ROYAL AUSTRALASIAN COLLEGE OF SURGEONS

AMC ANNUAL REPORT 2009

College Details

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Key:

(5) a number in brackets at the beginning of a line indicates a recommendation from the 2007 AMC accreditation report

♦ indicates an issue identified by the AMC for specific attention in the 2009 report

1. Context in which the Education and Training Program is Delivered

Governance

The Senior Governance committee of the College in the Education portfolio is the Education Board (EB). (see Appendix 2). It is chaired by the Censor in Chief (Mr Ian Civil). The Chairs of the various committees reporting to EB are on the Board as well as other members of Council and the External Community Advisor

The governance of the College educational programs has continued to evolve over the last 12 months as the new Surgical Education and Training (SET) program has been implemented. It was always anticipated that the Basic Surgical Training (BST) program would shrink as no new trainees have been accepted since 2007. Consequently the requirements and functions normally taken through the Board of Basic Surgical Training have significantly changed. By the start of 2010 it is anticipated that only a small number of BSTs will be continuing with the program. The vast majority have now been selected into SET or have decided to explore other career options.

Consequently the functions of the Board of BST have been re-structured. Although still reporting to the Education Board, its focus remains the support and supervision of basic trainees. The responsibility for the early examinations and oversight of the skills courses has been devolved to the Surgical Science and Clinical Examinations Committee and the Skills Education Committee (SEC) respectively. The Board of BST is no longer chaired by a Councillor and it is anticipated this Board will cease to function by the end of 2010.

As this change has occurred the Skills Education Committee is not only responsible for oversight of the mandatory courses but has responsibility for the development of simulated learning environments for clinical and non clinical skills. The SEC reports directly to the Education Board and is chaired by a Councillor (Mr Phil Truskett).

The College has continued to grapple with the formal assessment of training in the post Fellowship areas. FRACS will remain as the dominant surgical qualification; however many surgeons now obtain further and more specialised training and there is a desire to see this formally recognised and accredited by the College of Surgeons. After a period of discussion at the Council level over the past two years the governance process for post fellowship education and training (PFET) has been determined. The Post Fellowship Education and Training Committee is chaired by a Councillor (Mr Hugh Martin). This committee is now starting to assess programs of training that occur after Fellowship to see which ones have the rigor in both training and assessment to be accredited by the College and an associated Specialist Society.

The prominence of RACSTA continues to grow. As a key group of the College, their input is fundamental to our decision making and governance structures. Increasingly, RACSTA representatives are involved in College activities at all levels of the College, including Council. Importantly, the former committee structure has been re-structured into a Board to signify the importance of their role; the RACSTA Board reports directly to the Education Board. The RACSTA Board membership comprises trainees but the Board has decided to expand the membership to include an invited Councillor to improve communication and understanding of College initiatives and strengthen the connection to the College governance structure.

Within the Board of Surgical Education and Training (chaired by Professor Spencer Beasley), understanding of the relationship between the various specialty societies and the specialty training boards, supported through their structures, is maturing. This has specific importance where societies in the two countries relate to the one training board and is important in ensuring that there is clear communication and direction within each speciality in both countries

The College has continued to implement the model where the various specialty societies act as agents of the College in delivering the training program. This is done under the auspices of the accreditation that the AMC provides to the College education framework and its associated standards and procedures. Training in General Surgery was previously administered dominantly by the College with some input from General Surgeons of Australia (GSA) and the New Zealand Association of General Surgery NZAGS). This model has progressed so that GSA now administers the Australian based program, with a combination of their own staff and College staff employed within regional offices. The training provided by NZAGS continues to be administered mainly through College based staff.

The Court of Examiners (chaired by Dr Mark Edwards) will be continuously reviewing the Fellowship Examination to maintain its relevance, validity and transparency.

The Professional Development and Standards Board (PDSB) is the senior governance board of the College in the Fellowship portfolio and is chaired by Professor Guy Maddern. The Professional Standards Committee is chaired by Professor Michael Grigg and the Professional Development Committee by A/Professor Rob Atkinson. All three Chairs are councillors.

This structure supports the delivery and monitoring of the Continuing Professional Development (CPD) recertification program, and the various College courses provided to the Fellowship, including the delivery of the Supervisors and Trainers for SET (SATSET) program for supervisors

1.1 Interaction with the Health Sector

See below under the heading: Specific Issues Raised in the October 2008 Report, plus a Report on Recommendations of Findings by the AMC

1.2 Educational expertise

See below under the heading: Specific Issues Raised in the October 2008 Report, plus a Report on Recommendations of Findings by the AMC

1.3 Continuous Renewal

After much discussion between the Council members, Specialty Societies and the Fellowship at large, the College has decided to form an Academy of Surgical Educators. The Academy will comprise Fellows with an interest in surgical training and professional development and will report to PDSB. Governance will comprise a Board chaired by a Councillor and an Advisory Committee chaired by the Dean of Education. The focus of the Academy will include provision of support and training to surgeons involved with education, particularly College-based surgical education, and to provide links to education in the university sector.

Establishing an Academy as a resource to all the Specialty Societies as well as to the broader field of surgical educators will be an exciting opportunity to develop the skill base of surgeons involved in the surgical training program and to ensure those Fellows interested in education are afforded opportunities for professional development in this field.

See Appendix 3 for Policies relating to education, training and CPD reviewed and updated in 2008.

1.4 Specific Issues identified by the AMC for attention in the 2009 Report, plus a Report on Recommendations or Findings by the AMC

Interaction with the Health Sector — Jurisdictions and Health Administrators

♦ Progress in the development of better communication between the College and the jurisdictions

(5) Agree with jurisdictions on mechanisms to facilitate resolution of issues of concern, including workforce numbers. These could include (a) a high-level consultative forum, possibly along the lines outlined in this report, to meet at least twice a year, and (b) consultative arrangements at the jurisdictional level with the relevant Regional Committee (and representatives of the regional sub-committees of specialty boards) to identify appropriate posts for accreditation and to facilitate resolution of issues of concern including issues of workforce availability.

(6) Where jurisdictions have developed clear service expansion plans (e.g. new or expanded hospitals) accompanied by specific allocation of additional recurrent funding, RACS and jurisdictions agree, as part of the planning for those facilities, on the profile of SET2+ places to be created in the new facilities and the timing of their availability and accreditation, thus allowing additional SET1 places to be created in existing facilities in advance of the SET2+ places coming on line.

(9) Continue and strengthen its consultation with all groups affected by the implementation of SET, and in particular addressing communication gaps outlined ….

(25) Continue to collaborate with the jurisdictions to increase the output of well-trained surgeons.

The College continues to interact with the health care sector at multiple levels. At a senior governmental level the College continues to explore ways of increasing the number of training positions, particularly in the private sector and to secure support for supervisors and Fellows involved in formal educational and training roles.

The College actively contributes to discussions about Surgical Workforce in both Australia and New Zealand. Reports that we receive and literature reviews would indicate that the surgical specialties are not the most acute areas of workforce shortages. Although access to surgery is always a political issue as demonstrated by media interest in waiting lists, the commentary often reflects on inadequate or inefficient funding of the public hospital sector. Over 60% of the elective surgery in Australia and over 50% in New Zealand is undertaken in the private sector. Although the College is looking at all opportunities to improve workforce numbers and to increase training posts the focus of these issues has now moved from absolute numbers to effective use of resources by government.

The College has undertaken another census of the Fellows of the College to gain greater understanding of where the pressures will be in the coming ten years. The College has obtained an 80% response rate to this survey which will provide reliable data for evaluation. The assessment of this survey is underway as this report to the AMC is being prepared. These reports will be distributed broadly and the various Regional Committees will be seeking input from their respective Departments of Health with this data.

The development of the National Health Workforce Taskforce (NHWT) Agency will be a major area to embrace which the College looks to advance.

It has been a disappointment that the various jurisdictions have now removed their involvement from a number of College committees however, the development of the NHWT Agency and the ClinMed Qld may provide an avenue of mutually beneficial interaction between the College and government.. The College will continue to increase our engagement with these developing agencies at Federal and State level.

There have been a number of substantial reviews of the health sector over the past two years. The College has actively joined with these activities to ensure issues of training, expanding the workforce and standards have been profiled. Two substantial areas have been the COAG initiative looking at National Registration and Accreditation and the National Health and Hospital Reform Commission.

There is ongoing interaction at individual hospital level between individual training programs, supervisors and trainees that is both expected and encouraged.

Interaction with the Health Sector - Consumers

♦ Developments in consumer involvement in College processes

(9) Continue and strengthen its consultation with all groups affected by the implementation of SET, and in particular addressing communication gaps outlined ….

(10) Involve health consumers and patients in any future consultation about the goals and objectives of surgical training.

The College is substantially increasing the involvement of non-surgeons in the governance processes.

The College approach to consumer involvement has been to invite Expert Community Advisors onto key committees. This includes Council and the EB where their sound advice and wisdom has been greatly appreciated. Both Council and EB are now working on the appointment of second community advisors.

The continued involvement of trainees in the various education boards and committees has provided valuable input in relation to their role as the consumers of the training program.

The terms of reference for the Academy also include two external experts in Medical Education.

The College remains open to input but believes that contributions from individuals who can participate actively in issues of governance, professionalism, education or standards provide not only a community perspective but strong advice on improving College activities.

Educational expertise

(1) Ensure continuing support and resources for the College's Education Section

(12) Build on the increase in educational resources and facilitate the sharing of good educational practice by establishing regular and frequent meetings of specialty society and College educational staff.

The Dean of Education, Professor John Collins, retired from the position at the end of July 2009. The incoming Dean, Professor Bruce Barraclough, will commence with the College in October 2009.

The College continues to resource its educational activities to the limits of its financial capacity. This has included bringing Professor Fiona Patterson from the United Kingdom to facilitate a workshop on selection techniques and initiate the review of our interview techniques for training program selection (see section 7).

As the specialty societies gain more expertise in administering their own training programs, they are augmenting their staff profiles with more experienced staff with educational backgrounds. Some of these people are bringing skills in areas like curricula development. Some of the external specialties also call on consultants to advise them in specific areas of their activities.

The challenge for College staff and in particular the incoming Dean, is the ongoing cohesion and coordination of developments in this area. To facilitate this there have been regular meetings between College and Specialty Society staff who are involved in the educational areas. This was introduced in 2008 and occurs three times a year.

2. The Outcomes of the Training Program

2.1 Any Significant Changes introduced or planned

2.1.1 The purpose or mission of the College

No change from the purpose or mission which were outlined to the AMC in 2007.

2.1.2 The college's statement of the graduate outcomes for each of its training programs

No change from the graduate outcomes which were outlined to the AMC in 2007.

2.2 Report on Recommendations or Findings by the AMC

(7) Recognising the different needs of the specialty groups, aim to increase the uniformity between presentation of the aims and goals of training for nine surgical specialties particularly on the website, taking account of feedback from the trainee and supervisor groups.

2.2.1 In response to feedback from trainees, Fellows, and supervisors, during the last 12 months the layout of the College website has changed and the search function has been improved

2.2.2 A meeting between educational representatives of the College and from all of the nine specialties is planned to be held in October this year; this item is on that meeting's agenda.

3. The Training Program — Curriculum Content

3.1 Any Significant Changes introduced or planned

3.1.1 Curriculum framework

No change from the framework outlined to the AMC in 2007.

3.1.2 Structure, Composition and Duration

For most specialties there is no change from the structure, composition and duration which were outlined to the AMC in 2007. Cardiothoracic Surgery (CTS) and Otolaryngology, Head and Neck Surgery (OHNS) have indicated their intention to reduce their reliance on training in General Surgical post and/or other specialties during SET1 and instead, to keep trainees within their specialty.

The specialties regularly up-date their modules in-line with changing assessments (e.g. the Clinical and specialty specific SSE examinations) and with training opportunities, as well as changes within their specialty.

3.1.3 Opportunities for trainees to engage in research

Most specialties have not changed the opportunities for trainees to engage in research, from those which were outlined to the AMC in 2007. Plastic and Reconstructive Surgery (P&RS) has identified opportunities to introduce research positions into their training program.

(13) Define the educational objectives of the research components of training and review requirements against these objectives.

A number of the Boards have clearly defined objectives for research requirements and this will be an item for discussion at the SET review workshop in 2010.

Although the College is negotiating an MOU with the University of Sydney to discuss the incorporation of a research qualification into the training programs for General Surgery and Urology, these discussions are at a preliminary stage.

3.1.4 Flexible training arrangements and policies on recognition of prior learning

(14) Report to the AMC on the impact of SET on the availability of flexible training opportunities.

a. While SET has the potential for increased flexibility through, for example, early sign-off, RPL, rotations in private hospitals, and/or introduction of research and anatomy demonstration positions, the influence of this in most programs has been minimal.

RACSTA has a keen interest in promoting and supporting part-time training and is investigating a method by which part-time opportunities – current positions available and/or strategies to negotiate with employers – can be communicated to trainees.

b. The Recognition of Prior Learning Policy was approved in October 2008.

3.2 Specific Issues identified by the AMC for specific attention in the 2009 Report, plus a Report on Additional Recommendations or Findings by the AMC

(2) Report to the AMC on the schedule of planned changes in its educational programs and the proposed time of implementation

(11) Present to the AMC its timetable for the planned move to competency-based training and report annually on its progress.

As outlined in the timetable sent to the AMC in November 2007 and revised in August 2009 (Appendix 4) the College recognised the need to progress slowly on the planned move to competency-based training. Progress is on-track in a number of key areas including:

a. alignment of the Fellowship Examinations with the statements of required competence in each of the nine specialties

b. the introduction of Mini-CEX and DOPS for SET 1 trainees

c. accredited simulation training for all General Surgery trainees in laparoscopic skills

d. alignment of surgical sciences and clinical examinations with appropriate competencies

e. evaluation of selection processes

f. participation of supervisors and trainers in SAT SET 1 and the development of a second training program, to teach interviewing skills(see also Sections 7 & 9)

The next steps will be to systematically evaluate the impact of these changes (see Section 6) and to introduce the other proposed processes as the SET program evolves.

The main change planned to be introduced in 2010 is to the specialty specific Surgical Science Examination (SSE) (see Section 5).

(8) Develop concrete and evidence-based information regarding the definition of the 'non-technical' competencies.

The College was successful in being selected to participate in a government funded project administered by the Australian Society of Simulation in Healthcare (ASSH). Under this project, the College, in collaboration with the Monash University Centre of Medical and Health Sciences Education, developed and conducted a very successful two-day pilot course titled *Developing Non Technical Skills for Surgical Trainees Using Simulation.* The participants were SET3 and 4 trainees from six different surgical specialties.

The College recognises the importance of developing collaborative relationships to develop simulation learning technologies and is currently seeking ways to continue this course and to make it available for a wider range of trainees.

♦ The training organisation contributes to articulation between the specialist training program and prevocational and undergraduate stages of the medical training continuum

In the first half of 2009 the College conducted three surveys (medical students; PGY1-3; and potential training providers) to ascertain the need for, and feasibility of, a modified version of the Australian and New Zealand Surgical Skills Education and Training (ASSET) course to be made available to later-year medical students and/or PGY1 and 2 graduates.

Supported by the very positive responses to all three surveys, the College is hoping to develop and pilot the modified ASSET course during 2010.

(3) When differences continue between specialties in components of training, RACS should ensure that they are supported by a clear evidence-based educational rationale.

Based on the intrinsic variation in the technical and non-technical competencies required for the various surgical specialties, the College considers the differences between the specialties in curriculum content,

particularly in regard to the competencies of Medical Expertise, Technical Expertise and Judgement – Clinical Decision Making to be appropriate.

4. The Training Program — Teaching and Learning

4.1 Any Significant Changes introduced or planned

There is no change to the centrality of practice-based training during which trainees are required to become increasingly independent as outlined to the AMC in 2007.

The areas under development (2009-2010) are all being implemented to enhance the integration of practical and theoretical instruction. These areas are:

a. accreditation of formal courses

b. development of courses in non-technical competencies (see Section 3)

There are a plethora of formal courses, some of which address the technical competencies and are generally run by universities (basic sciences) the College or surgical specialties, other courses addressing the non-technical competencies are usually offered by agencies external to the College.

The College frequently receives requests from trainees – or potential trainees – for advice on which courses would be most appropriate for training, and from a range of agencies asking for College accreditation, or co-badging of their courses. To address the expectations of both of those groups the College has developed a process for accrediting formal courses. The accreditation process provides College standards for the development and conduct of courses, relevant to the training program, by external providers.

A survey canvassing the need amongst trainees and supervisors for training in the non-technical competences was conducted prior to the ASSH pilot course. The results of that survey informed the issues that were addressed in the pilot course and have now provided the College with a model for additional courses.

c. enhancement of e-learning as a training tool

Over recent years there has been rapid improvement of the technology and understanding of the most effective teaching and learning approaches to e-learning. E-learning is an ideal platform to enhance the integration of practical and theoretical instruction because of the time demands on trainees as well as their widely dispersed training locations. The College and a number of the specialties are currently developing strategies to maximise the use of this resource.

4.2 Report on Recommendations or Findings by the AMC

No recommendations or findings relevant to this Section

5. Assessment of Learning

5.1 Any Significant Changes introduced or planned

5.1.1 Assessment policy or principles

No change from the policy and principles which were outlined to the AMC in 2007.

5.1.2 Policies on and approaches to evaluation: the reliability and validity of assessment methods, the educational impact of assessment on trainee learning, the feasibility of the assessment items

No change from the policies on, or approaches to, evaluation which were outlined to the AMC in 2007.

The educational impact of assessment on trainee learning is an important consideration in evaluating current assessment tools and developing and designing new ones. There are a number of seminal publications by authors such as Marton, Entwhistle, Bowden and Ramsden that the College refers to in considering changes to assessment.

Research carried out by Prof Jenepher Martin for her PhD 'Laying the Foundations for Surgical Excellence: Strategic Alignment of Questions in Program Evaluation' focused on an analysis of the BST. Some of her findings in relation to trainee perceptions will provide valuable ongoing insights.

(16) Research thoroughly the strengths, weaknesses, practicalities and generalisability of the Mini-Clinical Evaluation Exercise and Direct Observation of Procedural Skills as assessment tools in the local hospital setting and make public its findings.

Except for the introduction of the Mini-Clinical Evaluation Exercise (Mini-CEX) and Direct Observation of Procedural Skill (DOPS) during 2008-2009, most of the assessment processes being used across the training program have been used for several years. Those specialties that did not have a requirement for a mid-term in-training assessment (as well as the end of term assessment) have added that requirement to ensure that all trainees are receiving feedback on their progress.

In general there have been few concerns about the implementation of the Mini-CEX and DOPS with positive feedback regarding the increased learning opportunities for trainees, a good training and educational focus to program and more detailed performance management. It has been noted that whilst clinical assessment is now an important part of training, it requires an increased time commitment for supervisors and that some struggling trainees find that additional assessments increases performance pressure.

A survey of supervisors who have completed the SATSET course will be undertaken by the Professional Development Department to determine the effectiveness of the course and the implementation of the work-based assessment tools.

The College continues to discuss with the Jurisdictions approaches that will provide adequate time for supervisory and assessment activities and has been responsive and flexible in working with the Boards to provide access to SAT SET for supervisors.

The College has revised its hospital accreditation requirements and has specified the minimum levels of support to supervisors. It is awaiting comment and further discussions with the NHWT.

(19) Report on the measures of validity and reliability of assessment processes that it identifies.

- For many years the reliability and validity of the former BST examination has been monitored through Rasch scaling. This same process is now being applied to the generic SSE. New standard setting processes were introduced during 2008 for the clinical exam and the specialty specific SSE (see Section 6.1.2)
- The validity of the in-training assessments used by each of the specialties to assess trainees at the middle and the end of each rotation has been improved by aligning them to the College Competencies and specialty competency statements.
- The validity of the Fellowship examinations is being improved by aligning them to the College Competencies and specialty competency statements.
- The reliability of the Fellowship examination is being improved as specialties develop and implement standardised assessment forms aligned to the specialty competency statements.

5.1.3 Introduction of new methods of assessment

At the June meeting of BSET the following recommendations were approved:

1. To change the format of the generic and speciality specific Surgical Science Examination (SSE) to better reflect the requirements of specialist SET training.
2. That the SSE comprises one generic paper and two speciality specific papers or other assessment tools as specified by specialty.
3. That the content of the generic SSE comprise Pathology and Physiology.
4. That the content of the speciality specific SSE comprise Anatomy, Pathology and Physiology relevant to the speciality.

5.1.4 Performance Feedback

- Provide feedback to supervisors on trainee performance where appropriate

a. The only change to the content of the performance feedback provided to examination candidates outlined to the AMC in 2007 is in relation to the generic clinical examination and the specialty specific SSE (aligned with the standard setting processes for those examinations, see Section 6). In all examinations the College continues to provide supervisors of failed candidates with detailed feedback so that they can counsel and advise the trainee.

b. Specialties have increased their use of on-line access for the completion and sharing of in-training assessments between supervisors, trainees and/or the specialty boards.

5.1.5 Process for identifying unsatisfactory performance by trainees

(17) Report in annual reports to the AMC on the procedures for identification and management of under-performing trainees.

No change from the policy and procedures which were outlined to the AMC in the 2008 report.

A detailed procedure document has been written to provide clear process directions for the Boards and the two largest specialties, GS and OS, have provided additional support for their supervisors in the form of manuals on performance management and templates for evidence collection, oversight and the development of remedial plans.

The College continues to discuss with the Jurisdictions approaches that will provide adequate time for supervisory and assessment activities and has been responsive and flexible in working with the Boards to provide access to SAT SET for supervisors.

5.2 Assessment of Specialist Training Overseas

Describe the College's process for assessing the equivalence of the education, training and experience of overseas-trained specialists to that of Australian trained specialists.

Detail any changes to the process over the last 12 months or planned in the next 12 months.

The process of assessment is set out in the policy 'IMG Specialist Assessment of International Medical Graduates in Australia' which is accessible on the College website and has not changed (see Appendix 5 for a copy of the policy).

The College plans to implement a uniform referee report in place of the current letters of support provided by applicants.

(20) Continue to publish data on timeliness and outcomes of applications from International Medical Graduates in the College's Activities Report.

A total of 112 applications for International Medical Graduate (IMG) Assessment were activated by the Department of IMG Assessment in 2008 of which 95 were completed. Of the activated applications 24 were for Area of Need positions and 88 were for Specialist Assessment. 28% of the applications activated came from doctors from English-Speaking Countries (ESC), 17% of the applications activated came from doctors from English-Speaking and Other Countries (ESC & Others) and 55% of the applications came from doctors from Non English-Speaking Countries. At the end of 2008 there were 34 International Medical Graduates undertaking a period of assessment of clinical practice as recommended.

See the Table from the 2008 Activities Report Appendix 6.

5.3 Report on Additional Recommendations or Findings by the AMC

(18) Consider whether in view of the improved in-course assessment the major summative exit examination in its present form could be reviewed.

Until the workplace based assessment processes and the changes to the specialty specific SSE are fully incorporated across the entire training program, it is not possible to evaluate elements of the exit examination that could be, or are being, addressed earlier in the program. Therefore a review of the Fellowship examination in this context is not being undertaken at this time.

(3) When differences continue between specialties in assessment and components of training, RACS should ensure that they are supported by a clear evidence-based educational rationale.

(15) Seek congruence of assessment processes between the specialties except when differences can be justified for educational reasons.

All of the assessment processes are aligned with the College Competencies. However changes in examination formats will be an on-going process. As changes to the specialty specific SSE are developed, the Clinical and Surgical Science Committee will be responsible to ensure that congruence in the assessment of the basic sciences is maintained.

6. The Curriculum — Monitoring and Evaluation

Provide details of the College's processes for the monitoring and evaluation of curriculum content, teaching and learning activities, assessment and program outcomes

6.1 Activities undertaken in the last 12 months

6.1.1 New evaluation activities initiated including methods to monitor the trainees' and the supervisors' opinion of the program

(23) Report in annual reports to the AMC on plans for trainee and supervisor evaluation of SET.

(28) Increase communication with supervisors and trainers about SET.

a. Surveys were conducted this year to gain information from interviewers and interviewees in OHNS on the revised format of questions in the interview (in-line with suggestions from the selection workshop, see Section 7).

b. Trainee evaluation forms are regularly used and are completed by each trainee at the end of each rotation. Unless an urgent issue is identified that needs the immediate attention of the board, the information from the trainee evaluations are compiled and used during re-accreditation of training posts.

   With approval from and in collaboration with all the training boards, the RACSTA Board has been reviewing all of the evaluation forms from the specialties, plus examples from other medical colleges to develop a generic trainee evaluation form.

c. Opportunities are provided at trainee seminars, workshops or conferences to seek feedback. Information from these meetings is presented by their trainee representative at board meetings where it may result in changes to components of the program, regulations, or communication strategies. Each Board's trainee representative is a member of the RACSTA Board, providing an additional avenue of feedback to BSET and the Education Board.

d. Some specialties (e.g. CTS; NS; GS) have incorporated a meeting for supervisors into their annual scientific meetings to canvass feedback on SET. See 2009 revised Table of *Communiciation with Supervisors and Trainees, Appendix 7.*

e. GS is planning to improve their communication with supervisors by introducing an annual supervisors' survey for program evaluation.

6.1.2 Evaluation activities completed

a. At the completion of the selection processes (2007; 2008; 2009) the Education Development and Research Department (EDRD) of the College evaluated the selection processes and results of each of the nine specialties. The results of these evaluations, together with identification of potential areas of risk, were sent to each specialty Board for their consideration in preparing for the next round of selection processes. The information also formed a basis for each Board to consider during the 2009 Selection Workshop (see Section 7).

b. In 2008 two new standard setting processes were introduced, one for the generic Clinical Examination (a modified Global Assessment Scale process) and another for the specialty specific Surgical Sciences Examination (an expert group bookmarking process or a modified Yes-No Angoff).

   - The Global Assessment scale has been found to make only a small impact on the number of candidates passing the clinical exam even though candidates are now required to pass at least two stations of each type (Examination, Communication, History and Procedure) as well as achieving the minimum passing score for the whole exam, rather than just achieving a minimum score.
   - It is too early to evaluate the impact of the bookmarking process on the specialty specific examinations except to note that each of the specialty panels has been consistent in the standard they have set across the three examinations that have been conducted so far.

6.1.3 Changes in the resources available to support the program

See Section 1, Educational Expertise

6.1.4 Summative assessment components

There have not been significant changes in the percentage of candidates passing the generic components of the SSE and clinical examinations or across the specialties in the Fellowship examination.

Because the specialty specific examinations for Cardiothoracic Surgery, General Surgery, Neurosurgery, Otolaryngology Head & Neck Surgery, Urology, and Vascular Surgery have only been run once (October 2008) it is too early to make judgements on the percentage of candidates passing or failing those examinations.

Statistics in tables relating to the Fellowship Examinations are a summary of two exams, held in May and September, and look at the "annual" pass rate of the Fellowship Examination (i.e. a candidate who sits twice in the one year, failing the first sitting and passing the second will only be represented once as a pass statistic).

See Appendix 8 for Tables showing the results of the Examinations in 2008

See Appendix 9 for Table showing the Trainees (and IMGS) who completed training and were admitted to Fellowship in 2008

6.2 Report on Additional Recommendations or Findings by the AMC

(21) Develop and report to the AMC on its plans to evaluate the introduction of the SET program.

As outlined above in 6.1.1 the specialties have increased opportunities for trainees and supervisors to provide feedback on the training program.

The College is monitoring overall progress and the impact of changes to training though regular reports by the specialties to BSET. Changes are also reviewed in relation to the 'Timetable for the planned move to competency-based training' (see Section 3 – 'Report on Recommendations and Findings by the AMC', and also Appendix 4).

(22) In recognition of the congruence and value gained from providing a Selection Workshop (item 7), a second workshop is planned for 2010 as a means to review the implementation of SET to date, and to discuss a consensus approach to those issues and implications identified. The college plans to introduce procedures to collect feedback on the training program from internal and external stakeholders such as health administrators and health consumer groups.

See Section 1, Interaction with the Health Sector - Consumers

7. Issues relating to Trainees

7.1 Selection

Any Significant Changes introduced or planned

7.1.1 Policy and procedures for trainee selection

- ♦ Progress in developing consistent selection criterion across specialties regarding previous surgical experience for selection into the SET program
- ♦ Any progress towards development of a centralised selection process for entrance into the SET program

No change from the policies or processes which were outlined to the AMC in 2007. However the detail of some of the processes has changed.

(3) When differences continue between specialties in selection processes RACS should ensure that they are supported by a clear evidence-based educational rationale.

(24) Report to the AMC on the evolution of the selection process, taking account of feedback from the specialty societies, the applicants and other stakeholders.

The nine specialties continue to use the same three selection tools (CV; Referee Reports and Interviews) with small variations in proportional weighting. All of the specialties except OS used the same on-line Referee Report in 2009.

A highly successful Selection Workshop held in April 2009 was attended by representatives from the 13 speciality boards and societies and facilitated by Prof Fiona Patterson and the Dean of Education. The outcome was to increase understanding of the principles of selection and to further refine the College approach to selection with the following agreed changes to:

- selection based on attributes rather than competence

- a review of selection tools – especially the Referee Reports – to reflect appropriate attributes
- expanding the interview process to a multiple station format – rather than a single panel
- minimum duration of interview
- revising the current interviewer training program to better reflect the changes of approach – this training to be ready for 2010 selection
- reviewing the eligibility criteria so that all eligibility requirements can be met by PGY2 applicants

The specialty boards also agreed to consider:

- simplifying eligibility requirements for potential applicants
- the possibility of scoring the CV for 'career trajectory'
- the possibility of a common CV and Referee Report

7.1.2 Comment briefly on the reasons for any disparity between the number of training positions available and the number of applicants for the positions, and any actions by the college and others to address it

(4) Report, as part of its College Activity Report, numbers of entrants into SET1 and SET2+ and the origin of these entrants (by PGY year, whether or not BST, IMG) by jurisdiction and specialty.

Due to less restrictive eligibility criteria, the number of applicants to the SET program is significantly higher than to the former SST program. In 2008, 742 individuals applied for selection across the nine specialities this number is significantly less than the 1,537 who applied in 2007. The high number of applicants in 2007 was accounted for as this was the first intake to SET and provided the opportunity to commence training in SET1 and SET2. 321 offers were made to the training program, 127, or 40% of whom were made to Basic Surgical Trainees (BST). The remainder were made up of trainees already in specialty-specific training, international medical graduates and 154 “new” persons – who had no previous relationship with the College. See Tables from the 2008 Activities Report — Appendix 10.

The disparity between the number of training posts and the number of suitable applicants for positions continues. The College has requested that over 50 new training positions per year be established but very few new positions have been forthcoming from hospitals. The College is working cooperatively with the Department of Health and Ageing (DoHA) in Australia to identify new posts in both public hospitals and in the private sector.

7.2 Trainee participation in training organisation governance

The College has an active trainees’ association (RACSTA) comprising specialty and regional representatives. Divided into educational, training, and support and advocacy portfolios, RACSTA works within the RACS governance structure to provide trainee input and opinion regarding issues of relevance to trainees. Issues of recent significance include trainee term feedback processes, safe working hours and fatigue management, orientation processes, training in the private sector, part time training, and bullying and harassment. RACSTA has also recently provided College-level input into examination and dismissal processes, non-technical skills development processes, modern communication techniques and mentoring programs.

7.3 Communication with Trainees

Any Significant Changes introduced or planned

7.3.1 Mechanisms to inform trainees about the activities of its decision making committees

a. RACSTA is taking an increasingly active role in participating in boards at various levels of the College Structure (Council; EB; BSET; specialty boards). In this role they both represent the trainees' perspectives at the meetings and communicate information back to the trainees.

b. As described in Section 6.1.1 the specialties have enhanced their communication processes to inform trainees (and supervisors) about their decision making processes as well as to collect information and feedback from the trainees (and supervisors). See 2009 revised Table of *Communiciation with Supervisors and Trainees, Appendix 7.*

7.3.2 The College's capacity to provide information to trainees about their training status

Until now, Specialty Boards have had responsibility to advise trainees of their training status. In the 2008 Service Agreements between the College and each of the specialties a plan was outlined for the College to send an iMIS extract to each trainee on all of their training activities, on at least an annual basis. This is being implemented in the next few months.

All Boards have implemented the College Trainee Agreement with this being a mandatory requirement for new trainees from 2010. The Trainee Agreement provides a basis for understanding the trainee's responsibility in regard to his/her status as a trainee, and the College's responsibility to the trainee.

Resolution of training problems and disputes

No change from the policies and processes which were outlined to the AMC in 2007.

Report on Additional Recommendations or Findings by the AMC

(26) Consider how trainees can be engaged as part of a more sophisticated communication strategy regarding the SET program.

a. In June 2009 RACSTA representative gave a presentation at the Leaders' Forum on 'Modern communication techniques'. Subsequently College Council agreed to review and adapt the previous Information Technology Advisory Group into a 'Communications Working Party' – with representation from RACSTA - under the Fellowship Services portfolio.

b. See above in Section 7.3.1

8. Implementing the Training Program — Delivery of Educational Resources

Supervisors, assessors, trainers and mentors

Any Significant Changes introduced or planned

To the process by which supervisors are appointed and/or to the roles of supervisors, assessors, trainers and/or mentors

a. There have been no changes to the way that supervisors are appointed or to their roles. Information about the roles of supervisors is outlined in the document for accreditation of hospitals for surgical training.

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

a. Some of the specialties have developed, or are planning to develop, manuals for their supervisors

b. The SAT SET program was developed in response to feedback from Fellows about the areas of supervision in which they felt they needed guidance and professional development (see Section 9). A second program, providing training for interviewing, will be introduced in 2010.

Report on Recommendation or Findings by the AMC

(27) Report in annual reports to the AMC on:

- changes in the workload of supervisors after the introduction of SET
- the introduction of training for supervisors and trainers in the new work-based assessment methods
- progress in developing a process for trainee evaluation of their supervision.

a. The reports from the specialty boards indicate varied responses to the changed workload after the introduction of SET.
   - CTS say that supervisors are happy with the improved information flow between themselves and the board, however they feel that too much has changed too quickly
   - GS and PS reported that supervisors are requiring more time to fulfil the increased requirements of teaching and formative assessment
   - GS also reported that they are receiving more queries from supervisors regarding remuneration due to the additional workload (see Sections 5.1.2 and 8.3.1)
   - OS indicate that supervisors are now more settled after some initial confusion through the change-over period about the new procedures and document requirements

b. SAT SET was designed to provide training for supervisors and trainers in the new work-based assessment methods (see Section 9, Report on Recommendations)

c. see Section 6.1.1

Clinical and other educational resources

Any Significant Changes introduced or planned

8.3.1 Changes to accreditation policy or criteria/standards

The College has revised its requirements and has specified the minimum levels of support for supervisors. It is awaiting comment and further discussions with the NHWT.

8.3.2 Access to outpatient and ambulatory experience

This was discussed during the 2007 accreditation when it was advised that the absence of consultative clinics in NSW remained a problem. The College has raised this with the appropriate authorities in the past but is powerless to change this established practice. The criteria for the accreditation of hospitals does highlight however, the need for a hospital to have in place appropriate outpatient and clinical experiences for surgical trainees before that site will be accredited for training.

The College has arranged a meeting with NSW jurisdictional representatives to discuss this matter again.

8.3.3 Mechanisms for monitoring the adequacy, supervision and organisation of rotations and posts

See Section 6.1.1 on trainee evaluation

See Appendix 11 for Hospital accreditations presented to BSET for approval in 2008

Specific Issues identified by the AMC for specific attention in the 2009 Report, plus a Report on Recommendations or Findings by the AMC

♦ Progress in achieving surgical training places in the private sector

The College is participating in the Enhanced Medical Education Advisory Committee (EMEAC) process. While the current accreditation document is applicable to both public and private settings it will be reviewed to provide further information for private settings.

(5) Once established, the jurisdiction-regional committee liaison processes be used to track progress on ensuring that all appropriate hospital posts are accredited for SET2+ training and that RACS' central office is advised of progress on this issue.

(6) Where jurisdictions have developed clear service expansion plans (e.g. new or expanded hospitals) accompanied by specific allocation of additional recurrent funding, RACS and jurisdictions agree, as part of the planning for those facilities, on the profile of SET2+ places to be created in the new facilities and the timing of their availability and accreditation, thus allowing additional SET1 places to be created in existing facilities in advance of the SET2+ places coming on line.

This is becoming more difficult to achieve due to our reliance on the jurisdictions to notify us when they have potential new sites that could be suitable for training.

However, there has been improved communication at Federal level in regard to support for and development of expanded settings for training and training in the private sector and the College will continue to explore and develop this avenue of communication.

9. Continuing Professional Development

Any Significant Changes introduced or planned

9.1.1 Changes to policy or principles relating to continuing professional development

There have been no changes to the Continuing Professional Development (CPD) Program during the reporting period.

However, commencing January 2010 there will be an additional requirement for Fellows to participate in the Australia and New Zealand Audit of Surgical Mortality (in States where there is one available).

There will also be a slight change to the verification aspects of CPD reporting. The percentage of Fellows randomly selected for audit will be increased, with a focus on just some aspects of participation rather than an entire audit of participation. Details are still to be confirmed.

9.1.2 Changes to the categories of activity recognised for continuing professional development

There have been no changes in the reporting period.

9.1.3 Changes to the college's process for endorsement of educational activities/meetings

There have been no changes in the reporting period.

9.1.4 Initiatives to evaluate professional development programs

The College considers that evaluation is an integral aspect of planning and delivery of its professional development activities. At the end of every activity, participants are invited to provide feedback to ascertain whether their expectations and learning needs have been met. They are also asked to identify learning outcomes. This information is collated into a report which is reviewed by the relevant oversight committee.

In addition, surveys are undertaken to evaluate the impact on practice of some courses. For example a survey of the Supervisors and Trainers for SET (SAT SET) Course participants is being undertaken to determine the effectiveness of the course and the implementation of the work-based assessment tools.

See Appendix 12 for Tables showing the rates of participation by College Fellows in the College's last CPD cycle

9.1.5 If applicable comment briefly on actions taken by the College in response to low participation rates or actions aimed at improving participation in CPD programs

Participation in the CPD (Recertification) Program

Participation rates in the CPD (Recertification) Program remain high. Data collection for 2008 is not yet complete, however there was a 95% compliance rate in 2007.

A series of reminder letters is sent to Fellows who have not participated in the CPD Program. Their names are also given to the relevant specialty society representative on the Professional Development and Standards Board for follow up. Fellows who do not participate in the Program (and comply) are ineligible to be listed on the publicly available ‘Find a Surgeon’ list on the College website.

Participation in Professional Development activities

Participation in the workshops and courses provided for Fellows also aligns with expectations, with over 1000 attendees attending 55 workshops. This represents an increase of 12% on 2007 data (see table below).

A needs analysis is sent to course registrants before each course to determine individual requirements and expectations. A report is then sent to the facilitator, which is particularly important if registrations are low to ensure that participant needs are being met. The report is also used to ascertain whether promotional information is clear and accurate.

Surveys are also undertaken to determine the needs of particular cohorts. For example a survey of College Fellows involved in surgical education was carried out in 2008. The survey results are being used to design additional modules to complement the SAT SET course.

Whole of College surveys are also carried out appraising professional development needs. For instance the 2006 survey identified ‘risk management’ and ‘governance’ as two areas where Fellows wanted more professional development. As a result, additional communication courses and one workshop focussing on the roles and responsibilities of committee and board members were offered. A further survey is planned for 2010.

Retraining

Any significant changes to the College's processes to respond to requests for retraining of its Fellows

There have been no changes in the reporting period.

Remediation

Any significant changes to the College's processes to respond to requests for remediation of its Fellows

There have been no changes in the reporting period.

Report on Recommendations or Findings by the AMC

(29) *Consider making the SATSET course, Assessment and Management of Trainees, mandatory for supervisors and trainers.*

Over 1000 Fellows have now attended a SAT SET Course since it was launched in May 2007. This number includes more than half of all supervisors of training (see table below, data as at June 2009).

The SAT SET courses are still in demand and are delivered at capacity. A further 25 courses will be offered in 2010. It therefore seems unnecessary at this time to make participation in the course mandatory.

Appendices

Appendix 1	List of Acronyms
Appendix 2	Governance Committees of the College Council
Appendix 3	Policies relating to education, training or CPD reviewed and updated in 2008
Appendix 4	Timetable for the planned moved to competency-based training
Appendix 5	IMG Specialist Assessment of International Medical Graduates in Australia Policy
Appendix6	Outcomes of applications from International Medical Graduates, 2008
Appendix7	*2009 Revised Table of Communiciation with Supervisors and Trainees – by specialty*
Appendix 8	Results of the Examinations in 2008
Appendix 9	Trainees completing training in 2008
Appendix 10	Selection into SET 2008
Appendix 11	Hospital accreditations presented to BSET for approval in 2008
Appendix 12	The rates of participation by College Fellows in the College's last CPD cycle, and the attendance at SAT SET workshops since its inception in April 2007

Appendix 1

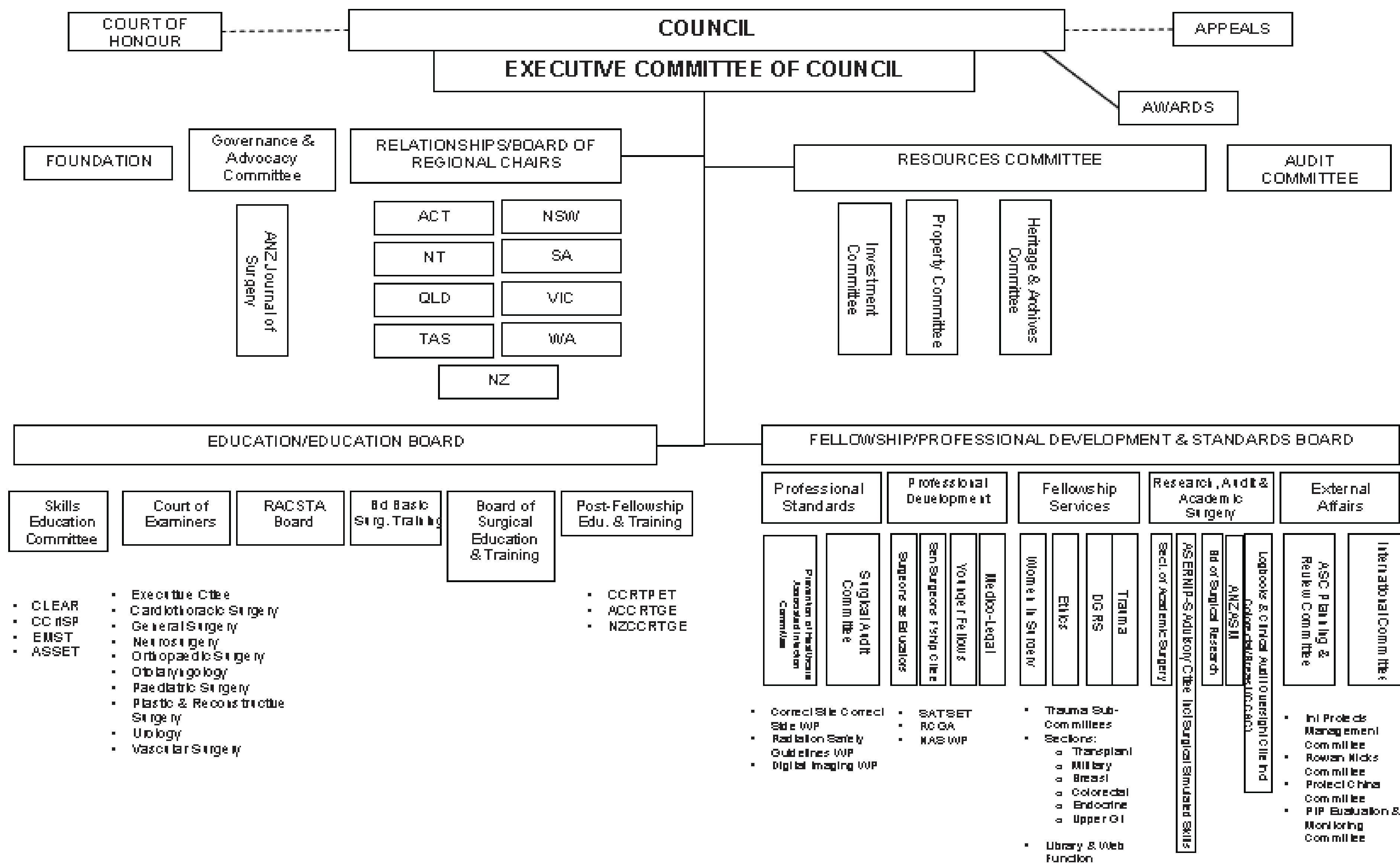
List of Acronyms

ASSET	Australian and New Zealand Surgical Skills Education and Training (course)
ASSH	Australian Society of Simulation in Healthcare
BST	Basic Surgical Training
BSET	Board of Surgical Education and Training
CPD	Continuing Professional Development
COAG	Council of Australian Governments
EB	Education Board
ESC	English-Speaking Countries
FRACS	Fellow of the Royal Australasian College of Surgeons
GSA	General Surgeons Australia
HWPC	Health Workforce Principal Committee
IMG	International Medical Graduate
iMIS	College business database software system
NHWT	National Health Workforce Taskforce
NZAGS	New Zealand Association of General Surgeons
PDSB	Professional Development and Standards Board
PFET	Post Fellowship Education and Training
RACS	Royal Australasian College of Surgeons
RACSTA	Royal Australasian College of Surgeons Trainee Association
SAT SET	Supervisors and Trainers for SET (course)
SET	Surgical Education and Training
SSE	Surgical Science Examination

Surgical Specialties

CS	Cardiothoracic Surgery
GS	General Surgery
NS	Neurosurgery
OS	Orthopaedic Surgery
OHNS	Otolaryngology Head & Neck Surgery
PS	Paediatric Surgery
P&RS	Plastic & Reconstructive Surgery
U	Urology
VS	Vascular Surgery

Appendix 2 Governance Committees of the College Council



Appendix 3

Policies relating to education, training or CPD reviewed and updated in 2008

Council Approved Policies		
SET Clinical Examination - Conduct	Jun '08	EDA
SET Generic Surgical Science Examination - Conduct	Jun '08	EDA
SET Specialty Specific Surgical Science Examination	Jun '08	EDA
Anatomy Committee Terms of Reference	Jun '08	EDA
Clinical Committee Terms of Reference	Jun '08	EDA
Pathology Committee Terms of Reference	Jun '08	EDA
Physiology Committee Terms of Reference	Jun '08	EDA
Skills Education Committee Terms of Reference	Jun '08	EDA
Terms of Reference Post Fellowship Education & Training Steering Committee	Jun '08	ETA
ASSET TOR	Oct '08	EDA
CCrISP Committee TOR	Oct '08	EDA
EMST Committee TOR	Oct '08	EDA
Surgical Science and Clinical Examinations Committee TOR	Oct '08	EDA
NZ Censor Position Description	Oct '08	EDA
Specialist Assessment of IMGs in Australia	Oct-08	ETA
Recognition of Prior Learning and Credit Transfer Policy	Oct-08	ETA
Accreditation of Hospital Posts	Oct-08	EDA
Rural Surgical Training Program	Sept-08	F&S

Appendix 4

Timetable for the planned moved to competency-based training

The Royal Australasian College of Surgeons recognises competencies as a holistic combination of knowledge, skills and attitudes which, whilst the competencies are articulated as nine separate facets, together define the high standard of safe and comprehensive surgical care for the community expected of every surgical graduate.

The College also recognises the difference between competence and performance. For this reason trainee assessment will focus on specific time/specific skill assessment (such as DOPS; Mini-CEX; and examinations) and longer term/wider perspective assessment in the workplace (such as log-books and in-training assessment).

However, the College acknowledges that workplace-based 'competency' assessment poses major challenges in its implementation including the need for:

- well trained supervisors and trainers who will be undertaking these assessments
- trials on the implementation of tools such as mini-CEX and the DOPS
- on-going evaluation to ensure that appropriate training experiences are being provided
- discussion with the jurisdictions in order for surgeons to have the time required to undertake these assessments.

The move to competency-based training (CBT) will be implemented slowly and carefully with due attention to the progress being made internationally in the introduction of CBT, and the need to maintain the high standard of the current training program.

As indicated in the time-line on the following pages, the plan to introducing CBT is based on the recognised need to progress slowly, being informed at each stage by evaluation of our own processes as well as information from international developments:-

- Introduction of competency-based assessment in the Fellowship Examination has already begun as the content is being aligned to the curricula. This will be a work in progress over several years and will be informed by experience as well as Workplace-based Assessment. Despite the publications available on the methodology to undertake this type of assessment, there is as yet no literature on its actual use in major examinations such as the Fellowship. For this reason it is not possible to give a specific timeline but reports to the AMC will cover the progress.
- Selection will be reviewed each year and clear recommendations made before the next round is undertaken.
- Curricula have been converted to a competency-based format and these will be continuously reviewed in the light of experience by each specialty and the published international literature.
- The increased use of simulation for training of technical skills will be carefully monitored

Importantly, on-going and meaningful consultation with the jurisdictions will be required to ensure that nay potential effect on the current workforce system is recognised and managed. For examples, such issues may arise if a trainee fails to reach the required standard and has to repeat a training period. The College and its specialties have experience in managing trainees who may be underperforming but the numbers may increase in this new system.

Up-dated timeline for the progressive implementation of SET as a competency based training program

Activity	⇩ 2007	2007	2008	2009	2010	2011	2012	2013+	Progress / Completed	Contingences and external factors
Research of international developments and world-best practice									On-going	
Involvement of specialty Boards and examination Courts and committees in writing, reviewing, and revising materials									On-going	This is an ongoing process because members of Boards and Courts are constantly changing, and relationships between the College and Specialties can also change
Definition of RACS competencies									Completed	
Definition of specialty specific competencies for training									Completed	
Definition of specialty specific modules – technical expertise; medical expertise; judgement – clinical decision making									Completed	
Definition of generic modules — non-technical modules									Completed	
Aligning specialty specific competencies with in-training assessment processes									Completed	
Development of specialty specific assessment matrix aligned with competencies									Completed	
Aligning specialty specific competencies with Fellowship Examinations									On-going	
SAT SET program for supervisors – Phase 1									See Report on progress	The introduction of CBT is contingent upon having trainers and supervisors who are skilled in the assessment and evaluation of competencies. CBT may require increased supervisor/ trainer time in the workplace. Negotiation and collaboration with Jurisdictions will be required to achieve recognition of designated time and/or paid supervision
Introduction of Mini-CEX and DOPS for SET1 trainees. This will be ongoing as trainees progress – introduced to all levels of training at appropriate intervals and frequency									See Report on progress	

Activity	⇧ 2007	2007	2008	2009	2010	2011	2012	2013 +	Progress / Completed	Contingences and external factors
Accredited simulated training in technical skills. This will include but not be limited to: ▪ Laparoscopic skills ▪ Colonoscopy skills ▪ Endoscopic skills And may require programs at basic, intermediate and advanced levels									On-going	This depends upon: ▪ Validation research demonstrating that these experiences enhance/facilitate training and can transpose to the clinical setting ▪ Broad access by trainees to high and low fidelity simulators ▪ Development of curriculum and validated assessment tools ▪ Availability of Simulation Trainers
Alignment of Surgical Science and Clinical examinations with appropriate competencies Development of generic and speciality specific components for the Surgical Science exam									Completed See Report for proposed changes	
Development of the Policy and procedures for the Recognition of Prior Learning									Completed	
Evaluation of selection processes to ascertain the extent to which they reflect the required competencies									Ongoing	
Evaluation of formative assessment processes (ITA; Mini-CEX; DOPS; log books) to ensure that they accurately identifying trainees' level of competence and performance at an early stage of training, and through out training									Ongoing	
Possible introduction of additional tools such as 360° to assess performance									See Report	
Evaluation of Fellowship Examination to ascertain the extent to which elements of the examination are being addressed earlier in the program									Yet to be considered - SET is only in its 2nd year	This will depend upon clear communication between specialty boards and the College, and cooperation between the specialty examination Courts
Evaluation of SET training program to ascertain effectiveness of training and identify; a. Additional competency training programs which may be required b. Principles on which training time may be varied c. Where there may be scope for shortening training period									a. See Report on progress b&c. SET is only in its 2nd year	

The development of web based educational materials to support training and encompass non-technical competencies									On-going	
SAT SET program for supervisors – Phase 2									See Report on progress	
Negotiating and collaborating with Jurisdictions to manage the risk of any adverse impact on workforce requirements and effect on employment conditions eg salary scale determinations									On-going	

Appendix 5 Specialist Assessment of International Medical Graduates in Australia Policy

Division: **Department:** **Title:**	**Policies and Procedures** **Education and Training Administration** **Specialist Assessment of International Medical Graduates in Australia**	**Ref. No.:** **Approval Date: Review Date: Revision No.: Page:**	**EDU_IMG_0003_P** **October 2008 October 2011** **0** **1 of 6**

1. PURPOSE AND SCOPE

The purpose of this policy is to define the assessment of International Medical Graduates (IMGs) in Australia according to the directions of Council and taking into account the relationship between the College and the Australian Medical Council (AMC).

2. KEYWORDS

As a fellowship based organisation, the Royal Australasian College of Surgeons commits to ensuring the highest standard of safe and comprehensive surgical care for the community we serve through excellence in surgical education, training, professional development and support.

3. VALUES

- Service and Professionalism
  performing to and upholding the highest standards

- Integrity
  upholding professional values

- Respect and Compassion
  being sympathetic and empathetic

- Commitment and Diligence
  being dedicated, doing one's best to deliver

- Collaboration and Teamwork
  working together to achieve the best outcome

4. BACKGROUND

The purpose of this policy is to define the assessment of International Medical Graduates' suitability for independent specialist surgical practice in Australia, according to the directions of Council and taking into account the relationship between the College and the Australian Medical Council.
The normal pathway to independent specialist surgical practice involves obtaining Fellowship of the College by completing a training program and exit examination. Under these circumstances the Australian jurisdictions and public can be assured both of the quality of training and the standards of the exit examination as all aspects are under the aegis of the College.
This policy defines the process for assessing the comparability of International Medical Graduates to holders of the College Fellowship, and hence their suitability for independent surgical practice.
Any IMG seeking Fellowship of the College will be assessed in accordance with this policy.
This policy should be read in conjunction with the following policies:

a. Clinical Assessment of International Medical Graduates in Australia
b. Endorsement of Occupational Training Visas in Australia
c. Selection to Surgical Education and Training
d. Articles 19 and 21 of the Articles of Association of the Royal Australasian College of Surgeons

5. BODY OF POLICY

Assessment Process

International Medical Graduates (IMGs) with formal postgraduate specialist qualifications may apply through the AMC for assessment of their qualifications. The AMC will verify the applicant's qualifications through the International Credentials Service of the Educational Commission for the Foreign Medical Graduates of the United States (ECFMG). The documents will be forwarded to the ECFMG for verification from the original issuing university or institution. The applicant will then be referred to the College for a specialist assessment subject to the provisions of this policy.

5.1.2. The specialist assessment of the IMG focuses on education, training, quality, quantity and scope of clinical experience, level of formal assessment including specialist qualifications in surgery, recency of relevant practice (i.e. practice within the last 2 years) and relevant professional skills and attributes in order to determine substantial comparability with Australian standards.

5.1.3. The College considers applications received under the following categories:

a. IMGs who wish to practice as an independent specialist

b. IMGs who wish to work in a position designated as an Area of Need (AoN). For more information refer to the AMC's website www.amc.org.au.

5.1.4. The College reviews the request based on the applicant's qualifications and experience as summarised above. This will determine the recommendation (refer Section 5.3 Assessment Recommendations).

5.1.5. The documentation required to commence a specialist assessment is obtained from the AMC. Applications for specialist assessment will be activated from the date all requested documentation and payment of the assessment fee is received by the College. Applications for AoN will proceed once the College has assessed and approved the designated AoN position and the activation date occurs when all requested documentation and payment of the assessment fee is received.

5.1.6. The specialist assessment of IMGs consists of a document based assessment and may include a face to face semi-structured panel interview. The interview is only available to IMGs who are deemed from the document based assessment to provide sufficient evidence of specialist training. The assessment interview panel composition is detailed in the College Policy on Terms of Reference for International Medical Graduate Assessment Interview Panels in Australia.

5.1.7. The Area of Need assessment should normally be completed within two months from the activation date and the specialist assessment within three months of the activation date.

5.2. Assessment Standards

5.2.1. A Specialist Assessment focuses on surgical qualifications and clinical experience in order to determine substantial comparability with a surgeon who has trained in Australia.

5.2.2. An Area of Need assessment focuses on surgical qualifications and clinical experience in order to determine substantial comparability with a surgeon who has trained in Australia with regard to the defined scope of practice. The level of experience of the IMG is assessed against a specified set of criteria derived from the requirements stated in the position description for the AoN position. The College will also undertake an assessment of the AoN position to make a determination on whether the position should be approved. The assessment will include a review of the workplace infrastructure and professional support relating to the position description.

5.3. Assessment Recommendation: Not Comparable

5.3.1. An IMG will be deemed not comparable if:

a. There is insufficient evidence of recency of specialist surgical practice in the relevant specialty comparable to that of an Australian or New Zealand trained surgeon in the specialty; or
b. There is insufficient evidence of completion of a comparable specialist training program to the College programs including the competencies, skills and attributes; or

5.3.2. Where an applicant is deemed not comparable they will be referred to the AMC to fulfil AMC requirements for medical registration and advised to apply in open competition to enter the College's Specialist Education Training (SET) program for further training.

5.5.3 An IMG may be assessed as not comparable on the basis of a document-based assessment alone, or by a subsequent assessment interview.

5.4. Assessment Recommendation: Partially Comparable

5.4.1. Following a paper-based assessment and an interview, an IMG will be deemed partially comparable if:

a. There is evidence of recency of surgical practice in the relevant specialty; and

b. There is evidence of completion of a specialist training program comparable to the College programs including the competencies, skills and attributes; and

c. The applicant has not completed a comparable exit examination to the College Fellowship Examination and/or the depth and scope of surgical practice in the specialty since the attainment of their surgical qualification is not of a sufficiently high standard or duration as to waive the need to sit the Fellowship Examination.

5.4.2. Where an applicant is deemed partially comparable they will be required to:

a. Undertake a designated supervision and/or oversight period of 12 - 24 months; and
b. Successfully complete any additional skills courses nominated by the Assessment Panel; and
c. Successfully complete the Fellowship Examination of the College; and

d. Upon satisfactory completion of (a), (b) and (c) be eligible to apply for Fellowship under Article 19.

5.5. Assessment Recommendation: Substantially Comparable

5.5.1. Following a paper-based assessment and an interview, an IMG will be deemed substantially comparable if:
a. There is evidence of recency of surgical practice in the relevant specialty; and
b. There is evidence of completion of a specialist training program comparable to the College programs including the competencies, skills and attributes; and
c. There is evidence of successful completion of a exit examination comparable to the College Fellowship Examination and/or the depth and scope of surgical practice in the specialty is of a sufficiently high standard as to waive the need to sit the Fellowship Examination.

5.5.2. In exceptional circumstances an IMG may be assessed as exceeding the standard of substantial comparability to an Australian or New Zealand trained surgeon within a defined scope of practice. Where the defined scope of surgical practice is considered valuable to the community and conforms to the goals of the College and specialty discipline, the IMG **may** be recommended to Fellowship within this defined scope of practice. Please refer to the policy on Authorisation to Approve Fellowship Pursuant to Article 21.

5.5.3. Where an IMG is deemed substantially comparable they will be required to:
a. Undertake a designated oversight period of between 12 months and 24 months; and
b. Successfully complete any additional skills courses nominated by the Assessment Panel; and
c. Apply for Fellowship under Article 21.

5.6. Assessment Recommendation: Area of Need Comparability

5.6.1. An IMG will be deemed to have comparability for an AoN position if:

a. There is evidence of recency of specialist surgical practice in the relevant specialty, comparable to that of an Australian or New Zealand trained surgeon within the defined scope of practice relevant to the AoN position; and
b. There is evidence of completion of a specialist training program comparable to the College programs including the competencies, skills and attributes relevant to those required for the AoN position.

5.6.2. An applicant deemed suitable for an AoN position will be required to undertake a designated period of supervision and/or oversight of between 12 - 24 months.

5.7. Notification and Feedback

Notification of the recommendation after assessment will be sent to the applicant and the AMC. The recommendation will include feedback on the decision making process and reasons for the outcome justifying (where applicable) why the applicant was not found to be substantially comparable.

5.8. Validity of Assessment/Validity Period

5.8.1. Supervision and/or oversight periods recommended in 5.4 and 5.5 must be commenced within 24 months of the recommendation dates otherwise the recommendation expires.

5.8.2. IMGs must complete all elements of the recommendation, including the Fellowship Examination if applicable, within 4 years from the date that the oversight and/or supervision period commences otherwise the recommendation expires.

5.8.3. The recommendation 5.6 is valid for a maximum of three years and is subject to the validity of the AoN position as determined by the relevant State Health Department.

5.9. Subsequent Assessments

IMGs may apply for subsequent assessments when:

5.9.1. An assessment is no longer valid (see 5.8 Validity of Assessment).

5.9.2. An assessment is still valid but the IMG submits new data and requests to have the initial recommendation reconsidered.

5.9.3. A complaint or appeal has resulted in a recommendation for reassessment.

5.10. Fees

5.10.1. Prior to the commencement of a specialist assessment, initial or subsequent, an Assessment Fee, is payable.

5.10.2. Supervision and Oversight of clinical practice incurs an additional fee.

5.10.3. Fees are approved by Council in October each year and published on the College website.

5.11. Educational support

5.11.1. An IMG who has undergone a specialist assessment and who is found to be partially comparable will have equal access to all educational opportunities that are currently offered to Australian and New Zealand trainees preparing for the Fellowship Examination.

5.11.2. Education opportunities can be accessed by all IMGs preparing for the Fellowship Examination at a fee.

5.12. Presenting for Examinations

IMGs required to present for the Fellowship Examination are referred to the respective policies in relation to the number of attempts an applicant is permitted to make to this Examination.

5.13. Appeal

Decisions relating to specialist assessment of International Medical Graduates in Australia may be reviewed or appealed in accordance with the College Appeals Mechanism.

3. PROCEDURES

6.1 Access

General public.

6.2 Communication

The most recent version of the policy will be available on the College website.

Approver CEO
Authoriser Council

Appendix 6

Outcomes of applications from International Medical Graduates, 2008

APPLICATIONS	Area of Need			
	ESC*	ESC** & Others	Non ESC*** Only	TOTAL
Activated	10	6	8	24
Completed	10	6	7	23
In Progress	0	0	1	1
COMPLETION TIME				
Less than 8 weeks	6	4	4	14
More than 8 weeks	4	2	3	9
SPECIALIST ASSESSMENT				
Activated	21	13	54	88
Completed	18	11	43	72
In Progress	3	2	11	16
COMPLETION TIME				
Less than 12 weeks	16	11	40	67
More than 12 weeks	2	0	3	5
ASSESSMENT OUTCOMES	ALL POSITIONS			
Undertaking clinical assessment specified	2	3	29	34
Partially Comparable	9	7	16	32
Substantially comparable	17	7	5	29
ASSESSMENT OF CLINICAL PRACTICE	TRAINING			
Undertaking/completed period of assessment of clinical practice specified	14	8	12	34

Source: RACS. Management Report, as at 31 December 2008

NOTES: *ESC: English-speaking Country. ** The category 'Non-ESC & Others' has been used to identify applicants from a Non-English Speaking Country that have completed subsequent training in an English Speaking Country.*** Non English Speaking Country has been used to identify applications from a Non-English speaking country that have **not** completed subsequent training in an English Speaking Country

Appendix 7

2009 Revised Table of Communiciation with Supervisors and Trainees – by specialty

Communication with Supervisors

	Majority of supervisors members of state committees	**Majority of supervisors members of Board**	**Board convenes special meeting(s) with supervisors**	**Annual scientific meeting**	**Other**
Cardiothoracic					Regular email and mail communication
General	Each hospital network has at least one supervisor member of the Regional Subcommittee of the BiGS. Meetings held regularly during the year.	No. General Surgery too large. Each Regional Chair (also a supervisor) sits on the Specialty Board.	Plan to introduce, but logistics difficult due to number of supervisors. However, investigating options in this regard. See "other".	- ASC – BiGS and Regional Subcommittees meet with communication to supervisors from this. - Three face to face meetings of the BiGS per year, 9 teleconferences - Regional Supervisor committees meet every two months, directly after the BiGS meeting.	Supervisors will receive copies of the Trainee newsletter. - Instead of physical meeting, may introduce biannual webinar regionally based or request a representative from each jurisdiction to represent those supervisors for a physical meeting. -Survey to be sent to all supervisors this year regarding training program -plan to produce a guide for supervisors
Neurosurgery			Yes – see ASM	Meeting with supervisors during the ASM	Regular email and mail communication and a special section in the NSA Newsletter for the SET Program
Otolaryngology Head & Neck	Regional training sub-committees have meetings throughout the year (amounts vary from state to state)	State Chairs are Board members and communicate supervisors comments from their state.	No	Special meeting at ASM for supervisors	Board Chair in email contact
Orthopaedic	All supervisors are members of their state-based Regional Training Committee (RTC). In NSW, supervisors sit on both a geographically-based "Board of Studies" and a Regional Training Committee. RTCs meet quarterly.	No RTC Chairmen sit on the AOA Training Committee. The Training Committee meets three times per year.		The AOA Training Committee meets at the AOA ASM. Meetings and seminars addressing education and supervision are convened on an ad hoc basis.	Regular e-mail communication.
Paediatric			✓ X2 per year	x2 per year special meeting included	Regular e-mail communication
Plastic &	✓				e-mail

Reconstructive					
Urology	All urology supervisors are members of the Section (State or NZ) training committee	State (or NZ) Head of training is a member of Board of Urology		Meeting of trainees and supervisors at ASM	Regular e-mail communication
Vascular			Board meets with supervisors in each Region, depending on where the Board meeting is being held.	Meeting of all vascular supervisors is held at the ASC.	Regular email communication

Communication with Trainees

	Trainee association	Trainee representation on Board	Trainee evaluation of each rotation	Annual scientific meeting	Other
Cardiothoracic					Regular email and mail communication
General	✓	Yes. Trainee rep on BiGS and in regional subcommittees	Trainee feedback for each rotation completed - introduced 2009. Or as requested in a particular region if quinquennial inspections are being carried out.	Trainee's day. Trainee exam demystifying session. Trainee presentation day. Trainee dinners. GSA meeting in SEPT each year has become a trainee driven and orientated meeting.	- Regular communication via queries, trainee newsletter, Website information, email blasts, mailouts. - One staff member per region and further three head office staff specifically for General Surgery training. - New trainee handbook and welcome kit will be sent October 2009. - Website updates to include an online trainee forum.
Neurosurgery	✓	✓	Conducted on a six monthly basis and will be online from 2010 onwards	Trainee breakfast meeting with Board Chairman	Regular email and mail communication and a special section in the NSA Newsletter for the SET Program Discussion forums during twice yearly compulsory trainee seminar
Otolaryngology Head & Neck		Trainee Rep on Board. Permanent Trainee Rep item on Board agenda.	Commenced 2009	Annual trainee conference at which attendance is compulsory. Compulsory attendance at Society ASM	Designated employee for trainee contact Trainees evaluate each rotation at their 6 monthly interview

Orthopaedic	Trainees can become members of AORA (Australian Orthopaedic Registrars' Association)	There is a registrar representative on each RTC and on the AOA Training Committee.	Trainee Report on Hospital Post evaluation at the end of each rotation	Trainees are invited to participate in the AOA ASM. AORA also convenes an annual conference	Regular email contact. The AOA Training Officer is the designated contact for Orthopaedic trainees.
Paediatric	Yes	Yes - regular e-mail contact pre- and post-Board meetings	Yes	Informal meetings as required	Annual individual interviews
Plastic & Reconstructive	✓	✓		Annual Registrars' Conference.	Interviews during Accreditation Inspections.
Urology		✓	✓	✓	Has a designated employee for trainee contact Trainee meeting held during registrar trainee week
Vascular	Yes	Yes	Yes		Trainee interviews are held annually. Trainee meetings are scheduled on a similar model to supervisors' meetings (i.e. if Board meeting is held in Brisbane, all QLD trainees are invited to attend a trainees' meeting). Regular email communication

Appendix 8

The results of the Examinations, 2008

CLINICAL EXAMINATION – CANDIDATES WHO PASSED THE EXAMINATION BY LOCATION, TYPE AND SPECIALTY (NOS & %)

Location ➡ & Type & Specialty ⬇		ACT	NSW	NT	QLD	SA	TAS	VIC	WA	Total AUST	NZ	O/S	Total
BST	No	0	12	0	6	2	1	12	3	36	13	0	**49**
	%	0	92%	0	100%	100%	100%	100%	75%	95%	81%	0	**91%**
SET	No	1	33	0	25	9	2	53	5	128	24	0	**152**
	%	100%	89%	0	89%	100%	100%	95%	83%	92%	96%	0	**93%**
CAR		0	0	0	0	0	0	3	0	3	0	0	3
GEN		0	27	0	15	3	2	30	4	81	11	0	92
NEU		0	2	0	2	0	0	2	0	6	2	0	8
ORT		0	2	0	1	5	0	6	1	15	3	0	18
OHN		0	0	0	0	0	0	1	0	1	3	0	4
PAE		0	0	0	1	0	0	0	0	1	0	0	1
PLA		0	0	0	0	0	0	1	0	1	0	0	1
URO		0	0	0	4	0	0	9	0	13	4	0	17
VAS		1	2	0	2	1	0	1	0	7	1	0	8
TOTAL PASS RATE NOS		**1**	**45**	**0**	**31**	**11**	**3**	**65**	**8**	**164**	**37**	**0**	**201**
TOTAL PASS RATE %		100%	90%	0	91%	100%	100%	96%	80%	93%	90%	0	**92%**

Source: RACS. Management Report, as at 31 December 2008

BASIC SCIENCE EXAMINATION – CANDIDATES WHO PASSED THE EXAMINATION BY LOCATION, TYPE AND SPECIALTY (NOS & %)

Location ➡ & Type & Specialty ⬇		ACT	NSW	NT	QLD	SA	TAS	VIC	WA	Total AUST	NZ	O/S	Total
BST	No	0	5	0	1	0	0	3	1	10	4	0	**14**
	%	0	71%	0	100%	0	0	100%	100%	67%	67%	0	67%
SET	No	0	9	0	7	2	1	7	3	29	2	0	**31**
	%	0	75%	0	88%	100%	100%	70%	75%	78%	100%	0	79%
CAR		0	0	0	0	0	0	1	0	1	0	0	**1**
GEN		0	5	0	5	1	1	4	3	19	1	0	**20**
NEU		0	1	0	1	0	0	0	0	2	0	0	**2**
ORT		0	1	0	0	1	0	1	0	3	0	0	**3**
OHN		0	0	0	0	0	0	0	0	0	0	0	**0**
PAE		0	0	0	0	0	0	1	0	1	0	0	**1**
PLA		0	0	0	0	0	0	0	0	0	0	0	**0**
URO		0	0	0	1	0	0	0	0	1	0	0	**1**
VAS		0	2	0	0	0	0	0	0	2	1	0	**3**
TOTAL PASS RATE NOS		**0**	**14**	**0**	**8**	**2**	**1**	**10**	**4**	**39**	**6**	**0**	**45**
TOTAL PASS RATE %		**0**	**74%**	**0**	**89%**	**50%**	**100%**	**77%**	**80%**	**75%**	**75%**	**0**	**75%**

Source: RACS. Management Report, as at 31 December 2008

SURGICAL SCIENCE EXAMINATION (GENERIC) – CANDIDATES WHO PASSED THE EXAMINATION BY LOCATION, TYPE AND SPECIALTY (NOS & %)

Location ➡ & Type & Specialty ⬇		ACT	NSW	NT	QLD	SA	TAS	VIC	WA	Total AUST	NZ	O/S	Total
BST	No	0	6	0	2	4	0	3	2	17	1	0	**18**
	%	0	100%	0	100%	100%	0	75%	100%	94%	100%	0	**95%**
SET	No	1	25	0	10	7	1	29	6	79	5	0	**84**
	%	100%	93%	0	83%	88%	100%	94%	100%	92%	100%	0	**92%**
CAR		0	0	0	0	0	0	1	0	1	0	0	**1**
GEN		0	21	0	6	3	1	19	3	53	4	0	**57**
NEU		0	1	0	1	0	0	1	0	3	0	0	**3**
ORT		1	1	0	0	2	0	3	1	8	0	0	**8**
OHN		0	1	0	0	0	0	0	1	2	0	0	**2**
PAE		0	0	0	0	0	0	0	0	0	0	0	**0**
PLA		0	0	0	1	0	0	1	0	2	0	0	**2**
URO		0	0	0	2	1	0	3	1	7	1	0	**8**
VAS		0	1	0	0	1	0	1	0	3	0	0	**3**
TOTAL PASS RATE NOS		**1**	**31**	**0**	**12**	**11**	**1**	**32**	**8**	**96**	**6**	**0**	**102**
TOTAL PASS RATE %		100%	94%	0	86%	92%	100%	91%	100%	92%	100%	0	**93%**

Source: RACS. Management Report, as at 31 December 2008

Surgical Science Examination (Specialty Specific)
Candidates who Passed the Examination by Location, Type and Specialty (Nos & %)

Location ➡ & Type & Specialty ⬇		ACT	NSW	NT	QLD	SA	TAS	VIC	WA	Total AUST	NZ	O/S	Total
SET	No	0	12	0	5	1	1	17	4	40	3	0	**43**
	%	0	46%	0	50%	20%	100%	68%	80%	56%	75%	0	**57%**
GEN		0	11	0	4	1	1	13	2	32	2	0	**34**
NEU		0	0	0	0	0	0	0	0	0	0	0	**0**
OHN		0	1	0	0	0	0	0	1	2	0	0	**2**
URO		0	0	0	1	0	0	3	1	5	1	0	**6**
VAS		0	0	0	0	0	0	1	0	1	0	0	**1**
Total Pass Rate Nos		0	12	0	5	1	1	17	4	40	3	0	**43**
Total Pass Rate %		**0**	**46%**	**0**	**50%**	**20%**	**100%**	**68%**	**80%**	**56%**	**75%**	**0**	**57%**

Source: RACS. Management Report, as at 31 December 2008

Fellowship Exam Annual Total Candidates

(number who presented by specialty and Location)

Location ➡ & Specialty and Memb type ⬇		ACT	NSW	NT	QLD	SA	TAS	VIC	WA	Total AUST	NZ	O/S No Address	Total Sitting
CAR	IMG	0	1	0	0	0	0	0	0	1	0	0	**1**
	Surgical Trainee	0	3	0	0	0	0	1	0	4	0	0	**4**
GEN	IMG	1	3	1	2	0	0	3	0	10	0	0	**10**
	Surgical Trainee	1	24	0	11	8	0	13	3	59	16	2	**78**
NEU	IMG	0	0	0	0	2	0	0	0	2	0	1	**3**
	Surgical Trainee	0	3	0	1	0	0	3	0	7	0	1	**8**
ORT	IMG	0	2	0	4	1	3	1	2	13	0	0	**13**
	Surgical Trainee	0	18	1	9	4	0	11	8	51	10	1	**63**
OHN	IMG	1	0	0	0	0	1	1	0	3	0	0	**3**
	Surgical Trainee	0	6	0	3	1	0	4	0	14	2	1	**17**
PAE	IMG	0	3	0	0	0	0	1	0	4	0	1	**5**
	Surgical Trainee	0	0	0	0	0	0	0	0	0	0	0	**0**
PLA	IMG	1	0	0	0	0	1	1	0	3	0	0	**3**
	Surgical Trainee	0	2	0	3	0	0	4	2	11	0	0	**11**
URO	IMG	0	1	0	1	0	0	1	1	4	0	0	**4**
	Surgical Trainee	0	8	0	1	1	0	5	1	16	2	0	**18**
VAS	IMG	0	1	0	2	0	0	0	1	4	0	0	**4**
	Surgical Trainee	0	4	0	0	0	0	2	1	7	2	0	**9**
TOTAL		**4**	**79**	**2**	**37**	**17**	**5**	**51**	**19**	**213**	**32**	**8**	**254**
IMG		3	11	1	9	3	5	8	4	44	0	2	**46**
Surgical Trainee		1	68	1	28	14	0	43	15	169	32	6	**208**

Source: RACS. Management Report, as at 31 December 2008

EXAM. 6: Fellowship Exam Annual Pass Rates

(number passed & % pass of all sitting)

Location ➡ & Specialty and Memb Type ⬇		ACT	NSW	NT	QLD	SA	TAS	VIC	WA	Total AUST	NZ	O/S No Add-ress	Total Number Passed	Pass Rate %
CAR	IMG	0	1	0	0	0	0	0	0	1	0	0	**1**	100%
	Surgical Trainee	0	2	0	0	0	0	1	0	3	0	0	**3**	75%
GEN	IMG	0	4	0	1	0	0	1	0	6	0	0	**6**	55%
	Surgical Trainee	2	17	0	8	6	0	11	2	46	15	1	**62**	81%
NEU	IMG	0	0	0	0	2	0	0	0	2	0	0	**2**	67%
	Surgical Trainee	0	3	0	1	0	0	1	0	5	0	1	**6**	75%
ORT	IMG	0	0	0	2	1	0	0	1	4	0	0	**4**	31%
	Surgical Trainee	0	15	1	8	3	0	10	7	44	10	0	**54**	86%
OHN	IMG	0	0	0	0	0	1	1	0	2	0	0	**2**	67%
	Surgical Trainee	0	5	0	3	1	0	3	0	12	3	1	**16**	95%
PAE	IMG	0	3	0	0	0	0	1	0	4	0	1	**5**	100%
	Surgical Trainee	0	0	0	0	0	0	0	0	0	0	0	**0**	0
PLA	IMG	1	0	0	0	0	1	0	0	2	0	0	**2**	67%
	Surgical Trainee	0	3	0	2	0	0	3	0	8	0	0	**8**	73%
URO	IMG	0	1	0	1	0	0	0	0	2	0	0	**2**	67%
	Surgical Trainee	0	6	0	1	1	0	5	1	14	2	0	**16**	84%
VAS	IMG	0	1	0	0	0	0	0	1	2	0	0	**2**	50%
	Surgical Trainee	0	4	0	0	0	0	1	1	6	2	0	**8**	89%
TOTAL		**3**	**65**	**1**	**27**	**14**	**2**	**38**	**13**	**163**	**32**	**4**	**199**	78%
IMG		1	10	0	4	3	2	3	2	25	0	1	**26**	57%
Surgical Trainee		2	55	1	23	11	0	35	11	138	32	3	**173**	83%

Source: RACS. Management Report, as at 31 December 2008

Appendix 9

Trainees (and IMGS) completing training in 2008

NEW FELLOWS ADMITTED IN 2008 BY APPLICANT TYPE AND SPECIALTY

Applicant Type➡ & Specialty ⬇	Surgical Trainees	Active Fellow*	IMG**	Total 2008
CAR	7	0	4	**11**
GEN	61	1	15	**77**
NEU	14	0	3	**17**
ORT	37	0	3	**40**
OHN	11	0	1	**12**
PAE	0	0	3	**3**
PLA	21	0	3	**24**
URO	16	0	3	**19**
VAS	4	0	2	**6**
TOTAL	**171**	**1**	**37**	**209**

Source: RACS. Management Report, as at 31 December 2008
* Includes one Fellow admitted to a second specialty
** Excludes international medical graduates (IMGs) who have undertaken formal surgical training

Appendix 10

Selection into SET 2008

SET Applications by Specialty and Location

Location ➡ & Specialty ⬇	ACT	NSW	NT	QLD	SA	TAS	VIC	WA	Total AUST	NZ	O/S	Total 2008
CAR	0	13	0	6	0	0	11	4	**34**	5	0	**39**
GEN	4	95	1	53	10	5	65	11	**244**	45	2	**291**
NEU	1	21	0	8	1	1	9	2	**43**	5	1	**49**
OHN	2	39	0	17	7	2	28	5	**100**	13	0	**113**
ORT	4	55	1	34	16	4	43	14	**171**	31	0	**202**
PAE	0	13	0	4	0	0	3	1	**21**	3	1	**25**
PLA	2	33	1	18	8	5	50	12	**129**	15	0	**144**
URO	1	26	1	19	5	2	30	9	**93**	12	0	**105**
VAS	1	20	0	7	1	0	9	5	**43**	6	0	**49**
TOTAL	**15**	**315**	**4**	**166**	**48**	**19**	**248**	**63**	**878**	**135**	**4**	**1017**

Source: RACS. Management Report, as at 31 December 2008

SET Accepted Offers by Specialty and Type

Type ➡ & Specialty ⬇	BST 1	BST 2	BST 3	BST 4	SET	IMG	Person	Total
CAR	0	1	0	0	0	1	6	**8**
GEN	0	30	9	6	0	1	83	**129**
NEU	0	2	0	1	1	0	9	**13**
OHN	0	3	4	2	7	0	12	**28**
ORT	0	15	20	21	0	1	21	**78**
PAE	0	0	1	1	3	1	2	**8**
PLA	0	0	4	0	9	0	3	**16**
URO	0	2	0	0	14	0	9	**25**
VAS	0	3	0	2	2	0	9	**16**
TOTAL	**0**	**56**	**38**	**33**	**36**	**4**	**154**	**321**

Source: RACS. Management Report, as at 31 December 2008

Appendix 11

Hospital accreditations presented to BSET for approval in 2008

Note:

Except when new posts are being accredited, or specific posts require attention, specialties tend to focus their inspections in specific regions each year in a three or five year rotation. Some posts have been accredited for short periods of time to bring them into line with those regional accreditation rotations.

Specialty		Posts accredited
Cardiothoracic Sugery	NZ	Dunedin Hospital, 1 post accredited for 2 years Waikato Hospital, 1 post accredited for 3 years
	SA	Royal Adelaide Hospital, 1 post accredited for 5 years Flinders Medical Centre, 1 post accredited for 5 years
	Vict	Austin Hospital, 1 post approved for 1 year Geelong Hospital, 1 post accredited for 3 years
	NSW	Prince of Wales Hospital, 1 post accredited for 2 years
	Q'land	The Prince Charles Hospital, 2 posts accredited for 3 years Princess Alexandra Hospital, 1 post accredited for 3 years
	WA	
General Surgery	NZ	Auckland Hospital, 6 posts accredited for 5 years Christchurch Hospital, 6 posts accredited for 5 years Dunedin Hospital, 4 posts accredited for 5 years Hamilton Hospital, 3 posts accredited for 5 years Middlemore Hospital, 6 posts accredited for 5 years Hawkes Bay Hospital, 2 posts accredited for 5 years Nelson Hospital, 2 posts accredited for 5 years North Shore Hospital, 5 posts accredited for 5 years Rotorua Hospital, 2 posts accredited for 5 years Tauranga Hospital, 3 posts accredited for 5 years Wellington Hospital, 5 posts accredited for 5 years Whangarei Hospital, 2 posts accredited for 5 years
	SA/ NT	Mount Gambier Hospital, 1 post is accredited for 5 year Royal Darwin Hospital, 3 posts accredited for 5 years
	Vict	
	NSW	Calvary Public Hospital, 1 post accredited for 1 year Manning Base Hospital, 1 post accredited for 1 year John Hunter Hospital, 1 post accredited for 1 year
	Q'land	Robina Campus, 1 SET1 position accredited for 12 months
	WA	St John of God Hospital, 2 SET1 positions accredited for 1 year Sir Charles Gairdner Hospital, 1 post accredited for 4 years Royal Perth Hospital, 1 post accredited for 1 year
Neurosurgery	Sarawak General Hospital, Malaysia, 1 SET1 position accredited for 2 years	
	NZ	Auckland City & Starship Children's Hospitals, 1 SET1 position & 2 posts accredited for 5 years Christchurch Hospital, New Zealand 1 SET1 position – 2 years Wellington Hospital, SET1 1 position 2 years
	SA	Flinders Medical Centre & Women's & Children's, 1 post accredited for 2 years Royal Adelaide Hospital, SET1 1 position 4 years
	Vict / Tas	Monash Medical Centre & Jessie McPherson Private, 1 SET1 position & 2 posts accredited for 5 years Alfred Hospital, SET1 1 position 1 year Austin Hospital, SET1 1 position 3 years Royal Hobart Hospital, 1 SET1 position & 1 post accredited for 5 years Royal Melbourne Public and Private, SET1 1 position 2 years
	NSW / ACT	St Vincent's Public and Private Hospitals, 1 post accredited for 1 year St Vincent's Hospital Sydney, 1 SET1 position 2 years Liverpool Hospital Sydney, 1 SET1 position, 1 post accredited for 5 years John Hunter Hospital, Newcastle, 1 SET1 position accredited for 2 years

		Royal Prince Alfred Hospital, Sydney 1 SET1 position accredited for 5 years Royal North Shore Hospital, SET1 1 position, 4 years Royal Prince Alfred Hospital, SET1 1 position 4 years St George Public and Private Hospitals, SET1 1 position 1 year Westmead Public and Private Hospitals, SET1 1 position 3 years Canberra Hospital, SET1 1 position 3 years
	Q'land	Princess Alexandra Hospital, 1 SET1 & 2 posts accredited for 5 years Gold Coast Hospital, SET1 1 position 2 years Royal Brisbane Hospital, SET1 1 position 3 years
	WA	Sir Charles Gairdner Hospital, SET1 1 position 2 years
Otolaryngology Head & Neck	NZ	
	SA	
	Vict	Monash Medical Centre, 4 posts reaccredited for 5 years St Vincent's Melbourne, 1 post accredited for 5 years; 1 SET1 position accredited for 12 months Royal Victorian Eye and Ear Hospital, 3 posts accredited for 5 years; 1 SET1 position accredited for 5 years Royal Children's Hospital Melbourne, 2 posts accredited for 5 years
	NSW	Prince of Wales Hospital, 1 post accredited for 5 years Sydney Children's Hospital, 1 post accredited for 5 years Royal North Shore Hospital, 2 posts accredited for 5 years St Vincent's Hospital,1 post accredited for 1 year Royal Prince Alfred Hospital, 2 posts accredited for 5 years Sydney Eye and Ear Hospital, 1 post accredited for year Gosford Hospital, 2 posts accredited for 1 year Wollongong Hospital, 1 post accredited for 1 year Princess Alexandra Hospital, 1 SET1 position accredited for 5 years St Vincent's Sydney, 1 SET1 position accredited for 1 year Royal Prince Alfred, 1 SET1 position accredited for 5 years Royal North Shore, 1 SET1 position accredited for 5 years
	Q'land	Royal Children's Hospital,1 post accredited for 5 years Ipswich Hospital, 1 post accredited for 5 years Princess Alexandra Hospital, 1 post accredited for 5 years Toowoomba Hospital, 1 post accredited for 5 years
	WA	Royal Perth Hospital, 1 post reaccredited for 5 years
Orthopaedic	A further 14 x SET 1 positions to commence in 2009 were also approved	
	NZ	
	SA/ NT	Royal Darwin Hospital, 1 post reaccredited for 2 years
	Vict	Epworth Private Hospital, 1 post accredited for seven months Royal Melbourne Hospital, 3 posts accredited for seven months
	NSW/ ACT	Gosford Hospital, 1 post accredited for 5 years Maitland Hospital, 1 post accredited for 5 years Port Macquarie, 1 post accredited for 5 years Dubbo Base Hospital, 1 post accredited for 5 years Gosford Hospital, 1 post accredited for 5 years Lismore Base Hospital, 1 post accredited for 3 years Nepean Hospital, 2 posts and 1 SET1 position accredited for 5 years Orange Base Hospital, 2 posts accredited for 5 years Tweed Heads, 1 post accredited for 3 years Westmead Hospital, 2 posts and 1 SET1 position accredited for 5 years Port Macquarie Hospital, 1 post accredited for 5 years Sydney Children's Hospital, 2 posts accredited for 5 years Wagga Wagga Hospital, 3 posts accredited for 5 years Wollongong Hospital, 2 posts accredited for 5 years
	Q'land	
	WA	Joondalup Health Campus, 1 post accredited for 1 year
Paediatric	Q'land	Royal Children's Hospital, 1 post accredited for 5 years (subject to 12 month progress review) Mater Children's Hospital, 1 post accredited for 5 years
Plastic & Reconstructive	NZ	Middlemore Hospital SET1, accredited for 1 year Hutt Hospital SET1, accredited for 1 year Waikato Hospital SET1, accredited for 1 year

		Christchurch Hospital 1 SET1 position and 1 post, accredited for 1 year
	SA	Royal Adelaide Hospital, 1 post accredited for 5 years Women's and Children's Hospital Adelaide, 1 post accredited for 5 years Queen Elizabeth Hospital, 1 post accredited for 5 years Flinders Medical Centre, 1 post accredited for 5 years
	Vict	Alfred Hospital, Frankston Hospital, Geelong Hospital, Royal Melbourne Hospital, Southern Health(Dandenong), Expanded settings posts have been approved at the following institutions: The Alfred Hospital The Frankston Hospital
	NSW/ ACT	An expanded settings post have been approved at: The Sydney Adventist Hospital (NSW)
	Q'land	
	WA	An expanded settings post have been approved at: The Mount Hospital (WA)
Urology	NZ	Auckland accredited for 5 years
	SA	
	Vict / Tas	Geelong, 1 post accredited for 5 years The Alfred Hospital, 1 post accredited for 5 years Monash Medical Centre, 2 posts accredited for 5 years Frankston, 1 post accredited for 1 year Box Hill, 1 post accredited for 1 year Hobart, 1 post accredited for 1 year
	NSW/ ACT	Westmead, accredited for 5 years Royal Prince Alfred, accredited for 5 years Canberra, accredited for 1 year Nepean Hospital, accredited for 5 years The Tweed Hospital, accredited for 5 years Royal Newcastle Centre, 2 posts accredited for 5 years Royal North Shore, 1 post accredited for 1 year Lake Macquarie Private, 1 post accredited for 1 year Sydney Adventist Hospital, 1 post accredited for 1 year
	Q'land	Ipswich Hospital, 1 post accredited for 5 years Greenslopes, 3 posts accredited for 5 years
	WA	Sir Charles Gairdner, 1 post accredited for 5 years Royal Perth, 2 posts accredited for 1 year
Vascular	NZ	Christchurch Hospital, inspected 30 June, 2008
	SA	
	Vict / Tas	Geelong Hospital, Monash Medical Centre,
	NSW/ ACT	Royal North Shore Hospital, 1 year Royal Prince Alfred Hospital, 5 years Canberra Hospital, Wollongong Hospital,
	Q'land	
	WA	

Appendix 12

The rates of participation by College Fellows in the College's last CPD cycle, and the Attendance at SAT SET workshops since its inception in April 2007

Attendance at RACS Professional Development Activities by Region and Specialty

A total of 55 workshops were delivered in 2008 with 1028 participants, compared with 47 workshops with 914 participants in 2007. There was an increase of 12% in attendance in 2008 compared with 2007.

Location ➡ & Specialty ⬇	ACT	NSW	NT	QLD	SA	TAS	VIC	WA	Total AUST	NZ	O/S	Total 2008	Total 2007	% Change 2007/ 2008
Fellows														
CAR	1	9	0	4	3	0	7	1	25	6	0	31	27	15%
GEN	3	74	12	55	25	15	84	36	304	30	3	337	264	28%
NEU	0	8	0	1	1	2	6	1	19	1	1	21	30	-30%
ORT	1	32	0	19	29	5	35	5	126	11	1	138	119	16%
OHN	1	21	1	11	8	1	11	9	63	17	0	80	72	11%
PAE	0	15	0	10	3	0	1	3	32	3	0	35	33	6%
PLA	1	7	0	6	8	4	18	2	46	8	0	54	43	26%
URO	1	15	0	1	0	2	11	2	32	17	0	49	64	-23%
VAS	0	8	1	2	2	2	6	3	24	0	0	24	27	-11%
OBS&GYN	0	0	0	0	0	0	0	0	0	0	0	0	3	-100%
OPH	0	3	0	1	0	0	1	0	5	1	0	6	7	-14%
Total Fellows	8	192	14	110	79	31	180	62	676	94	5	775	689	12%
Non-Fellows														
Region ➡ & Type ⬇	ACT	8.5	NT	QLD	SA	TAS	VIC	WA	Total AUST	NZ	O/S	Total 2008	Total 2007	% Change 2007/ 2008
SET	3	9	10	40	6	1	16	12	97	6	0	103	40	158%
IMGs	2	3	3	24	0	2	7	5	46	5	0	51	70	-27%
Other Health care	4	30	1	17	16	1	23	1	93	4	2	99	115	-14%
Total Non-Fellows	9	42	14	81	22	4	46	18	236	15	2	253	225	12%
Fellows and Non-Fellows														
Region ➡ & Grand Total⬇	ACT	NSW	NT	QLD	SA	TAS	VIC	WA	Total AUST	NZ	O/S	Total 2008	Total 2007	% Change 2007/ 2008
Grand Total	17	234	28	191	101	35	226	80	912	109	7	1028	914	12%

Source: RACS Events Report as at 31 December 2008

Note: The number of Active Fellows practicing in the nine specialties is 4871 (December 2008 data)

SAT SET Attendance

April 2007 – June 2009

	ACT	NSW	NT	QLD	SA	TAS	VIC	WA	NZ	O/S	**TOTAL**
Cardiothoracic	1	15	0	6	3	10	10	2	6	0	**53**
General	9	69	3	38	36	0	95	41	39	0	**330**
Neurosurgery	2	12	0	3	2	0	6	3	2	0	**30**
Orthopaedics	1	30	0	29	38	9	44	9	17	1	**178**
Otolaryngology	3	25	2	8	6	3	34	7	27	0	**115**
Paediatrics	3	19	0	13	5	0	6	3	6	1	**56**
Plastic & Reconstructive	3	10	0	12	10	4	24	9	10	0	**82**
Urology	0	25	0	8	2	2	21	10	10	0	**78**
Vascular	3	12	1	5	5	2	8	2	2	0	**40**
Total Fellows	**25**	**217**	**6**	**122**	**107**	**30**	**248**	**86**	**119**	**2**	**962**
IMG	0	0	2	0	1	2	1	1	5	0	12
Trainee	1	0	0	0	1	0	1	0	0	0	3
Other	0	3	1	0	1	0	3	2	3	0	13
Total Non Fellows	**1**	**3**	**3**	**0**	**3**	**2**	**5**	**3**	**8**	**0**	**28**
Grand Total	**26**	**220**	**9**	**122**	**110**	**32**	**253**	**89**	**127**	**2**	**990**
Supervisors:											
No. of Supervisors in State	5	113	3	52	33	6	87	35	56	0	**390**
No. of supervisors who have attended SAT SET	3	51	1	25	16	2	55	24	29	0	**206**
% of supervisors who have attended SAT SET	**60**	**45**	**33**	**48**	**48**	**33**	**63**	**69**	**52**	**0**	**53**