ROYAL AUSTRALASIAN COLLEGE OF SURGEONS

SUPPLEMENTARY REPORT TO THE AMC — June 2010

College Details

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In the letter dated April 27, 2010 the AMC requested a supplementary report providing feedback on three areas:

1. The action taken by the College in relation to each of the recommendations made by the AMC in 2007.
2. The developments that are occurring across the specialties and the College's response to specialty specific developments
3. The College's assessment of the success of its selection policy and the feedback from jurisdictions and health services on selection into SET1 positions

1. Actions taken in relation to each recommendation

There were 29 recommendations in the 2007 Accreditation report. See Table 1, pages 4-9 for the College action responses to each of those recommendations.

2. Developments occurring across the specialties and the College's response

Variations between the nine surgical specialties as to how they organised, delivered and assessed their training was the subject of Recommendations 3; 7; 15; See Table 2, page 10 for the College response to specialty specific changes.

3. Assessment of the success of the selection policy including feedback from jurisdictions and health services

The College believes that the change to one single selection process has been successful. This is based on data collated in preparation for the SET review (conducted April 22 & 23, 2010) (see Appendix 2, page 10-12) which showed that there has been no significant change in:

- the numbers of applicants to specialty surgical training and the proportion of successful applicants
- the percentage of trainees who have passed / failed the generic basic sciences examinations, and
- the proportion of trainees leaving and/or being dismissed from the program.

The same set of data indicated that, despite some concerns expressed about the junior nature of trainees coming into SET, the demography of new trainees coming into the program includes a very wide spread of prior experiences and numbers of years in PGY.

Feedback from the jurisdictions and health services (as provided for the SET Review) is more variable.

- They support the principle of early selection into specialty training, for example:
  - Queensland stated that "it believes the program has improved the quality and efficiency of surgical training"

However a number of concerns were expressed, some of which were about local recruitment, and others relating to administrative issues. For example:

- Both NT and WA expressed concerns about the impact of national selection and training on their workforce
- NSW identified a "significant tension between hospitals expectations of a surgical trainee and what SET1 trainees in fact are capable of doing. Feedback from heath services indicates that they expect a SET trainee for be able to occupy a

Surgical Registrar position, which means that the have surgical experience and expertise and are able to participate in after hours rosters".

- The College sees this as a workforce issue relating to the way that hospitals deploy their staff

- ACT and SA expressed concerns about the increasing number of 'non-accredited surgical registrars' i.e. PGY's who are working in surgical units who are attempting to be selected
  - The College sees this as a natural outcome of the change from BST & AST to SET and the high demand for places in surgical training. It is also relating to the increasing number of people graduating with medical degrees
  - The College is concerned about the continued use of the term 'non-accredited surgical registrars' for people who are not in training. If a hospital has a position which is suitable for training the College would welcome the opportunity to accredit it.
- Victoria and NSW wrote that they would like more involvement in the recruitment procedures
  - Jurisdictions have been invited to participate in the interview process by all specialty boards and over a number of years. There have been only rare incidences of those invitations being taken up.

Some jurisdictions identified ways that their concerns could be addressed. For example:

- Queensland and NT (as well as NZ) said that they were keen to explore options for expanding training into non-tertiary hospitals and regional settings.
  - The processes for accrediting new surgical training positions is in the public domain and the College would welcome any opportunities to work in conjunction with the jurisdictions to expand training opportunities

Table 1 AMC Recommendations and Actions Taken

Recommendation		Actions
1	Ensure continuing support and resources for the College's Education Section	• The Academy of Surgical Educators was established at the beginning of 2010 • An additional staff member is being employed in the College as a Research Assistant for the Dean • Funding has been allocated to improve the e-learning part of the College website • Additional courses are being developed for supervisors, trainees and IMGs o Two more pilot programs, based on the successful 2009 ASSH course, providing training in some of the non-technical competencies for trainees o A second SAT SET program is under development o Courses for IMGs and their supervisors/ trainers are being developed with support from Commonwealth STP funding o Negotiations are being conducted with representatives from the Royal College of Surgeons of Edinburgh to introduce their NOTSS program for the training surgeons to give feedback to colleagues and trainees based on structured observations of non-technical aspects of performance during intraoperative surgery o The College is in the process of developing MOUs with several Australian universities to improve opportunities for the provision of collaborative professional development courses (for trainees and Fellows), especially in the competencies of Teaching and Learning, and Management and Leadership
2	Report to the AMC on the schedule of planned changes in its educational programs and the proposed time of implementation	• Two specialties (Cardiothoracic Surgery and Otolaryngology Head and Neck Surgery) plan to increase the training time in their own specialty by reducing the time spent in their early years of training in General Surgery from the beginning of 2011 (see Table 2) • A clearer understanding of likely changes to the assessment of generic and specialty specific basic sciences will be know following the relevant College meetings in June 2010. • A clearer understanding of any potential changes to the Fellowship Examination will be known following the Fellowship Examination Review (May 20, 2010) • All surgical specialties were represented at both of those meetings • General Surgery; Orthopaedic Surgery, Plastic & Reconstructive Surgery and Urology are introducing on-line logbooks to replace the current paper-based log-book. This is an administrative change, rather than a change in the program.
3	While recognising the inherent difference between specialties, continue to ensure greater coherence in key training processes. When differences continue between specialties in selection processes, assessment and components of training, RACS should ensure that they are supported by a clear evidence-based educational rationale	• All components of the training program of all nine surgical specialties are based on the nine RACS competencies o Whilst the specialties define, teach and assess, medical expertise and technical competence differently there is close alignment of the specialties across the other seven competencies • The selection processes of all specialties are now based on attributes, all use a series of mini-interviews and all except Orthopaedics (Aus) use the College Referee reports. The main differences between the specialties is in the relative weighting of the three selection tools (within a define formula) and comparative weighting of the attributes according to differences in specialty requirements • Differences in assessment processes are currently being negotiated (see Recommendation 2) • Differences in duration of training – i.e. that Cardiothoracic Surgery, Neurosurgery, and Paediatric Surgery require six years of training whilst the other specialties require five years is an issue which is being discussed.

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	Published in the Activities Reports
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. 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	• One of the major themes of the 2010 Annual Scientific Congress was on improving the input and influence of surgeons within the health sector • Because jurisdictions are based in the regions, discussions between College representatives and the jurisdictions occur at the regional level on an ongoing basis. The outcomes of these discussions are reported through the state committees to Council. • The process for accrediting new surgical training positions remains unchanged and is in the public domain. • Hospitals are invited to self-nominate through the College Education and Training Administration Division as a potential training position for accreditation. • When a hospital submits an application for accreditation it is forwarded to the appropriate surgical specialty which reviews the application and reports back to the College through the Board of SET
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	Unfortunately there has been very little opportunity to be involved in this kind of discussion. The College would welcome any opportunities to work in conjunction with the jurisdictions to expand training opportunities. The processes for accrediting new surgical training positions remains unchanged and is in the public domain
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	• There are no differences in the aims and goals of training between the specialties. All support the same commitment to ensuring the highest standard of safe and comprehensive surgical care for the community we serve through excellence in surgical education, training and professional development • The feedback from the recent Communication Needs Survey indicates that trainees and Fellows across all of the specialties are looking to the College to provide greater on-line training, education, and professional development resources • The presentation of their training programs on the specialty specific websites is a challenge for the College (See Table 2). o It is hoped that the introduction of a new educational web and hub and the expansion of e-learning on a common platform will provide opportunities for a united web presence
8	Develop concrete and evidence-based information regarding the definition of the 'non-technical' competencies	• The College has a clearly defined Code of Ethics • In November 2009 the College published a booklet on Bullying and Harassment. This is available on-line and from the College in hardcopy format. • Negotiations are being conducted with representatives from the Royal College of Surgeons of

		Edinburgh to introduce their NOTSS program for the training surgeons to give feedback to colleagues and trainees based on structured observations of non-technical aspects of performance during intraoperative surgery • The College is in the process of developing MOUs with several Australian universities to improve opportunities for the provision of collaborative professional development courses (for trainees and Fellows), especially in the competencies of Teaching and Learning, and Management and Leadership • The pilot non-technical training course run with the support of ASSH in 2009 will be offered twice in 2010 • Currently the College is developing on-line training materials for all trainees (and supervisors) on components of the non-technical competencies and/or adult learning skills that have been identified as problematic. These include goal setting and self assessment.
9	Continue and strengthen its consultation with all groups affected by the implementation of SET, and in particular addressing communication gaps outlined above (jurisdictions, trainees, supervisors)	• The Surgical Leaders forum is held three times each year and is well attended by jurisdictional and surgical specialty representatives. Guest speakers at recent forums have been drawn from such diverse groups as the WA Department of Health; the National Health and Hospital Reform Commission; the recently formed Health Workforce Australia, as well as the Shadow Minister for Health and Ageing. • The jurisdictions were very pleased to be consulted as part of the SET Review and the College received submissions most regions. Representatives from Queensland, South Australia and Victoria attended the workshop. • Prior to the SET Review workshop (April 2010) supervisors and trainees were surveyed on their experiences with SET
10	Involve health consumers and patients in any future consultation about the goals and objectives of surgical training	• Professor Bettina Cass AO has taken a position as the second "Expert Community Advisor' together with Hon. Geoffrey Davies on College Council • Two of the seven members of the Board of the Academy of Surgical Educators are community representatives
11	Present to the AMC its timetable for the planned move to competency-based training and report annually on its progress	• As detailed in the 2009 report • Improving the skills of supervisors and trainers to conduct work-place-based assessment is key to this process. Currently 1100 supervisors and trainers have participated in the first SAT SET course which introduces the DOPS and Mini-CEX
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 College organises three meetings per year between College and Specialty Society staff who are involved in the administration of educational areas (introduced in 2008) • A further annual meeting to provide a forum for discussion of educational topics of common interest such as e-learning, web design and support for supervisors was introduced in 2009 for College and specialty staff involved in the development of educational and training. • The Dean has recently completed a round of meetings with representatives from each surgical specialty board

13	Define the educational objectives of the research components of training and review requirements against these objectives	• The College recognises the importance of research in the continuing renewal of the profession as well as the need to train future researchers and foster a research milieu within the College • All Fellows of the College are required to conduct audits • The Scholarship Program, under the umbrella of the Foundation for Surgery, offers more than $1 million in funding annually to the most academic and able surgical trainees and Fellows o Currently a number of scholarship holders are undertaking their PhD • Trainees and Fellows can undertake a Master of Surgery at the University of Sydney
14	Report to the AMC on the impact of SET on the availability of flexible training opportunities	• SET has not impacted on the availability of flexible training. The College policies and procedures trainees wishing to take flexible training has not changed. • The College sees flexible training as a workforce matter. Trainees who have attempted to negotiate with their employing hospital for work flexibility have reported that the hospitals are reluctant to support that training and have discouraged them from pursuing it. • RACSTA have established a mechanism for trainees wishing to take up flexible training to contact each other to discuss job sharing possibilities.
15	Seek congruence of assessment processes between the specialties except when differences can be justified for educational reasons	This issue has been reviewed in both the SET review (conducted on April 22 & 23, 2010) and the Fellowship Examination Review (May 20, 2010)
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	• Too early in the new training program for a full review to occur. • Data from the SET Review is currently being analysed.
17	Report in annual reports to the AMC on the procedures for identification and management of under-performing trainees	• No change to procedures as outlined in 2007 • A component of the first SAT SET course provides participants with training in the College procedures for identifying and managing under-performing trainees
18	Consider whether in view of the improved in-course assessment the major summative exit examination in its present form could be reviewed	• Too early in the new training program for a full review to occur. • The review of current Fellowship examination processes occurring on May, 20, 2010 may contribute to future changes
19	Report on the measures of validity and reliability of assessment processes that it identifies	• Too early in the new training program for a full review to occur. • It is planned that much of the relevant data will be collected and stored on-line
20	Continue to publish data on timeliness and outcomes of applications from International Medical Graduates in the College's Activities Report	Published twice yearly in the Activities Reports
21	Develop and report to the AMC on its plans to evaluate the introduction of the SET program	A 2 day workshop to review and evaluate the introduction of SET was conducted April 22 & 23, 2010. The outcomes and recommendations from that workshop will be considered at the next meetings of BSET and EB in June, 2010
22	Introduce procedures to collect feedback on the training program from external stakeholders such as health administrators and health consumer groups.	• Representatives from each jurisdiction were invited to make submissions to the SET Review • Representatives from 3 jurisdictions attended the SET Review, participating as guest speakers and members of discussion groups • Professor Bettina Cass AO has taken a position as the second "Expert Community Advisor' together with Hon. Geoffrey Davies on College Council • Two of the seven members of the Board of the Academy of Surgical Educators are community representatives

23	Report in annual reports to the AMC on plans for trainee and supervisor evaluation of SET	• Both trainees and supervisors were surveyed (on-line) to collect information prior to the SET review workshop (see above)
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	• A new Interviewer workshop has been developed introducing the changed interviewing format. o 14 facilitators from a range of Specialties were trained in March o Workshops for the following specialty groups responsible for conducting interviews have been arranged for 2010 Paediatric Board; Vascular Board; Neurosurgery Board; Orthopaedic Board; General Surgery Board; Cardiothoriacic Board; OHNS Board; NZ Orthopaedic Association; NZ OHNS • Additional information is provided to assist specialty boards in the writing of scenarios and criteria aligned with attributes • Specialty boards continue to invite JRs to participate in the interviewing, with very minimal support or response • All of the interviewers, and the applicants who were interviewed, in the Australian OHNS 2009 selection were surveyed between the interview and the publication of selection results. The feedback indicated that a large majority (90%+) interviewees like the new mini-interview format, and the majority of the interviewers liked the kinds of questions being asked and the scoring process
25	Continue to collaborate with the jurisdictions to increase the output of well-trained surgeons	• Funding in the private sector is not conducive to accreditation of training posts • It is not easy for jurisdictions to identify potential new posts in the public sector for accreditation o Accreditation of new posts depends on existing workforce, case-load, case-mix and the availability of supervisors o A recent calculation suggests that each new post requires ~$1mil per annum through-put to be able to sustain a trainee
26	Consider how trainees can be engaged as part of a more sophisticated communication strategy regarding the SET program	This is an on-going process: • In 2010 RACSTA have developed an on-line Trainee Evaluation Survey that will be implemented for the first time at the end of the second rotation • Two RACSTA representatives (the Chair and the Education Portfolio Chair participated in the SET Review — The Chair made a presentation on behalf of trainees • There are two RACSTA representatives on the College Communications Working Party • The introduction of a new educational web and hub and the expansion of e-learning will involve consultation with RACSTA
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.	• Pragmatically the College is expecting that the supervision and training workload will continue to increase with the introduction of workplace assessments. • This is unfortunately occurring in the context of a changing workforce demographic in public hospitals where more surgeons are working as consultants and VMOs. o In this capacity they are not paid for the time that they spend with the trainees • In the SET Review survey of Supervisors there was a variable response to the question about changes. 26.5% of the respondents said that their role had changed greatly; 34.2% said that it had changed a little; and 39.3% said it was about the same. • The on-line survey of former SAT SET participants that was conducted in 2009 indicated that the overall impression of the course was positive. Suggested ways to improve the course included: increased time, and access to refresher courses (the latter is provided on-line). • In 2010 RACSTA have developed an on-line Trainee Evaluation Survey that will be implemented

		for the first time at the end of the second rotation in 2010
28	Increase communication with supervisors and trainers about SET	• Funding has been made available for the development during 2010 of another SAT SET program to be offered in 2011. • Both trainees and supervisors were surveyed (on-line) to collect information prior to the SET review workshop (see above) • Specialties provide training (including SAT SET courses) for supervisors at their annual conferences
29	Consider making the SATSET course, Assessment and Management of Trainees, mandatory for supervisors and trainers	• Not yet considered because of the continuing high demand for access to the workshops (10 per year) being offered with over 1100 attendees • All of the surgeons who provide the training, as well as all of the participants is all done on a voluntary, pro bon basis, usually in Australia that means that they are involved in these activities without any support from their employers

Table 2 Developments occurring across the specialties and the College's response

Specialty Specific Developments	College response
From the beginning of 2011 Cardiothoracic Surgery and Otolaryngology Head and Neck Surgery plan to increase the training time in their own specialty by reducing the time spent in their early years of training in General Surgery	The College supports this change because it is in-line with the SET expectation that each specialty will take responsibility for their training from the beginning of SET1
The proposed introduction by Urology of assessment of their trainees on the anatomy examination from USA during SET3-4	College supports this proposal because it is in-line with the proposed recommendation from the SET review that there be assessment of specialty specific anatomy throughout training.
The presentation of their training programs on the specialty specific websites is a challenge for the College, particularly as each specialty keeps their curriculum materials password protected.	• The new Dean has recently completed a round of meetings with representatives of each of the surgical specialties. At these meetings one of the key points for discussion was the enhancement of e-learning • The meeting of educational officers from all of the specialties in October, 2009 provided a forum for sharing experiences and plans in providing training resources via the web. From that meeting there is improved understanding and communication between the College and some specialties, particularly Orthopaedic Surgery and Urology. • It is hoped that the introduction of a new educational web and hub and the expansion of e-learning on a common platform will provide opportunities for a united web presence
Cardiothoracic Surgery has not yet introduced mini-CEX and DOPS assessments	This is partly due to the fact that currently CT trainees spend their first two years in General Surgery posts. This will change from the beginning of 2011.
Some of the surgical specialties (Neurosurgery; Paediatric Surgery) have introduced Procedural Based Assessment (PBA) to assess specific key procedures in the later years of training	The College support the introduction of PBAs because it is in line with the intention of enhancing workplace-based assessment through a range of processes including PBAs; NOTSS; and the Surgical Safety Checklist (designed under the auspices of WHO and launched in Australia and New Zealand in August 2009)

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
NOTSS	Non-Technical Skills for Surgeons
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
STP	Specialist Training Program
WHO	World Health Organisation

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

COLLATED DATA RELATING TO SET

The following tables have been compiled for the SET review in response to questions about:

- The PGY levels of trainees at the commencement of their SET training (3 graphs 2008; 2009; & 2010)
- The workload for SET trainees in their early years of training including the numbers of courses that SET trainees are required to do
- The numbers of SET trainees who are failing the early examinations
- The numbers of SET trainees who are leaving the program.

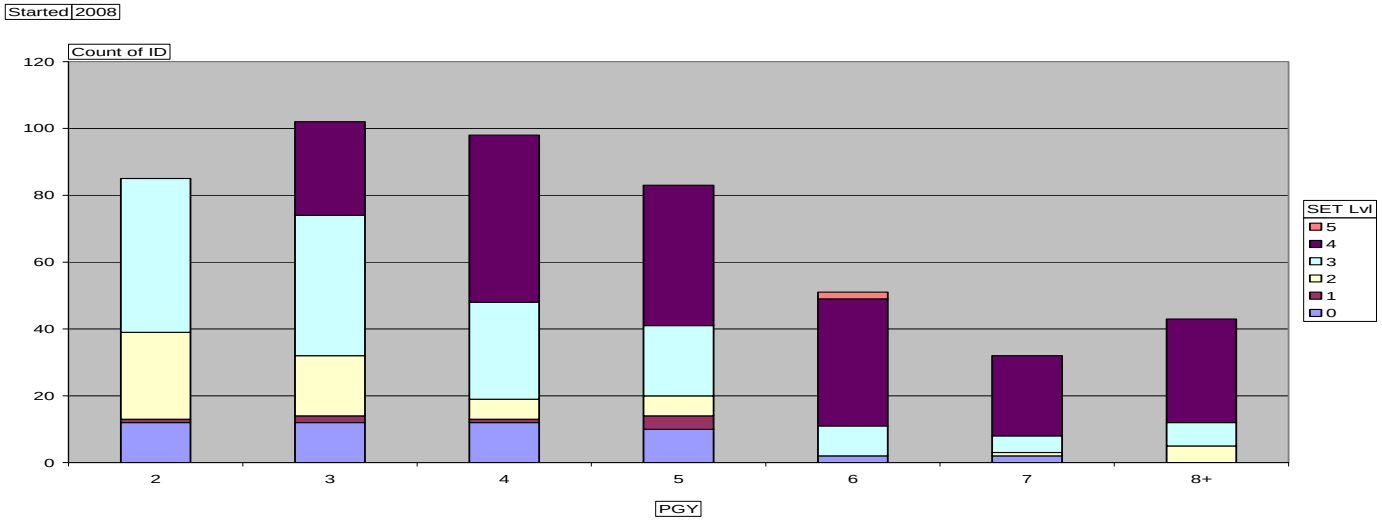
1.1 SET trainees selected to start in 2008; 2009; & 2010 indicating their PGY year at the time they were selected

The following three graphs show the PGY level that trainees were in when they were selected (horizontal axis), and the SET level they commenced training (vertical axis). Whilst there is an increasing tendency to appoint trainees into SET1, there appears to be little correspondence between PGY level and level of appointment.

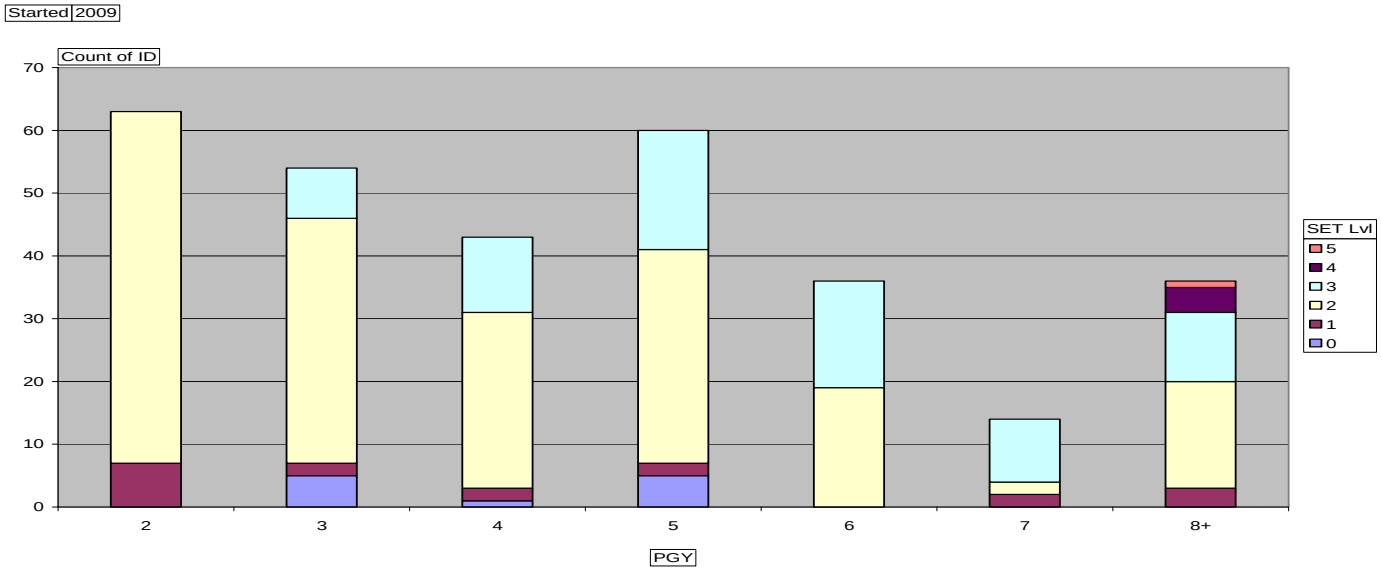
Notes:

1. The trainees identified as being in SET level 0 were on varying types of leave and did not commence their training in the year after being selected.
2. PGY8+ is a very inclusive category and includes over 100 trainees (across the 3 tables) who were in PGY10-20+ when they were selected.

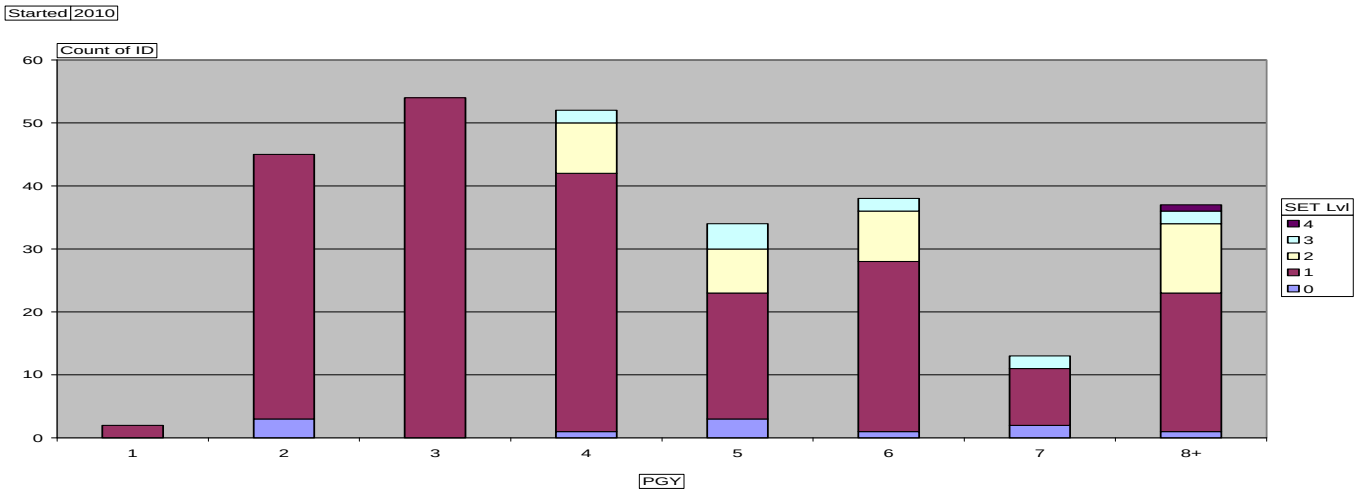
Started 2008



Started 2009



Started 2010



1.2 Total number of trainees selected into SET Trainees and the numbers required to do the four College courses 2008-2010

		2008	2009	2010
Number of trainees selected to commence training in SET		476	321	329
SET trainees required to do each of the four College courses	**ASSET**	84	73	87
	CCrISP	49	55	99
	EMST	103	17	25
	CLEAR	188	124	115

1.3 Pass and Fail rates for the early examination BST/SET 2005-2009

	Total number candidates	Number who passed	% of candidates who passed	Number who failed	% of candidates who failed
2005 BST					
Basic Science	293	225	77%	68	23%
Clinical	172	152	88%	20	12%
2006 BST					
Basic Science	315	273	87%	42	13%
Clinical	225	218	97%	7	3%
2007 BST					
Basic Science	249	226	91%	23	9%
Clinical	299	292	98%	7	2%
2008 BST					
Basic Science	21	14	67%	7	33%
Clinical	54	49	91%	5	9%
2008 SET					
Basic Science	39	31	79%	8	21%
Clinical	164	152	93%	12	7%
Specialty Specific *	60	45	75%	15	21%
2009 BST					
Basic Science	2	1		1	
Clinical	7	6		1	
2009 SET					
Basic Science	126	106	84%	20	16%
Clinical	136	116	85%	20	15%
Specialty Specific *	136	95	70%	41	30%

* Specialty Specific Examination in the Basic Sciences includes trainees from Cardiothoracic; General; Neurosurgery; OHNS; Urology; and Vascular;

1.4 Attrition in surgical training programs 2006 - 2009

	Total number trainees **	With-drawn	Total terminated	Sub-categories of total terminated				Total attrition	
				Terminated – mis-conduct	Terminated – non-financial	Time expired (inc max exam attempts)	Terminated – other (incl deceased)	*n*	%
2006									
BST*	753	36	15		8	7		51	7%
SST**	942	15	7		6		1	22	2%
TOTAL	**1,695**							**73**	**4.3%**
2007									
BST*	729	48	22		7	14	1	**70**	10%
SET*									
CAR	36							**-**	
GEN	364	1	1				1	**2**	
NEU	8							**-**	
ORT	227							**-**	
OHN	78							**-**	
PAE	20	1						**1**	
PLA	76	1						**1**	
URO	78		1				1	**1**	
VAS	34							**-**	
Total SET	**921**	**3**	**2**				**2**	**5**	0.5%
TOTAL	**1,650**	**51**	**24**		7	14	**3**	**75**	**4.5%**
2008									
BST*	281	18	53		37	16		**71**	25%
SET*								**-**	
CAR	30							**-**	
GEN	414	11	3		2		1	**14**	
NEU	46	2						**2**	
ORT	239	1						**1**	
OHN	92	2						**2**	
PAE	17	1						**1**	
PLA	85							**-**	
URO	103	1						**1**	
VAS	43	-						**-**	
Total SET	**1,069**	**18**	**3**		2		**1**	**21**	2%
TOTAL	**1,350**	**36**	**56**		41	16	**1**	**92**	**6.8%**
2009									
BST*	84	14	27		16	11		**41**	49%
SET*									
CAR			1			1		**1**	
GEN		22	18	1		14	3	**40**	
NEU		1	1	1				**2**	
ORT			2	1		1		**2**	
OHN		3	1				1	**4**	
PAE		2						**2**	
PLA		1						**1**	
URO								**-**	
VAS			1			1		**1**	
Total SET	**1,236**	**29**	**24**	**3**	**-**	**17**	**4**	**53**	4.2%
TOTAL	**1,320**	**43**	**51**	**3**	**16**	**28**	**4**	**94**	**7.6%**

*Source: iMIS **Source: RACS Activities Report Note: 'Withdrawn' includes movement to other specialties