations.

Team findings

The team is of the view that Neurosurgery is a well-organised specialty with a clear sense of direction.

The Board of Neurosurgery has clearly paid considerable attention to its curriculum and the structure of training, in particular the three-level sequential aspect of the curriculum. The team considers that the Board of Neurosurgery is further advanced in outlining its program and graduate outcomes than many of the other surgical specialties. The team commends the Board for its progress while noting that this important work must be finalised.

The selection process in Neurosurgery includes performance in the Generic Surgical Sciences Examination and the Anatomy Examination, and assessment of the CV as well as referee reports. From these inputs up to 24 applicants are selected annually for interview. Trainees responding to the AMC survey agreed that criteria for selection into the program are clear and that the selection process follows the published criteria.

The practice undertaken by Neurosurgery to interview all referees for applicants for training, rather than depend on the written referee report, was highly commended by the team, especially given the issues identified in review of written reports for other specialties.

The Board indicated that the paucity of applicants from Queensland, South Australia, Northern Territory and New Zealand is of concern, particularly since trainees tend to stay or return to their state of origin. The team was advised that the Board of Neurosurgery is examining why applicants

are not applying from the above regions. It also intends to approach the Australian Indigenous Doctors' Association regarding the barriers for Aboriginal and/or Torres Strait Islanders in applying for Neurosurgery training. The team encourages the Board to progress this work as discussed under standard 7.1.

The issue of diversity of trainees and flexibility of training was a recurrent theme across all specialties. In the additional information from the College provided to the team, the team noted that there were no Neurosurgery trainees undertaking part-time training and only four on interrupted training. Trainees reported in the AMC survey that given the demanding requirements for training in Neurosurgery, flexible training is not an option. The Board of Neurosurgery needs to reconsider these issues in depth and in light of the team's overall assessment regarding selection, diversity and flexibility of training.

There is a minimum of four rotations required of trainees in Neurosurgery, compared to eight rotations in a number of other specialties. To gain the required breadth of experience, a number of trainees may have to spend up to 12 months outside their region. The team was advised that trainees know by June or July their rotations for the following year, a relatively good standard of practice, although the team encourages the College to develop a practice whereby trainees are given a plan for their rotations at the commencement of their training program. Refer to standard 8.2 for further discussion of this issue.

According to the AMC survey, both trainees and supervisors are satisfied with the process of supervision.

The Board of Neurosurgery advised the team that no specialist international medical graduate has been recognised in Australia as substantially comparable to an Australasian neurosurgeon, although one of the respondents to the AMC's survey of specialist international medical graduates identified themselves as such. This contrasts with other specialties where up to one third have been assessed as substantially comparable.

Comments made by the six Neurosurgery respondents to the AMC specialist international medical graduate survey were varied. Even though their experiences of the assessment process varied, the issues mirrored the experiences of specialist international medical graduates across the College. The discussion under standard 10 regarding the need to consider experience of both training and post-training experience in the assessment of comparability has particular relevance for Neurosurgery.

Orthopaedic Surgery

RACS has devolved the delivery, administration and management of the SET program in Orthopaedic Surgery in Australia and New Zealand to the Australian Orthopaedic Association (AOA) and the New Zealand Orthopaedic Association (NZOA) respectively.

Orthopaedic Surgery is defined as the medical specialty that focuses on the diagnosis, care and treatment of patients with disorders of the bones, joints, muscles, ligaments, tendons, nerves and skin. These elements make up the musculoskeletal system. The surgeons who specialise in this area are called Orthopaedic Surgeons. Orthopaedic Surgeons are involved in all aspects of health care pertaining to the musculoskeletal system. They use medical, physical and rehabilitative methods as well as surgery.

As of 2016, there were 280 trainees (234 in Australia and 46 in New Zealand) in Orthopaedic Surgery training.

In Australia and New Zealand, the current program in Orthopaedic Surgery is structured over a five-year period. In certain circumstances, training may be completed in four years. Trainees must complete a minimum of eight rotations. The program and assessment requirements are outlined in the RACS Guide to SET booklet and the SET Program Regulations in New Zealand and AOA policies and Progression Requirements in Australia, according to the delegations of the

AOA/RACS Service Agreement. AOA has spent several years developing a new AOA 21 curriculum for introduction in 2018.

Team findings

The College has devolved autonomy for the program in Orthopaedic Surgery to AOA through a service agreement, whereas NZOA has a partnering agreement, and is more closely aligned to the College. The NZOA Annual Report shows evidence of this close relationship with the College and how RACS initiatives are melded with those of NZOA. The AOA and NZOA Presidents report they meet regularly.

A regular interaction between AOA and the College occurs at the Board of Surgical Education and Training. AOA seeks more involvement in College governance. The team heard from stakeholders that the interface issues between AOA and the College have a negative impact, in particular relating to the lines of accountability for training not being sufficiently clear. The team considers the governance arrangements between the College and AOA are unwieldy and could be better harmonised. The discord between the AOA and the College was clearly expressed to the team by the AOA and is also evident to trainees, as commented by some of them in the AMC survey. Such disharmony does not reflect well on either the AOA or the College.

The team commends the AOA on its Reconsideration, Review and Appeals Policy which could serve as a well set-out example for the College. Refer to standard 1.3 for further discussion of this issue.

The team commends the new curriculum, AOA 21, which has been developed with external consultation, including an educational expert. It has a strong underlying pedagogy. AOA 21 was launched in 2017 for introduction in 2018. Instead of five one-year stages, AOA 21 will have three key phases of training comprising: Introduction to Orthopaedics (approximately 12-18 months); Core Orthopaedics (approximately 36 months); and Transition to Consultant Practice (approximately 12 months). The first phase will focus on foundation (non-technical) and trauma competencies. There will be barrier assessments at the end of each phase where progression decisions will be made based on a programmatic assessment framework. In the third phase, there will be a stronger focus than previously on preparedness for practice.

The curriculum for AOA 21 has not been approved by the College nor does AOA intend to seek approval as it considers its Service Agreement with the College provides it with autonomy to make such decision about the program. In relation to the New Zealand program, beginning at the commencement of the strategic education review in 2012 leading up to the design of AOA 21 and continuing until present, AOA made offers to the NZOA to join AOA 21, but cost has been an issue for NZOA. The NZOA is utilising AOA's previous curriculum, which was developed before 2011 and is watching progress before committing. In feedback on the draft accreditation report, it was reported that NZOA has advised that it would like to adopt AOA 21 Curriculum and other aspects of AOA 21 and planning is now underway.

The current Orthopaedic Surgery curriculum outlines outcomes across the nine RACS competencies and these have been mapped to both assessment and stages of training. Trainees in Australia and New Zealand report expectations are very clear.

There are no specific cultural competence learning outcomes or assessments in the previous AOA curriculum, this has been addressed in the AOA 21 Curriculum, which includes Cultural Awareness and Sensitivity in the Advocacy section. Further, it is suggested that addressing the health needs of Indigenous peoples could feature more explicitly in the purpose statements of both AOA and NZOA.

There are several differences between the Australian and New Zealand programs. As noted above, from 2018, the curricula will be different as AOA rolls out AOA 21, and the selection processes are slightly different. The team does not view this as an issue as long as there is alignment of selection criteria, the graduate learning outcomes, and the expectations of the College. The

Fellowship Examination remains common at present and New Zealand has a very high pass rate in the examination.

The team commends both AOA and NZOA for mentioning community and patients in their mission statement. 'The AOA is the peak professional body in Australia for advancing excellence of orthopaedic practice in the interests of patients and the community, and in the training of surgeons to world-class standards'. The NZOA has on its website 'Promoting excellence in patient care and advocating for the needs of patients with orthopaedic conditions.'

The ratio of trainees to supervisors is low in Orthopaedic Surgery, often 1:1, and no more than 2:1 in Australia and 6:1 in New Zealand. This is considered a strength of the training program.

Once a trainee has completed their training, it is intended that they will be able to work unsupervised as an Orthopaedic Surgeon. Stakeholders uniformly praised the level of technical expertise of newly qualified Orthopaedic Surgeons. That said, Orthopaedic Surgery trainees met by the team indicated that they would graduate with major gaps in their training, almost all of whom included procedural skills as one such gap.

Other observations made by some trainees relate to the fees they are required to pay to the College, the value and benefit of which is not apparent to them, in particular given that the AOA delivers the training program. Under standard 7.3 of this report, the need for transparency of the fee-setting process is recommended which applies equally to Orthopaedic Surgery.

While diversity and equal opportunity are mentioned by AOA in policy, there is little evidence of this in the trainee complement. Likewise, the NZOA website might mention more on diversity and inclusion.

Very few trainees have worked part-time, with a few more having interrupted their training. This remains an issue for the College in general but the accreditation process of training posts by the specialties, including Orthopaedic Surgery, does provide an opportunity for dialogue between the specialty and the hospital system for the benefit of trainees. The team considers that the Training Committee/Board must do more with jurisdictions to promote flexible training.

While the rules state that if a trainee has more than six weeks off in a six-month rotation that rotation is not counted as valid, the team heard this could be discretionary, and that decision making around this is not transparent. The AOA and NZOA are encouraged to consider this issue in the broader context of addressing the barriers to flexible training.

The AMC trainee survey indicated that some Orthopaedic Surgery trainees have real issues to raise about their training and supervision experiences, and the specialty should consider how it improves support for such trainees. Refer to standard 7.5 for further discussion of this issue. The team was reassured that the specialty is taking seriously the RACS BRIPS program and this is to be commended and must be sustained.

The issues concerning specialist international medical graduate assessment for eligibility for specialist registration in Australia and entry to fellowship are covered in detail under standard 10. Of particular relevance to Orthopaedic Surgery is the emphasis on judging an experienced specialist international medical graduate by an examination rather than by observed experience and patient outcome (with only 5% recommended as substantially comparable). The survey of Orthopaedic Surgery specialist international medical graduates provided much negative comment and dissatisfaction about the process they were undertaking. There were allegations (not uniformly expressed) that the process was unclear, unfair, costly, and that the emphasis on judging an experienced specialist international medical graduate by an examination rather than solely by observed experience and patient outcome was misplaced. The team was informed by the chair of the AOA Federal Training Committee that the Committee is of the view that the UK orthopaedic examination is not to the same standard as the Australasian examination. Both the College and the AOA should heed the conditions and recommendations detailed under standard 10.

However, it should be noted that the New Zealand Board of Orthopaedic Surgery's recommendations to MCNZ on eligibility for vocational registration in Orthopaedic Surgery are more consistent with the need to take into account the mitigating effect of post-training experience (with 33% being recommended for supervision pathway).

Otolaryngology Head and Neck Surgery

The SET program in Otolaryngology Head and Neck Surgery is administered in Australia conjointly by the College and the Australian Society of Otolaryngology Head and Neck Surgery (ASOHNS), and in New Zealand conjointly by the New Zealand Society of Otolaryngology Head and Neck Surgery (NZSOHNS) and the New Zealand office of the College.

Otolaryngology head and neck surgeons investigate and treat conditions of the ear, nose, throat, and head and neck, such as nasal and sinus conditions, snoring and breathing problems, tonsillitis, cancers of the head and neck including thyroid surgery, voice problems, plastic surgery of the nose and face, hearing difficulties and deafness, and tumours of the head, neck and ears.

As of 2016, there were 88 trainees (72 in Australia and 16 in New Zealand) in Otolaryngology Head and Neck Surgery training.

The program in Otolaryngology Head and Neck Surgery is conducted over a minimum of five years. All training terms are six months in duration. Trainees are required to satisfactorily complete a minimum of 10 six-month accredited clinical rotations, unless the Board of Otolaryngology Head and Neck Surgery approves recognition of prior learning or early completion of training. The program and assessment requirements are outlined in the RACS Guide to SET booklet and the SET Program Regulations.

Team findings

The Board is 18 months into a review of its curriculum, considering its effectiveness in meeting training program outcomes. As part of this review, the Board is planning to transition to a competency-based curriculum. Several specialties now outline expected standards of performance at particular stages, a move away from time-based training. Otolaryngology Head and Neck Surgery is introducing minimum and maximum periods of time in which competencies at each level must be achieved. The ability to alter the program in a flexible manner according to the trainee's ability is considered an important initiative.

The Board is developing nine key skills as part of the curriculum, including cultural competency. The Board of Otolaryngology Head and Neck Surgery is developing a specific Aboriginal and Torres Strait Islander and Māori curriculum module to ensure the health needs of these groups are being addressed. A copy of the draft module was provided to the team. The team commends the Board for the inclusion of cultural competency as a core part of the curriculum.

There are currently no defined graduate outcome statements, and this is an area that is being considered in the curriculum review. It is planned that the new curriculum will be used to measure teaching and assessment outcomes.

The expected implementation date for the new curriculum is February 2018. The team commends the Board for embarking on this review. The development of graduate outcome statements and the implementation and evaluation of the curriculum will be areas of interest to the AMC in future reporting. Refer to standards 2.3 and 3 for further discussion of these issues.

The Board indicates that most rotations are 12 months, with some being six months. There are also interstate rotations. The training experience of each of the rotations is quite different as each hospital has a particular subspecialty, although some hospitals have a general spread of patients. New South Wales has the biggest spread in terms of rotations. The Board reported that while it tries to accommodate and relocate trainees in their home state, there was some question regarding whether this is advantageous in terms of training continuity.

While the Board is commended for the planned innovative approaches in providing a more flexible program for trainees, the current lack of flexibility within the program requires further attention. The AMC survey indicated that most trainees strongly disagree that part-time posts are available within their training site. Trainees expressed concerns that part-time training is difficult to access, and felt that it may reflect badly in their assessments.

The survey of trainees also indicated there seems to be no flexibility in the rules around the length of time that can be missed from a rotation. The College's policies on interrupted training state that this can only occur in six-month blocks that align with the prescribed College 'terms'. This means that if a trainee requires interruption outside of these periods, they are required to take longer time off training than requested, i.e. 12 months instead of six months. The team has heard that this is hugely disruptive for both training and overall mental health and wellbeing. This is an area that requires further attention from the College and the Board. Refer to standard 3 for further discussion of this issue.

The team was informed of a proposal by the New Zealand chair of the Board of Otolaryngology Head and Neck Surgery to amend the current rules to make the interruption rule more 'user-friendly'. The team considers this proposal should be shared with other surgical specialties.

The team notes that the Board is considering an increase in procedural-based assessment and assessment by direct observation. This may increase the workload of supervisors, the impact of which will need continued monitoring to ensure the assessment is being implemented as expected, and not placing an unrealistic burden on supervisors.

The team notes that Otolaryngology Head and Neck Surgery is the only surgical specialty to date that has implemented changes to support entry of Aboriginal and Torres Strait Islander doctors to surgical training. In 2017, a training position will be prioritised for Indigenous doctors who meet the minimum standards for interview. Otolaryngology Head and Neck Surgery is commended for this initiative and it is hoped other boards will follow this lead in future selection rounds. Refer to standard 7.1 for further discussion of this issue.

As discussed under standard 8.2, the Board also supports training and education opportunities in diverse settings aligned to the curriculum requirements, including rural and regional locations, and settings which provide experience of the provisions of health care to Aboriginal and Torres Strait Islander peoples in Australia and/or Māori in New Zealand. This is a significant strength of the specialty.

Trainees undertake outreach visits which provide experience of the provision of health care to Aboriginal and Torres Strait Islander peoples in Australia and/or Māori in New Zealand. These outreach clinics include: Deadly Ears Program – Queensland; Kimberley Region Outreach Clinics – Western Australia; Yatala Outreach Clinic – South Australia. The team commends this program and recommends other specialty training programs may also wish to consider implementing a similar program.

The team heard that there are currently no trainee representatives on some of the regional Otolaryngology Head and Neck Surgery training committees. As this is a forum in which many significant discussions take place regarding rostering and movement between rotations, trainees consider it is important that there is adequate representation and input into these discussions. This is an area for further consideration by the specialty. Trainee engagement and input into discussions regarding the flexibility of the training program is required.

Paediatric Surgery

The Board of Paediatric Surgery is responsible for the delivery of the SET program in Paediatric Surgery in Australia and New Zealand, reporting to Board of Surgical Education and Training.

Paediatric Surgery is defined as the specialty that includes surgeons who have specialist training in the management of children (usually up to the age of about 16 years) who have conditions that may require surgery. Specialist paediatric surgeons normally deal with non-cardiac thoracic

surgery, general paediatric surgery and paediatric urology. Their responsibilities include involvement in the antenatal management of congenital structural abnormalities, neonatal surgery and oncological surgery for children.

As of 2016, there were 31 trainees (28 in Australia and 3 in New Zealand) in Paediatric Surgery training.

The Paediatric Surgery program is structured over a seven-year sequential curriculum in four phases: SET 1 (12 months), Early SET (24 months), Mid SET and Senior SET (8 six-month rotations). The specific program and assessment requirements are outlined in the RACS Guide to SET booklet and the SET Program Regulations.

Team findings

As a small specialty, Paediatric Surgery takes advantage of its size to keep closely in tune with its trainees. Trainees appear to be comfortable approaching the chair of the Specialty Training Board when issues or concerns arise. The Board of Paediatric Surgery has actively engaged with its trainees individually and through its trainee representative who is a full and respected member of the Board. The annual Registrar Training Seminar, which is compulsory for all active trainees, is an excellent opportunity to bring the Board into contact with all trainees and to stay abreast of their current issues.

A small specialty can have advantages, but also potentially makes it more difficult for trainees to safely and confidentially report bullying or poor behaviour within such a small network of trainees and supervisors. The Board should consider, in conjunction with the College's complaints process, developing a safe and completely confidential process for identifying and addressing poor behaviour within the specialty, ideally at an early stage. The Board must be cognisant of the fact that there is still significant fear and stigma attached to raising concerns about the behaviour of other surgeons (particularly senior surgeons and supervisors) or acknowledging personal difficulties that may be perceived as weaknesses. Refer to standards 6.1 and 7.4 for further discussion of this issue.

SET 1 trainees are closely supervised and assessed within the Paediatric Surgery program throughout the first year (fixed assessment program). This is a relatively recent change which allows for the early identification of possible weaknesses or potential unsuitability of trainees. If problems are identified, there is an opportunity to establish a performance management plan to address concerns in a timely way. The quarterly review of trainee assessments by the Board also enables it to keep a close eye on trainee progress.

Trainees are encouraged by the Board to complete the same RACS training courses as the Paediatric Surgery supervisors (for example, the Keeping Trainees on Track (KTOT)), Foundation Skills and Supervisors and Trainers in Surgical Education and Training (SATSET) courses). The Board Chair even became a trainer for one of the training modules in order to give his trainees access to this course at low cost and quickly. This has helped trainees understand and take a more mature role in seeking and accepting feedback. The Board also considers it will help trainees to be proactive in addressing concerns with their supervisor or other colleagues before they reach the level of a complaint. The Board would like to see access for trainees to attend the fellows training courses which it considers will enable trainees to become both better students and teachers.

Paediatric Surgery currently relies on training posts and hospitals to provide training in cultural competence rather than mandating or providing any training or support of their own. The Board should highlight the essential nature of these skills by mandating that each trainee receives cultural competency training during the program. Refer to standard 3.2 for further discussion of this issue.

Paediatric Surgery is heavily invested in the BRIPS program and its outcomes which is commended by the team. The specialty advocates for improvement in training conditions for

women surgeons. The team commends the innovative proposals to address the issue of parental leave inequities or loss due to mandatory interstate training moves in mid and senior SET. This issue of parental leave loss is an example of the kind of concerns the College will need to tackle if it is fully committed to addressing and eliminating the barriers for women entering and staying in surgery.

The team considers that the Board needs to address the barriers to flexible training at the hospital-level, by considering the imposition of conditions on training posts, rather than expecting the trainee to negotiate individually. Given there are more training posts than trainees, it would seem to be an opportunity to push harder for this much-needed change. The team commends Paediatric Surgery for the flexible position about to be created at Gold Coast Hospital. The Board should continue to actively show its support for the creation of flexible training posts and for seeing flexible training become a more common reality, keeping in mind that there is still a high-level of fear associated with asking for or pursuing this option. It might be helpful for the Board to consider easing the strict requirement that applications for flexible training must be made no less than six months prior to the commencement of the rotation; it can be challenging to forward plan pregnancies and other unexpected personal issues that might impact on full-time training.

The Board is committed to a move towards competency-based training, a process which is nearly complete. The team encourages the Board to finalise the paediatric surgical assessment form which will include the full list of competencies required and when trainees are expected to achieve them. This transparency and outlining of clear expectations is essential for competency-based training and will allow those who achieve the competencies to finish training more quickly. Competency-based training will also provide greater possibilities for flexible training posts by allowing trainees to take family or other leave, outside of the currently very rigid six-month scheduled blocks, without losing credit for training time. Refer to standard 3 for further discussion of issues relating to the structure of the curriculum including flexible training.

As discussed previously, Paediatric Surgery was the first of all Specialty Training Boards to invite a community representative on to its Board. This has been very positive, providing a unique and useful external perspective for discussion and decision making for the Board. The Board is commended for its commitment to the ongoing presence of a community member on the Board. To build on this success, and leadership within the broader College, the Board is encouraged to develop a more formal process for selection and ongoing support and training for this role. Ideally, this will be done in conjunction with the College who should be developing College-wide resources and support for representation by consumers and community. While individual consumer representation is very useful, the Board is also encouraged to consider structured mechanisms for collecting feedback from a broader group of external stakeholders. The Board's initial outreach to the Cystic Fibrosis and Pull-Thru Network organisations is a commendable start and should be continued and expanded to include other health consumer groups, in order to gain a better understanding of community views and expectations of the Paediatric Surgery training program. Refer to standards 2 and 6 for further discussion of this issue.

Plastic and Reconstructive Surgery

The SET program in Plastic and Reconstructive Surgery is administered and overseen in Australia by the Australian Society of Plastic Surgeons Inc. (ASPS) and in New Zealand by the New Zealand Association of Plastic Surgeons (NZAPS). As per the service agreements between the ASPS and RACS and NZAPS and RACS, the Societies respectively provide administrative support to the RACS Australian Board of Plastic and Reconstructive Surgery and the RACS New Zealand Board of Plastic and Reconstructive Surgery. Both specialty boards report to the Board of Surgical Education and Training.

Plastic and Reconstructive Surgery is defined as a wide-ranging specialty involving manipulation, repair and reconstruction of the skin, soft tissue and bone. Plastic Surgery is a specialty not

restricted to one organ or tissue type. The main emphasis is on maintaining or restoring form and function, often working in a team approach with other specialties.

As of 2016, there were 96 trainees (80 in Australia, 15 in New Zealand, and one from overseas) in Plastic and Reconstructive Surgery training.

Plastic and Reconstructive Surgery trainees who begin training at SET 1 are expected to complete five years of training. Each year of training is divided into two surgical terms. Trainees must complete a minimum of ten rotations (each of six months full-time equivalent clinical training time). Trainees are rotated through a minimum of four training units during the program. This will often include two different jurisdictions in Australia and in New Zealand and always involves at least two cities. The program and assessment requirements are outlined in the RACS Guide to SET booklet and the SET Program Regulations.

Team findings

The Australian Board of Plastic and Reconstructive Surgery and New Zealand Board of Plastic and Reconstructive Surgery Boards each report a good relationship with the College. The relationship between the Australian and New Zealand Boards is very collegial. The New Zealand Board notes that since there has been a separation between them, small irritants have been removed from the relationship.

The two Boards have the same curriculum and examinations. The Boards are in the midst of a significant curriculum review, with a proposed change to a competency-based curriculum in 2019. The examples of the new competency-based curriculum, provided to the team in draft form for facial and breast surgery, set out the expectations of trainees by SET phase (early, mid and late) to guide trainees in their learning. The revised curriculum will incorporate entrustable professional activities to foster trainees' development of an increasing degree of independence in relation to learning. Consultation on all modules will take place in 2018. The team considers it would be appropriate to review the curriculum once it is finalised (with a target set for 2019).

The current curriculum has little on cultural competence; while there are plans to incorporate content on cultural competence into the new curriculum, the team was left with the impression that this would link mainly to the communication competency rather than to all RACS competencies. Refer to standard 3.2 for further discussion of the inclusion of cultural competence content in the curriculum.

There is currently a deficit in the experience available to trainees with regard to aesthetic surgery which is a significant part of plastic and reconstructive surgery practice, but not often available in public hospitals. Currently the training sites have difficulty providing aesthetic surgery experience for their trainees, and so those graduating from the training program will have a gap in this area of practice. This is discussed in further detail under standard 4.

The presence of post-fellowship fellows within the hospital can decrease clinical experience of other trainees. The team heard this varies from hospital to hospital.

Although the training program is five years in duration, trainees can spend many years trying to enter the program, which results in the effective lengthening of the training program. The introduction of competency-based training will help by allowing those who achieve the competencies to finish training more quickly.

The team noted that trainees have very limited opportunities for flexible training. There is no part-time training available and there is a limited number of trainees in interrupted training, with restrictive rules for interrupted training similar to the other specialties. The team notes that while the Boards are working to remove some of the barriers to flexible training, further work is needed. Refer to standard 3 for further discussion of issues relating to the structure of the curriculum including flexible training.

The Australian and New Zealand Boards are enthusiastic about the BRIPS program, and consider it has made a difference, especially in regional areas. The Boards consider that the cultural change is occurring, but needs to continue, as not all fellows have insight into their behaviour. The team heard that accreditation of training posts has been withdrawn due to issues of bullying and harassment, which is to be commended. The team noted the need for protection for 'whistle-blowers'. Refer to standard 7.5 for further discussion.

The team heard that trainees often work a one in two on-call roster, with fatigue a potential issue. The Boards reported that while rest periods are organised, they may be somewhat ad-hoc and are usually employer driven. Refer to standard 8.2 for further discussion.

Urology

The new Surgical Education and Training (nSET) program in Urology is administered by the Urological Society of Australia and New Zealand (USANZ). The College collaborates with the USANZ, as an agent of RACS, to administer the program. The Board of Urology has oversight for the conduct of the training program in Australia and New Zealand, reporting to the Board of Surgical Education and Training.

Urology is defined as the medical specialty dedicated to the treatment of men, women and children with problems involving the kidney, bladder, prostate and male reproductive organs. These conditions include cancer, stones, infection, incontinence, sexual dysfunction and pelvic floor problems. Urologists prescribe and administer medications and perform surgical procedures in the treatment of disease or injury.

As of 2016, there were 104 trainees (92 in Australia and 12 in New Zealand) in Urology training.

The nSET program in Urology commenced in 2016 replacing the previous six-year program. The nSET program is structured over a five-year sequential curriculum. The five stages are as follows: nSET 1 (core surgery general skills), nSET 2 (first year advanced clinical urology training); nSET 3 (second year advanced training); nSET 4 (third year advanced training); nSET 5 (senior registrar level). Trainees must complete five 12-month rotations. The program and assessment requirements are outlined in the RACS Guide to SET booklet and the SET Program Regulations.

Team findings

Urology has very capable leadership and has produced comprehensive documentation as part of this AMC accreditation. The Board of Urology appears to be acutely aware of possible directions for improvement and strives to select the best trainees and deliver a high-quality training program. The Board successfully interacts with other surgical specialties and notably has flagged the Orthopaedic Surgery curriculum as a framework on which to further develop its own curriculum.

The Board acknowledges the need for curriculum development and, in particular, the need to better define program and graduate outcomes. As in all specialties, the former is more difficult because of varying rotations of the trainees: that is, one trainee may be exposed to a strong cancer centre in SET 2 and another might not get that rotation until later in training. However, urgently required is a more detailed and accurate definition of the scope of practice of an urologist on the day he/she is awarded fellowship. This will not only be of assistance to hospital credentialing bodies but will also more precisely guide both training and assessments. A timetable for this curriculum development is required as it appears to be currently somewhat 'open-ended'.

The Board of Urology is very aware of the critical importance of trainee selection and the inappropriateness of research being a key discriminator. The Board appears keen to explore avenues to ensure those trainees that are selected have all the necessary aptitudes for a career in Urology – both technical and professional.

There is wide recognition within the specialty that selection of trainees with the necessary attributes is critical to delivering the best urological care to the community. All disciplines within

the College and all specialist medical colleges struggle to translate performance in the workplace prior to selection into the selection process. The difficulty can largely be attributed to non-discriminating referee reports – almost always scored to a high level and seemingly regardless of what wording is used in the assessments. The Board is encouraged to look at collective referee reports from the place of work, coordinated by the local urologists as a collective but considering feedback from multiple sources including other junior colleagues and non-medical staff. Imperative in such a ‘global assessment’ would be an appraisal of inherent technical ability. Refer to standard 7.1 for further discussion of this issue.

The team considers that there is a need to increase the ‘efficiency’ of training so that the current high standard of the graduating surgeon can be accomplished within safe working hours. This must occur without prolonging either training or prevocational training. Feedback from Urology training supervisors highlighted the conflict that often arises between clinical service demands and training. The Board of Urology should look at strategies to ensure that training is achieving the correct priority in the workplace and that supervisors are not conflicted such that clinical service delivery receives an emphasis that compromises training. Refer to standard 3 for further discussion of this issue.

Urology currently uses multi-source feedback (MSF) only for the trainee in difficulty. There is a perception that wider use would produce an excessive load on the training supervisors. As there is mostly only 1-3 trainees for each training supervisor, the team considers that MSF assessment is logistically plausible as a regular routine training assessment (e.g. annually) and would provide valuable early feedback to the trainee regarding their broader ‘professional qualities’ and how they are perceived by both colleagues and other health professionals with whom they interact. Refer to standard 5.3 for further discussion of this issue.

The assessment processes are particularly well developed, again with strong leadership from the Chair of Examiners and a dedicated pool of Urology examiners for the Specialty Surgical Sciences Examination and Fellowship Examination. Parts of the Fellowship Examination were observed by the team and were conducted to a very high standard.

The structure of the program appears inherently fair to trainees with respect to being able to train mostly within a single region and rotations are general 12-monthly within that region. Handover takes place between supervisors of training within each region as trainees rotate across the training sites.

Vascular Surgery

The College collaborates with the Australian and New Zealand Society for Vascular Surgery (ANZSVS), as an agent of RACS, to administer the SET program in Vascular Surgery. The Board of Vascular Surgery has oversight for the conduct of the training program in Vascular Surgery, reporting to the Board of Surgical Education and Training.

Vascular Surgery is defined as a specialty of surgery in which diseases of the vascular system, or arteries and veins, are managed by medical therapy, minimally-invasive catheter procedures and surgical intervention and reconstruction.

As of 2016, there were 46 trainees (41 in Australia and 5 in New Zealand) in Vascular Surgery training.

The program in Vascular Surgery is structured over a five-year sequential curriculum in posts accredited by the Board of Vascular Surgery. Trainees must complete 10 six-month rotations at different accredited training posts. Trainees are allocated to a single training post for two concurrent six-month rotations, and may not be placed at the same training post during SET 2-5. The training program is bi-national and trainees are expected to spend at least one year in an interstate or overseas post. The program and assessment requirements are outlined in the RACS Guide to SET booklet and the SET Program Regulations.

Team findings

The Board of Vascular Surgery reported to the team that it has a close working relationship with the College through structured information processes and the existence of appropriate supporting committees. However, an area of concern to the Board is the lead time given to implement decisions made by College and the Education Board. As discussed under standard 1, greater time to enact the changes was requested by the Board of Vascular Surgery.

The Board of Vascular Surgery conducted a review of the program in 2015, and the revised regulations included: management of underperforming trainees; role of the Board in rating of assessments; role of supervisors; and review of required rotations of each trainee. The Board reported that the regulations are now reviewed annually.

Trainees reported satisfaction and pride in being in the Vascular Surgery training program.

The current curriculum sets out the expectation of trainees by SET year and is in sufficient detail to guide training. Assessments seem appropriate with examinations and workplace-based assessments (WBAs) spaced at regular intervals. If underperformance of a trainee is identified, the frequency of WBAs is increased. Non-technical skills assessments are included in the WBA. There are a number of vascular-specific online modules available and used by trainees. There is an acknowledgement that some are in need of updating and this process has commenced.

The Board of Vascular Surgery reviews trainees regularly to ensure that exposure and experience matches the expected outcomes. Learning plans may be altered to ensure achievement of required competencies. There has been progress on moving towards a competency-based model of education and assessment.

The teaching of cultural competence is considered appropriate in New Zealand however there is a need for greater emphasis in Australia. As discussed under standard 3, the Board must appropriately address cultural competence in the curriculum.

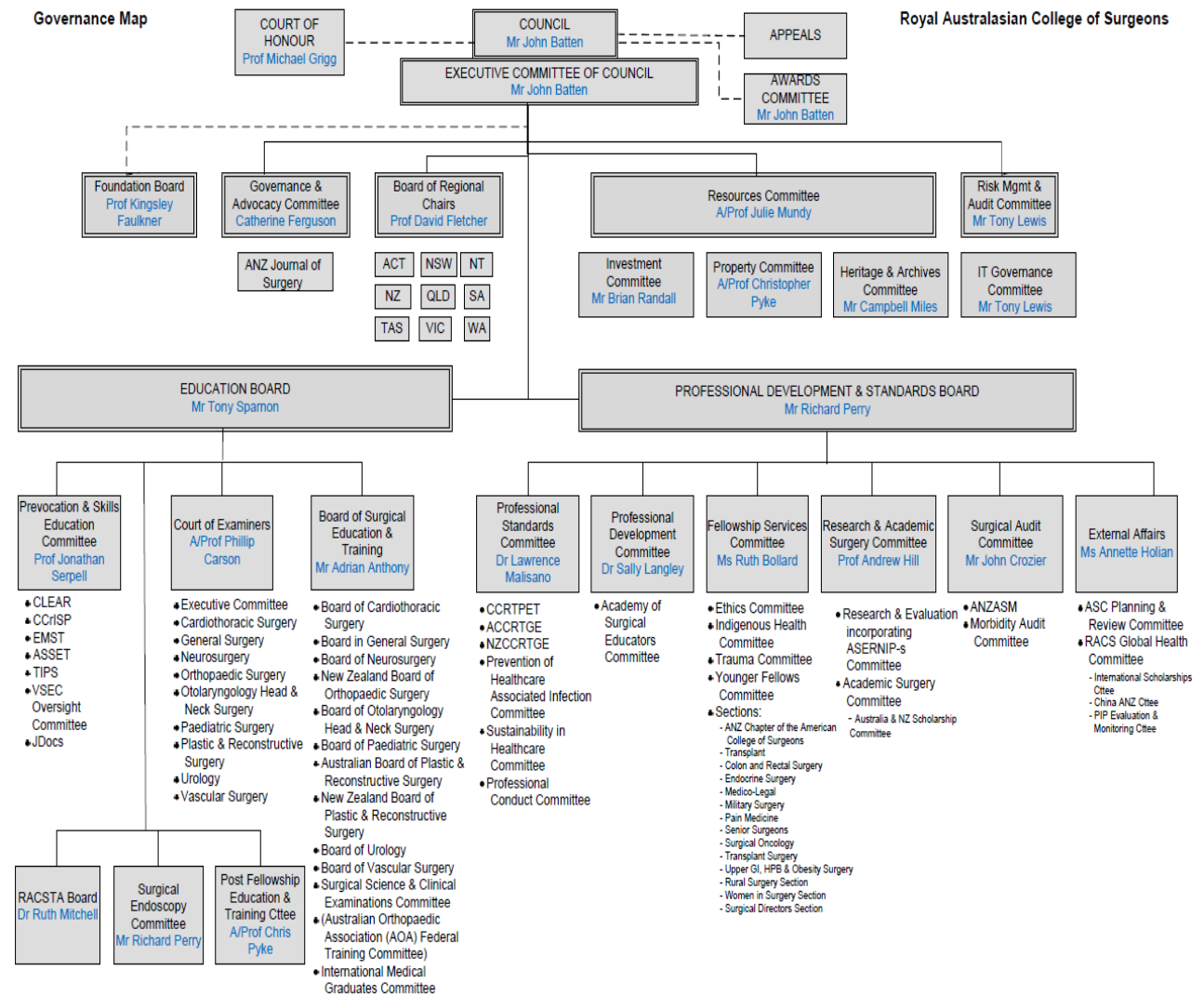
The Board takes the BRIPS initiative seriously and supports the RACS process. The Board expressed some concerns about the lack of follow-up when issues of discrimination, bullying and sexual harassment are passed on to the College according to process. Information from the College to the Board was felt to be slow and incomplete. It is unclear if this is related to confidentiality issues and further clarity on the role of the Board versus the College would be appreciated. Of note, Vascular Surgery has removed accreditation from a training site/position where there were complaints of bullying indicating they take the issues seriously and this is commended by the team.

In relation to training sites and posts, the team was informed that, at some sites, trainees are required to be on-call one week in two, and it is therefore considered that fatigue is an issue in some locations. The team recommends that the Board monitor this issue through its accreditation processes. Refer to standard 8.2 for further discussion.

As discussed under standard 9, the disagreement between the ANZSVS and the College on the Society's proposal to mandate its audit tool as the only acceptable practice assessment system was reported to the team. Although the College identifies the Society's tool as excellent, its position is that there are other acceptable tools. This has been discussed repeatedly between parties and has yet to be resolved. This should be addressed as it is a significant point of discord in an otherwise well-functioning specialty. Refer to standard 9.1 for further discussion of this issue.

There is a mechanism for assessing and evaluating specialist international medical graduates which can successfully lead to fellowship. The processes were cited as time consuming but reaching an appropriate conclusion. The Board reported that it is supportive of the recent improvements in the College's International Medical Graduate department. Refer to standard 10 for further discussion.

Appendix One RACS Governance Map



Appendix Two Membership of the 2017 AMC Assessment Team

Professor Chris Baggoley AO (Chair) BVSc (Hons), BMBS, B Soc Admin, FACEM, FRACMA
Professorial Fellow, School of Medicine, Faculty of Health Sciences, Flinders University. Adjunct
Professor, Department of Medicine, University of Adelaide

Professor Phillippa Poole (Deputy Chair) BSc, MBChB, MD, FRACP
Head, Department of Medicine, Faculty of Medical and Health Sciences, University of Auckland

Ms Susan Biggar BA, MA
National Engagement Adviser, Health Practitioner Regulation Agency

Dr Kenneth Harris MD, FRCSC
Deputy CEO, Executive Director, Office of Specialty Education, Royal College of Physicians and
Surgeons of Canada (via teleconference from Ottawa)

Dr Tammy Kimpton BMed, FRACGP.
General Practitioner, Scone Medical Practice. Former President, Australian Indigenous Doctors'
Association

Adjunct Professor Linda Mellors PhD (Med), BA, BSc (Hons), GradCert (HlthSrvMgt), GAICD,
WCLP Chief Executive, Health Services, Mercy Health

Professor Michael Permezel MBBS, MRCP, MRACOG, MRCOG, FRACOG, MD, FRCOG
Professor, Department of Obstetrics and Gynaecology, Mercy Hospital for Women, Austin and
Repatriation Medical Centre, University of Melbourne

Dr Jonathan Sen MBBS, BHSc (Hons)
General Medical Registrar, Austin Health and Northern Health

Dr Leona Wilson ONZM BMedSc, MB ChB, MPH, FRCA, FANZCA, FAICD
Specialist Anaesthetist, Wellington Hospital

Ms Jane Porter
Manager, Specialist Training and Program Assessment, Australian Medical Council

Appendix Three List of Submissions on the Programs of RACS in 2017

Australian and New Zealand College of Anaesthetists
Australian and New Zealand Gastric and Oesophageal Surgery Association
Australian and New Zealand Society for Vascular Surgery
Australian Commission on Safety and Quality in Health Care
Australian Medical Association
Australian Orthopaedic Association
Australian Private Hospitals Association
Australian Society of Plastic Surgeons
Department of Health, Western Australia
General Surgeons Australia
Health Complaints Commissioner, TAS
Health Consumers Alliance of SA
Health Quality & Safety Commission New Zealand
Health Workforce Principal Committee
Healthcare Consumers Association of the ACT
Leaders in Indigenous Medical Educators (LIME)
Ministry of Health and Health Workforce New Zealand
New Zealand Association of General Surgeons
New Zealand Association of Plastic Surgeons
New Zealand Medical Association
New Zealand Orthopaedic Association
New Zealand Private Surgical Hospitals Association
NSW Ministry of Health
Office of the Health Ombudsman, QLD
Queensland Health
Royal Australasian College of Physicians
Royal Australian and New Zealand College of Obstetricians and Gynaecologists
Royal Australian and New Zealand College of Ophthalmologists
Royal Australian and New Zealand College of Psychiatrists
Royal College of Pathologists of Australasia
South Australia Health
South Australian Medical Education & Training
The University of New South Wales, Faculty of Medicine
The University of Newcastle / University of New England, Joint Medical Program
The University of Queensland, School of Medicine
The University of Western Australia, Faculty of Medicine, Dentistry and Health Sciences
University of Notre Dame Australia, School of Medicine Fremantle
University of Otago, Faculty of Medicine
University of Wollongong, Graduate School of Medicine
Urological Society of Australia and New Zealand

Appendix Four Summary of the 2017 AMC Team's Accreditation Program

Location	Meeting
SYDNEY, NEW SOUTH WALES	
<i>Monday, 27 March 2017 – Dr Tammy Kimpton, Ms Susan Biggar, Ms Juliana Simon (AMC Staff)</i>	
NSW Ministry of Health	Health Department Representatives
Royal North Shore Hospital	Senior hospital executives
	Directors of Surgery / Supervisors
	Trainees
	Members of Surgical Team
RACS NSW Regional Office via teleconference	Trainees from John Hunter Hospital
	Supervisors from John Hunter Hospital
	NSW State Committee
<i>Tuesday, 28 March 2017 – Dr Tammy Kimpton, Ms Susan Biggar</i>	
Liverpool Hospital	Senior Hospital Executives
	Directors of Surgery / Supervisors
	Trainees
	Representatives of Related Health Disciplines
Bankstown-Lidcombe Hospital	Senior Hospital Executives
	Directors of Surgery / Supervisors
	Trainees
BRISBANE, QUEENSLAND	
<i>Tuesday, 28 March – Adjunct Professor Linda Mellors, Dr Kenneth Harris, Associate Professor David Hewett, Ms Karen Rocca (AMC Staff)</i>	
Queensland Regional Office	Queensland State Committee
Queensland Health	Health Department Representatives
Princess Alexandra Hospital	Senior Hospital Executives
	Directors of Surgery / Supervisors
	Trainees
	Members of Surgical Team
<i>Wednesday, 29 March – Adjunct Professor Linda Mellors, Dr Kenneth Harris, Associate Professor David Hewett</i>	
Queensland Regional Office via teleconference	Trainees from Gold Coast Hospital
	Supervisors from Gold Coast University Hospital
Greenslopes Private Hospital	Senior Hospital Executives
	Directors of Surgery / Supervisors
	Trainees

Location	Meeting
AUCKLAND, NEW ZEALAND	
<i>Wednesday, 29 March – Professor Phillippa Poole, Dr Leona Wilson, Mr Philip Pigou (MCNZ CEO)</i>	
Middlemore Hospital	Senior Hospital Executives
	Directors of Surgery / Supervisors
	Trainees
	Members of Surgical Team
	Representatives of Related Health Disciplines
	New Zealand National Board
	Teleconference with International Medical Graduates, New Zealand
<i>Thursday, 30 March – Professor Phillippa Poole, Dr Leona Wilson, Mr Philip Pigou (MCNZ CEO)</i>	
Middlemore Hospital via teleconference	Ministry of Health and Health Workforce New Zealand
	Trainees from Dunedin Hospital
	Supervisors from Dunedin Hospital
	GS and OHNS Training Board New Zealand Subcommittee Chairs
	Trainees from Christchurch Hospital
	Supervisors from Christchurch Hospital
MELBOURNE, VICTORIA	
<i>Thursday, 30 March – Professor Michael Permezel, Dr Kenneth Harris, Ms Jane Porter (AMC Staff)</i>	
St Vincent's Hospital	Senior Hospital Executives
	Directors of Surgery / Supervisors
	Trainees
	Members of Surgical Team
Royal Children's Hospital	Senior Hospital Executives
	Directors of Surgery / Supervisors
	Trainees
<i>Friday 31 March – Professor Michael Permezel, Dr Kenneth Harris</i>	
RACS Victorian Regional Office	Victorian Regional Committee
Department of Health, Victoria	Health Department Representatives
Frankston Hospital	Senior Hospital Executives
	Directors of Surgery / Supervisors
	Trainees
	Representatives of Related Health Disciplines
ADELAIDE, SOUTH AUSTRALIA	
<i>Monday 8 May – Professor Chris Baggoley, Dr Jonathan Sen, Dr Kenneth Harris</i>	
South Australia Health Department	Health Department Representatives
Royal Adelaide Hospital	Senior Hospital Executives
	Directors of Surgery / Supervisors
	Trainees
	Representatives of Related Health Disciplines
	Members of Surgical Team
	Teleconference with Alice Springs Hospital Trainees

Location	Meeting
<i>Tuesday 9 May – Professor Chris Baggoley, Dr Jonathan Sen</i>	
RACS South Australian Regional Office via teleconference	Specialist International Medical Graduates, Australia
	Trainees from Bunbury Regional Hospital, Alice Springs Hospital, Calvary Hospital, Royal Hobart Hospital
	Supervisors from Bunbury Regional Hospital, Alice Springs Hospital, Calvary Hospital, Royal Hobart Hospital
RACS Annual Scientific Congress, Adelaide Convention	South Australia Regional Committee
	Australian and New Zealand Society for Vascular Surgery

Team meetings with Royal Australasian College of Surgeon's Committees and Staff

Monday 3 April – Wednesday 5 April 2017

Professor Chris Baggoley AO, Professor Phillippa Poole, Ms Susan Biggar, Dr Kenneth Harris, Dr Tammy Kimpton, Adjunct Professor Linda Mellors, Professor Michael Permezel, Dr Jonathan Sen, Dr Leona Wilson, Ms Jane Porter (AMC staff), Ms Juliana Simon (AMC Staff)

Meeting	Attendees
<i>Monday, 3 April 2017</i>	
Standard 1: Context of training and education	President Chair Professional Development Standards Board Treasurer
Standard 2: Outcomes of specialist training and education	Vice President Chair, Expert Advisory Group Censor-in-chief/ Chair, Education Board NZ Censor Chair, BSET Member, BSET Acting CEO Director, Education Development and Assessment Director, Education and Training Administration Dean of Education Manager, Complaints Resolution Director, Relationships & Advocacy
Standard 3: The specialist medical training and education framework (curriculum)	Censor-in-chief/ Chair, Education Board Chair, BSET Chair, Board of Paediatric Surgery Chair, Board of General Surgery Chair, Australian Board of Plastic and Reconstructive Surgery
Standard 5: Assessment of learning	Chair, Board of Urology Chair, Board of Vascular Surgery Chair, AOAFTC Dean of Education Director, Education Development and Assessment Director, Education and Training Administration Manager, Education Development and Research

Meeting	Attendees
<i>Tuesday, 4 April 2017</i>	
Board of Paediatric Surgery	Chair, Board of Paediatric Surgery Members
Board of General Surgery	Chair, Board of General Surgery Members Director, Education and Training, GSA
AUS and NZ Boards of Plastic and Reconstructive Surgery	Chair, Australian Board of Plastic and Reconstructive Surgery New Zealand Chair, Board of Plastic and Reconstructive Surgery Members Education and Training Manager, ASPS Training and Membership Service Coordinator, NZAPS
Board of Cardiothoracic Surgery	Chair, Board of Cardiothoracic Surgery Members
Board of Neurosurgery	Chair, SET Board of Neurosurgery Members, SET Board of Neurosurgery (one member via teleconference) Trainee Representative, SET Board of Neurosurgery Chief Executive Officer, NSA
Board of Urology	Chair, Board of Urology Training Manager, USANZ
AOA Federal Training Committee and NZ Board of Orthopaedic Surgery	Chair, AOA Federal Training Committee Member, AOAFTC Members, NZOA National Education Manager, Australia National Education Manager, New Zealand
Board of Otolaryngology Head and Neck Surgery	Chair, Board of Otolaryngology Head and Neck Surgery Member SET Administrator, ASOHNS
Board of Vascular Surgery	Chair, Board of Vascular Surgery Members General Manager, ANZSVS Executive Officer, ANZSVS
Standard 10 - Assessment of specialist international medical graduates	Censor-in-chief/ Chair, Education Board Member, NZOA Chair, BSET Deputy Treasurer/ Deputy Chair, BSET (IMG) Chair, Board of Paediatric Surgery Chair, AOAFTC Chair, Board of Vascular Surgery Director, Education and Training Administration Manager, International Medical Graduates Clinical Director IMG Assessment

Meeting	Attendees
Standard 9 - Continuing Professional Development	Chair, Professional Development & Standards Board Chair, Professional Development Chair, Professional Standards Post Fellowship Education and Training Committee Executive Director of Surgical Affairs (Australia) Executive Director of Surgical Affairs (New Zealand) Dean of Education Acting CEO Manager, Professional Standards
<i>Wednesday, 5 April 2017</i>	
Standard 5 - Assessment of Training, including WBA	Chair, Court of Examiners Senior Examiner, General Surgery Specialty Representative, Cardiothoracic Exam Committee Chair, SSE and CE Committee Examiner, General Surgery Court of Examiners Senior Examiner, Urology Court of Examiners Dean of Education Director, Education Development and Assessment Manager, Examinations Department Manager, Education Development and Research
Community Representatives	Council Member (AUS) Council Member (NZ) Community Representative Expert Community Advisor
Standard 7 - Trainees	Censor-in-chief/ Chair, Education Board Chair, Court of Examiners Post Fellowship Education and Training Committee Chair, Surgical Science and Skill Examination Committee Chair, BSET SSE and CE Committee Member Deputy Treasurer/ Deputy Chair BSET (IMG) Chair, PDSB Clinical Director, IMG Assessment Dean of Education Director, Education and Training Administration Director, Education Development and Assessment
Women in Surgery	Chair, Women in Surgery Members
Indigenous Health Committee	Chair, Indigenous Health Committee Deputy Chair, Indigenous Health Committee Indigenous Health Committee member/past-chair Manager, Fellowship Services Policy Support Officer

Meeting	Attendees
Standard 8.1 - Supervisory and educational roles	Chair, PDSB Censor-in-chief/ Chair, Education Board Chair, Court of Examiners Post Fellowship Education and Training Committee Chair, Surgical Science and Skill Examination Committee SSE and CE Committee Member Dean of Education Director, Education and Training Administration
Younger Fellows	Younger Fellows Committee Member / Observer on Council SA, NT, NSW, QLD Representatives Deputy Chair, New Zealand
Royal Australasian College of Surgeons Trainees' Association (RACSTA)	Chair, RACSTA Training Portfolio, RACSTA Executive Support and Advocacy Portfolio, RACSTA Executive
Standard 8.2 - Training sites and posts	Chair, Court of Examiners Post Fellowship Education and Training Committee Member Chair, BSET Deputy Treasurer/ Deputy Chair BSET (IMG) SSE and CE Committee Member Director, Education and Training Administration
Standard 6 - Monitoring and evaluation	President Chair, PDSB Censor-in-chief/ Chair, Education Board Chair Surgical Science and Skill Examination Committee Dean of Education Director, Education Development and Assessment Manager, Education Development and Research

Team meetings with Royal Australasian College of Surgeon's Committees and Staff

Wednesday 28 June – Thursday 29 June 2017

Professor Chris Baggoley AO, Professor Phillippa Poole, Ms Susan Biggar, Dr Kenneth Harris (via video), Dr Tammy Kimpton, Adjunct Professor Linda Mellors, Professor Michael Permezel, Dr Jonathan Sen, Dr Leona Wilson, Ms Jane Porter (AMC staff), Ms Juliana Simon (AMC Staff)

Meeting	Attendees
<i>Wednesday, 28 June 2017</i>	
Meeting with New Council	President Vice President Censor-in-Chief Treasurer Chair, Professional Development and Standards Board Acting CEO Dean of Education Director, Education Development and Assessment Director, Education and Training Administration Acting Director, Fellowship and Standards Manager, Surgical Training Manager, Education Development and Research

Meeting	Attendees
Standard 4 - Teaching and learning	Manager, Prevocational and Online Education Manager, Education Development and Research
Standard 1.5 - Education Staff	Acting CEO Dean of Education Director, Education Development and Assessment Director, Education and Training Administration Acting Director, Fellowship and Standards Manager, Surgical Training
<i>Thursday, 29 June 2017</i>	
AMC Team prepares preliminary statement of findings	AMC Team
Team presents preliminary statement of findings	AMC Team RACS Council Senior Staff Senior Education Staff Principal Advisors to Council

