ROYAL AUSTRALASIAN COLLEGE OF SURGEONS

AMC ANNUAL REPORT 2010

A. College details

Name: Royal Australasian College of Surgeons

Address: College of Surgeons' Gardens
Spring Street
MELBOURNE, VIC 3000

Date of last AMC assessment: 2007

Periodic reports since last AMC assessment: 2008, 2009, 2010 (supplement)

Reaccreditation due: December 2011

Officer to contact concerning the report: Professor Bruce Barraclough

Telephone number: +61 3 9276 7468

Email: bruce.barraclough@surgeons.org

Structure of the report

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B. Response to AMC recommendations and questions

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B. Response to AMC recommendations and questions

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

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

Please include an update on changes to the assessment of generic and specialty specific basic sciences, and potential changes to the Fellowship examination.

Changes to the assessment of generic and specialty specific basic sciences

At the Board of SET meeting held on June, 11, 2010 there were two key decisions, plus a number of associated decisions, relevant to this issue:

a. The new generic anatomy syllabus was approved.
   - The first examination based on that syllabus will be conducted in January 2012
   - Information about the structure and content of the revised generic basic sciences examination will be published on the College website following the Surgical Sciences and Clinical Examination meeting in November 2010.

b. Each specialty board was asked to review their syllabus and plans to assess the basic sciences, including determine the timing and tools for assessment, to be presented at the October 2010 meeting of BSET.
   - Each specialty will introduce any revised basic sciences assessment processes from the beginning of 2012
   - Information about any change in structure and content of the revised specialty basic sciences examinations will be published on the College website following approval from BSET.

Transition arrangements will be developed taking into consideration any potential negative impact on trainees in the program at the time of the publication of the changes. For example, the changes to the new generic anatomy examination will be published on the College website in November 2010 that is before the Trainees who will be in SET2 in 2012 commence training.

Potential changes to the Fellowship examination

The Review meeting held in May 2010 was wide ranging in its discussions, considering many possible ways to improve the Fellowship Examination. These included the structure and content of the examination; the reporting of results; training for examiners; and work of the court of Examiners. Any potential changes are still under discussion. The following is a summary of the outcomes of the workshop:

- Recommendation for retention of the Fellowship Examination
- Encourage BSET to strengthen its formative assessment processes
- Better alignment of each specialty curriculum with assessment, including the Fellowship Examination
- Develop processes to assess and report on validity and reliability of the examination processes
- Removing pure basic sciences from the Fellowship Examinations and include in the Specialty Specific Surgical Sciences Examinations
- The focus of the Fellowship Examination should be clinical decision-making, clinical application of knowledge and professional judgement
- Early electronic notification of results
- Simplify Court process in determining results
- Training for examiners
- Develop a process for the assessment of examiners performance and to provide examiner feedback
- Have a separate meeting of the Executive Court of Examiners outside of examination periods
- Review the format of the Full Court Meeting
- There should be 2 deputy Chairs of the Court of Examiners: one an Australian, the other a New Zealander.

Following the Review meeting three working parties were established to review:

a. the close marking system
b. the configuration of the examinations: frequency, size, location etc.
c. the IT support that is required for:
   - organisation of the Fellowship Examination
   - assessment of examiner performance and standard setting of the exam
   - technology related to conduct of the exam itself

The outcomes from these working parties will be reported back to the next Court of Examiners meeting at the end of September.

Note: No changes to the Fellowship Examination content or processes will be made without providing appropriate notification for all potential candidates.

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.*

Please expand on the differences in specialty requirements that require different weightings of the selection tools for different specialties, and provide evidence to support the differences. Please also include an update on the progress of discussions around differences in durations of training in different specialties.

Differences in weighting of selection tools

There is no educational evidence to support differences in the weighting of the selection tools between the surgical specialty boards. This is the reason that, since commencing selection of trainees into the SET program, the College has consistently been working with the specialty boards to reduce the differences between specialties. It has also been working to eliminate any weighting differences within specialties which conduct separate select processes in Australia and New Zealand.

Table 1 (below) shows the range of weighting of tools prior to the introduction of SET (2006-7); the agreed range of weightings achieved at a workshop in 2007; the actual specialty weighting in 2010; and the actual range of weightings in the most recent round of selection. Note: 2010 was the first year that there was no difference in weighting within any specialty between Australia and New Zealand.

Table 1: Specialty weighting of the selection tools 2010

	CV	**Referee Report**	**Interview**
Range of weighting 2006-2007	**15-30%**	**15-50%**	**25-55%**
Agreed range for weighting (2007)	15-25%	35-45%	35-45%
Actual weighting (2010)			
Cardiothoracic Surgery	20	35	45
General Surgery (Australia & New Zealand)	20	40	40
Neurosurgery	15	40	45
Orthopaedic Surgery (Australia & New Zealand)	20	40	40
Otolaryngology Head & Neck Surgery (Aust & NZ)	25	35	40
Plastic & Reconstructive Surgery (Aust & NZ)	20	35	45
Paediatric Surgery	15	40	45
Urology	20	35	45
Vascular Surgery	25	35	40
Actual range of weighting 2010	**15-25%**	**35-40%**	**40-45%**

Differences in duration of training

There has been no change in the duration, or requirements, of training in any of the surgical specialties since the inception of SET. The minimum of any training program has been 5 years and the maximum has been 6 years (see Table 2 below).

Since the inception of SET, whilst working with the other specialties, General Surgery has expressed concerns about the use of their training posts for the early years of SET training in other specialties.

In 2010 two specialties (Cardiothoracic Surgery and Otolaryngology Head and Neck Surgery) notified BSET that they intend to change the requirement that their trainees spend the initial year of training in General Surgery or surgery in general. This means that trainees selected in 2010 to commence in 2011 will go directly into training in their chosen specialty.

In 2010 the Vascular Surgery Board has accredited SET 1 training posts to commence in the 2011 training year. This means that training in Vascular Surgery will also become a five year training program. Appropriate surgical terms for SET1 posts are in General Surgery, Vascular Surgery, and Cardiothoracic Surgery. Posts may also include a term of no more than 25 weeks in Interventional Radiology or Plastic Surgery, and no more than 12 weeks in General medicine/cardiology.

In Paediatric Surgery the composition of training will change in 2012 so that in first year trainees will spend time in a paediatric surgery unit to evaluate their suitability for training and to teach standardised early SET surgical competencies. This first year will be followed by 1–2 years in surgery in General posts depending on prior learning, competency and completion of early SET mandatory courses and examinations. This experience in General posts is seen as necessary so that their trainees gain competencies in adult pathologies which may occur in children and adolescents. The final four years of paediatric training will be similar to current program except for formalised competency testing before progression from mid to late SET

The Boards of Urology argue that their trainees need a wide experience of surgical procedures before beginning training in their specialty. Urology also requires their trainees to do what they call a 'Provisional Fellowship' year in their 6th year of training (see Appendix 4).

Differences in the total number of years of training is not currently being addressed because of the discussions of what it would mean to move from time-based training to a competency-based program (see the update on the evaluation of the introduction of the SET, Recommendation 21)

Table 2: Duration of training for each surgical specialty – 2010 and 2011

Training requirements	**Total number of years**		**Years in General Surgery or surgery in general**		**Years in Specialty**	
	2010	**2011**	**2010**	**2011**	**2010**	**2011**
Cardiothoracic Surgery	6	6	1	0	5	6
General Surgery (Australia & New Zealand)	5	5	NA	NA	5	5
Neurosurgery *	6	6	0	0	6	6
Orthopaedic Surgery (Australia & New Zealand)	5	5	0	0	5	5
Otolaryngology Head & Neck Surgery (Aust & NZ)	5	5	1	0	4	5
Plastic & Reconstructive Surgery (Aust & NZ)	5	5	0	0	5	5
Paediatric Surgery	6	6	2	2	4	4
Urology	6	6	2	2	4	4
Vascular Surgery	5	5	1	0	4	5

* includes one full year of research for all trainees

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.

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.

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.*

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.*

Proposed changes to the website

The aims and goals of surgical training are the same across the nine surgical specialties. However, five of the nine surgical specialties currently have training materials on separate websites, with different passwords.

Feedback from Fellows and Trainees on the current website is that they find it difficult to navigate and move between the areas that interest them. The College is currently working through a two year plan to up-date and improve the website. Part of that plan includes the development of learning management system (LMS) that will be designed to:

- Create a better user environment to improve access to knowledge
- Integrated and seamless access to learning and educational material
- An integrated knowledge exchange providing educational resources for surgeons
- A process to identify new content and new learning resources to be shared amongst trainees and Fellows

It is envisaged that to achieve that integration and seamless access, trainees and Fellows will use a single password so that the user will be unaware of differentiation when moving between the LMS and the Web or between College and specialty resources.

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

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

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

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

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.*

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

The College's response in the 2010 Supplementary Report addressed several positive points but did not address the specific details of the recommendation. Please respond.

Please refer to the answer to Recommendation 21

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

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

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.*

17 *Report in annual reports to the AMC on the procedures for identification and management of 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.*

Please include an update on the review of current Fellowship examination processes.

Please refer to the answer to Recommendation 2

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

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

Please include an update on the evaluation of the introduction of the SET.

The Board of SET meeting held on June, 11, 2010 received the report from the two day SET review workshop held in April 2010. From that report Specialty Training Boards were asked to investigate required changes to transition the SET Program from time-based training, to competency based training, based on the principles outlined by Prof. Spencer Beasley (the Beasley Plan) and report back to the next BSET meeting in October.

- The Beasley Plan proposes more flexibility for trainees to move through three levels of training rather than year levels, based on their competence and satisfactory performance in defined requirements (e.g. examinations; courses, etc):
  - I. Early SET: may take 1-3 years <u>Level A</u>
  - II. Mid SET: 1-3 years <u>Level B</u>
  - III. Late SET: 1-3years <u>Level C</u>
  - IV. PFET: course or overseas training

In their investigations Boards were requested to consider the following:

- Revised assessments to enable reports to identify the incompetent; the slow but satisfactory learner; the "normal" satisfactory learner; and the advanced trainee.
- Changes to the Dismissal Policy to identify who can be dismissed and when
- A "progression review" policy to regulate when trainees are reviewed to determine their position in the SET continuum, and its effect on their post allocation (if any)
- Identification of "normal progress" – that is, standards for each identified level of training within the training program.
- Guidelines on how interruption and research fits into a more flexible program. That is, is it acceptable for someone who is identified as a slow learner to take 7 years to undertake clinical rotations plus interrupt for 2 years and do 2 years of research, thereby taking 11 years between commencement and attaining the fellowship?
- Review of the impact of variable paced learning on post availability and therefore selection. If some trainees occupy training posts for longer periods will this reduce through-put and opportunities for new trainees.
- Early Examination attempts. Does the 4 strikes policy stay in place, but perhaps with the 3 years instead of 2 to complete (reducing pressure on the trainee to undertake the February sitting in 1st year)?
- That further training be developed for supervisors and trainers to improve the effectiveness of all aspects of training, including work-place based assessment

22 *Introduce procedures to collect feedback on the training program from external stakeholders such as health administrators and health consumer groups.*

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

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.*

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

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

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.*

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

The AMC also requires a response to the following question arising from the 2009 annual report:

Clinical and other educational resources
Please report on the outcomes of College meetings with NSW jurisdictional representatives to discuss the absence of consultative clinics for outpatient and ambulatory experience in NSW.

The issue of access to outpatient and ambulatory patients in NSW is just one of a number of issues relating to improving surgical training which the College is discussing with jurisdictional representatives. Other related issues include lack of protected time and opportunity for teaching, and on-going problems of rostering and safe working hours.

The problem of access to consultative clinics has been discussed with the NSW jurisdictional representatives for many years (since outpatient clinics were closed in the 1980s after a dispute with the government). More recently that component of funding for NSW hospitals has been transferred back to the Commonwealth.

To address the lack of opportunity for trainees to work with outpatients and ambulatory patients in NSW a number of measures have been cobbled together:

- Some consultants continue to run small teaching clinics in some hospitals
- Trainees get access to pre-operative patients in emergency departments when they are on-call
- Some surgeons prove access to training within private rooms, offices and day surgeries
- Uninsured patients are seen in consultants' rooms and placed on the waiting lists of public hospitals
- Follow-up also occurs in the consultants' rooms

This access is variable because of the many cost involved as well as being dependant on the good-will of the consultants. It is also variable across the surgical specialties. Because they tend to remain in the same region for most of their training, the greatest problem is for trainees in General Surgery and Orthopaedic Surgery. Trainees in the smaller specialties are moved around and are currently able to access outpatients in other regions.

These problems are not going to be resolved by the College, or the jurisdictional representatives, until the larger issues of priorities and funding are addressed, whether it is for protected time for teaching, safer management of rostering, or for the provision of regular outpatient clinics.

C. Statistics

Please provide data, split into each calendar year (or part thereof) since the last progress report or AMC visit, showing:

a. the number of trainees entering each college training program, including basic and advanced training;
b. the number of trainees who completed training in each program;
c. the number of trainees undertaking each college training program;
d. each summative assessment activity (e.g. Part 1 and Part 2 exams) and the number and percentage of candidates sitting and passing each time they were held; and
e. the number and proportion of college fellows participating in the college's continuing professional development programs.

See Tables 3 - 26 in Appendix 2

D. Summary of significant changes

Please provide a summary of all significant changes introduced or planned since the last progress report or AMC visit, structured according to the nine sets of AMC Accreditation Standards

1. *Context in which the education and training program is delivered*

Guidance: Examples of significant changes:

- Changes to governance, structures, functions and policies relating to education, training and continuing professional development;
- Changes to the college's relations with health care services;
- Changes to training resources such as administrative/technical staff and educational expertise.

Governance

The College revised its Constitution through 2009 and a new version was accepted formally at the Annual General meeting in May 2010. Although many of the alterations were to modernise the language and approach of the Constitution it introduced some key changes. One of these is that the Chair of the Trainees Association is now a formal co-opted member of Council with full voting rights, except for votes concerning Office Bearer positions.

Consequently, the role of trainees in College activities and decision making has continued to advance with a vital committee (RACSTA Board) structure supported by management and Councillors, presence on all training and educational committees (apart from the Court of Examiners) and now formal presence on the Council of the College. Given the substantial time pressures on trainees, the College is indebted to them for their enthusiasm and commitment which in some cases extends over many years. The current Chair of RACSTA is Dr Greg O'Grady, who is a General Surgery trainee from New Zealand.

The senior governance committee of the College in the Education portfolio is the **Education Board** (EB). (see attached diagram Appendix C). It is chaired by the Censor in Chief (Professor Mark Edwards). 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 (Professor David Barr, AM).

The governance of the College educational programs has continued to evolve. The functions of the Basic Surgical Training (BST) Board have now been absorbed into other areas as the BST program is formally closing. The BSTs have now either been accepted into one of the nine Surgical Education Training programs or have explored other career pathways.

As expected the **Skills Education Committee** is becoming more prominent and Professor Phil Truskett continues to chair this committee. One of the important activities now oversighted by this group is the accrediting of external courses or programs that would be relevant to the training of surgeons. It is anticipated that courses focused on the basic clinical sciences like Anatomy, Physiology, Pathology and Biochemistry and have often been accredited will be progressively accompanied by more courses focusing on surgical skills, care of the surgically unwell or emergency care. The accreditation process of the College reviews both the relevance of the program to surgical trainees, its capacity to be delivered reliably and whether it is comparable to components of the surgical education and training program that are currently delivered through the College or its partners.

The **Court of Examiners** is undertaking a substantial review of its activities with working parties established to review the structure of the examination and timing of components, the active alignment between the assessment processes and the curricula for the trainees and the methodology / support that is required from a logistical and information technology perspective. The Court is currently chaired by Professor Spencer Beasley.

The **Board of Surgical Education and Training** (BSET) is chaired by Dr Simon Williams and oversights the nine training boards that is responsible for the delivery of the actual training programs. These continue to be defined by Memoranda of Understanding and Service Agreements between the College and the thirteen Speciality Societies and Associations who act as the agents in delivering the program. All the thirteen Societies and Associations are autonomous bodies with their own governance structures. The last report detailed how General Surgeons Australia (GSA) was more formally involved with the delivery of the educational program. Over the past twelve months the Australian and New Zealand Vascular Society (ANZSVS) went through a re-incorporation process and accepted responsibility for running their program directly.

The SET program was the focus of a review workshop earlier in the year. Major issues are being addressed by working parties reporting through to the Board of SET in conjunction with the individual training boards providing responses.

The **Post Fellowship Education and Training Committee** (Chaired by Dr Hugh Martin, AM) is now involved with the formal accreditation of courses or formal training programs that are occurring in the Post Fellowship arena. A number of programs are being prepared by external groups for formal review by this committee. To date the Neurosurgical Society of Australasia (NSA) post fellowship program in spinal surgery has been reviewed and formally approved by Council. This review confirms that the curricula of the program and assessment are appropriate, capacity issues have been addressed and that regular monitoring and reporting will occur. The programs do not speak to "ownership" of operative procedures or specific domains of competence. It is accreditation of a specific program and it is expected that in some areas a number of programs will be accredited formally by the College.

The senior governance committee in the Fellowship portfolio is the **Professional Development and Standards Board**. This is chaired by Professor Guy Maddern. The **Professional Standards Committee** (Chaired by Professor Grigg) continues to oversight the Continuing Professional Development (CPD) program. With the introduction of the national Medical Board of Australia and compulsory CPD it is anticipated that issues of non-compliance will become more significant. The College is more formally handling issues of Code of Conduct breaches. The Code of Conduct concerns relate frequently to areas of professionalism and behaviour as well as technical skills. In handling these the College takes an educational model where the offending trainee or Fellow is reminded of their ongoing commitment to the Code and they sign a Statutory Declaration of adherence and acceptance that if the Code is breached again then their Fellowship or place on the training program may be rescinded.

The **Professional Development Committee** (Chaired by Professor Vonau) continues to oversight the development of training programs specifically aimed at the non-technical competencies for Fellows. As an example the program for Surgical Supervisors has developed modules in the assessment of trainees, the interviewing processes for selection and is now developing a program of providing support to marginal trainees. Importantly these programs will be of the rigour that they will be recognised for prior learning in the Graduate Diploma for Surgical Educators that is being developed between the College and the RMIT and then the Master of Surgical Education that is being developed with the University of Melbourne.

The **Academy of Surgical Educators** has now been established. The Board of the Academy is chaired by Professor Vince Cousins and specifically includes a number of external medical educationalists to bring vigour to our ongoing considerations of the College programs. The Academy has a key Advisory Committee chaired by Dean of Education (Professor Bruce Barraclough AO). Issues such as general membership of the Academy have now been resolved and the aim is to utilise the skills of the Academy Board and Advisory Committee to ensure the educational programs and in particular the assessment processes are progressively reviewed and where appropriate updated.

College interactions with the Health Sector

The College continues to interact with the Health Sector at all levels of government being National, Commonwealth, and State based. In some areas this is actively encouraged and the College is both formally and informally involved in educational and workforce initiatives. In other areas the interaction is not as well regarded and individual Fellows are utilised at the discretion of the government or local hospital. The College actively promulgates its policies, procedures and position papers to improve communication at all levels. The College also produces its Activity reports about numbers of trainees and Fellows as well as completing a formal census which was distributed in June 2010. All of this material is available on the College web-site.

The College is working actively with the Australian Health Practitioners Regulatory Authority, Medical Board of Australia, Health Workforce Australia and the Australian Medical Council to ensure the progression of standards in training, the expansion of training opportunities and the support of training in all environments. As an example there are workshops about expanding training in the Private Sector involving the Private Hospitals, Departments of Health and other Medical Colleges being conducted in August and September this year.

The College continues to use jurisdictional representatives on a number of our committees and in particular selection committee processes for trainees and the actual interview committees for International Medical Graduates. The College has highly appreciated the involvement of these representatives. Unfortunately this is becoming more difficult to achieve and in a number of areas this has ceased without any replacement process being successful.

Changes to the training resources and educational resources

Professor Bruce Barraclough AO commenced in the role of Dean of Education in October 2009. Major initiatives now underway include progression of the Academy of Surgical Educators (see above), developing major links with a number of Universities and some of the other post-graduate medical colleges to expand opportunities for surgical education and thirdly the re-vamping of our on-line educational capacity. In this last

area, the College is now placing significant investment to provide a revitalised web presence and provide access to on line learning.

The requirement for more capacity in the on line learning area will require not only new infrastructure in the form of hardware and software but also in the educational staff profile. Additional staff has been appointed to the Academy of Surgical Educators and also the creation of a position of elearning manager has occurred. It is anticipated that further organisational change will be required to fully support these on line initiatives.

The Dean of Education now holds regular meetings with all College management staff to ensure a cohesive approach to all the educational initiatives, debriefings and updates on key relationships of College related groups, Specialty Societies and external educational providers such as the Universities. He also attends the regular meetings of the Senior Managers of the Specialty Societies to provide updates as to the College activities.

In the last few months the College has developed a process for **accreditation of courses** which are suitable for trainees. A range of courses offered by the College, specialty boards and universities have already been submitted for accreditation.

Consumer Involvement with the College

This is happening at several levels. At the Governance level Hon Geoffrey Davies AO has been the Expert Community Advisor on Council for a number of years and brings a very senior understanding of the law. Professor Bettina Cass AO has now also been appointed as an Expert Community Advisor and brings a strong perspective in both Sociology and Social Policy. Further Expert Community Advisors will be appointed.

Professor David Barr AM continues in his role on the Education Board.

2. *The outcomes of the training program*

Guidance: Examples of significant changes:
- Changes to purpose or mission of the college;
- Changes to statement of graduate results for training programs.

- There has been no change to the purpose or mission of the College.
- There has been no change to the statement of graduate outcomes or results of the training program.

3. *The training program – curriculum content*

Guidance: Examples of significant changes:
- Changes to the curriculum framework;
- Changes to structure, composition and duration;
- Changes to opportunities for trainees to engage in research;
- Changes to flexible training arrangements and recognition of prior learning;
- Changes to education and training programs in sub-specialties.

- There has been no change to the curriculum framework based on the nine RACS competencies
- Four specialties are planning changes to the structure, composition and duration of training. Two of these will commence in 2011, and two in 2012 (see also the answer to the question on 'duration of training' Section 2, Recommendation 3)
  - Two specialties (Cardiothoracic Surgery and Otolaryngology Head and Neck Surgery) have advised that trainees commencing training in 2011 will go directly into their specialty rather than spending the first year training in surgery in general
  - Following the 2010 assessment and review of the SET6 year of training, in 2012 the Board of Urology will implement a more streamlined, efficient and robust process. They plan to identify and accredit SET6 posts within Australia and New Zealand. From 2012 onwards trainees will have the option of selecting their SET6 posts from a list of accredited positions (see Appendix 4).
  - Rather than spending their first two years in General Surgery, from the beginning of 2012 paediatric trainees will spend their first year in a paediatric surgery unit. This will be followed by 1–2 years in surgery in General posts.

  These changes are in line with the College determination that specialty boards are responsible for their trainees from the time that they commence training in SET and throughout their training.
- There have been a number of changes to opportunities for access for trainees to engage in research and/or to the ways in which trainees can fulfil research requirements

- The Foundation for Surgery manages an increasing number of scholarships which are open to both Trainees and Fellows wishing to enrol in a higher degree – usually a PhD. http://www.surgeons.org/Content/NavigationMenu/Research/Scholarshipprogram/Scholarshipandfellowshipopportunities/Research_Scholarship2.htm
  Currently there are 17 scholarship holders enrolled in a PhD and 3 more intending to enrol.
- Three surgical specialty boards (General Surgery; Urology and Vascular Surgery) have worked with the College and the University of Sydney to develop a 'FRACS/Doctorate of Clinical Training'

This latter change is supported by the College because it reflects the College plans to form closer relationships with a number of universities as well as to encourage trainees to take on formal research training.

- Neurosurgery has modified the research paper requirement, effective immediately during 2009. The modifications resulted in papers presented at an NSA meeting or alternate national and international meeting subject to competitive abstract selection being acceptable. This increased accessibility for trainees to complete this requirement.
- Otolaryngology Head and Neck Surgery (OHNS) board supports research opportunities for trainees by offering several scholarships to selected trainees to undertake research prior to commencing their clinical training. It also offers scholarships to trainees who may wish to interrupt training for research activities. These scholarships are funded by the Garnett Passe and Rodney Williams Research Foundation, which has been set up specifically to further research in OHNS related activities
- The Orthopaedic board has provided their trainees with clearer guidelines on their research requirements, plus standardised assessment and completion sign off forms

These changes have been supported by the College because they reflect the expectation that specialty boards will encourage and support research within the training program, and where possible, facilitate opportunities for trainees to meet the research requirements.

- Urology strongly encourages research amongst trainees, both in clinical posts and in full-time research posts. However, full-time research is no longer an allowable alternative for core clinical training.

This change is within the College research policy which states that if "a trainee wishes to undertake an extended research period, the trainee may apply for interruption of training in accordance with the College Trainee Registration and Variation Policy"

- There has been no change to the way in which requests for flexible training and recognition of prior learning are addressed by the specialty boards. Examples of how these polices are being applied include:
  - General Surgery identified an increase on the number of requests for flexible learning, the majority of which they were able to accommodate.
  - Urology have given some trainees exemption from undertaking the CLEAR course by providing evidence of completion of a similar course as part of a higher degree. Some trainees who have undertaken SET1 in another surgical specialty have been accelerated into SET3 based on prior clinical experience and availability of SET3 posts.

- The following change is being made to the education and training programs in one surgical specialty.
  - OHNS board is currently writing a curriculum for indigenous health for Australia and New Zealand

The board will be supported by the College in this project as it is in-line with CPMC support for the development of improved curriculum addressing the needs for greater understanding of indigenous health.

4. *The training program – teaching and learning*

Guidance: Examples of significant changes:
- Changes to teaching and learning approaches;
- Changes to formal educational courses.

- Some changes to teaching and learning approaches have been instituted:
  - In reviewing their program the Orthopaedic board have more clearly defined outcome requirements for each topic in their clinical modules, defining the expected knowledge, skills and professional qualities, for SET1, 2-3 & 4-5 trainees. Their review has also resulted in the addition of journal and operative lists that guide learning opportunities.
  - Paediatrics are re-writing their modules to incorporate a framework for acquiring competency in module components related to SET training level
  - The other specialty boards have also begun to define expected skill and knowledge requirements for different stages within SET training.

  These changes are supported by the College as they are an important step in moving towards both competency based training and trainees being more able to monitor and direct their own learning.

- The following changes to formal educational courses have been/are being implemented:

- Neurosurgery board has modified the schedule of skills courses, effective from 2011. The modifications resulted in ASSET being a requirement for SET1, CCrISP for SET2 and EMST for SET3. These changes were made to ease the time and financial pressure on trainees during their SET1 year. The previous requirement was for ASSET and CCrISP to be done in SET1 and EMST in SET2.
- Neurosurgery board has also modified the number of neurosurgical training seminars, effective from 2011. The modifications resulted in a requirement of attendance at 8 training seminars (2 each year from SET2 to SET5 inclusive) rather than 9 training seminars. This was done to ease the pressure on trainees preparing for the Fellowship Examination during their SET6 year.
- In 2009 and 2010 the Board of Plastic and Reconstructive Surgery has instigated a specific SET1 educational course. This has been held in Sydney in those two years and is specifically for the first year entrance to Plastic Surgery training. It concentrates on the more basic skills and knowledge required to start training in Plastic Surgery and is therefore held early in the year. This is in addition to the long term existence of a SET 2 to 5 conferences.
- The Urology Board undertook a review of the Anatomy of Complications course in 2009 which had been a compulsory component for SET5 trainees. Due to a number of issues relating to applicability, logistics and funding, this course will be replaced by skills courses on anatomy and vascular injury. It is proposed that these courses occur in each Section during the 2nd half of each year for SET3-SET5 trainees.

The College supports all of these changes because they reflect on-going evaluation of the needs of trainees in the early years of SET, and the implementation of appropriate education processes to address those needs.

5. *Assessment of learning*

Guidance: Examples of significant changes:
- Changes to assessment policy or principles;
- Changes to evaluation of assessment methods;
- Changes to assessment methods;
- Changes to performance feedback;
- Changes to processes for identifying unsatisfactory performance by trainees;
- Changes to processes for assessing overseas-trained specialists.

- There have been no changes to assessment policy or principles
- There have been no changes to the evaluation of assessment methods since the SET review in April 2010, and the Fellowship Examination Review in May 2010, as reported in the RACS Supplementary Report to the AMC in June, 2010.
- Changes to assessment methods
  - Some specialties have made changes to their in-training assessment reports and/or processes
    - The Neurosurgery in-training assessment report was modified in July 2009. The changes reduced the number of competencies per assessment area to four instead of five and made the standards more achievable and reflective of actual expectations. The assessment areas were also categorised under the RACS competency headings
    - The Board of Urology has revised their in-training assessment forms to be more specific to trainee's level of training - SET1, SET2 and SET3-SET6. The report for SET3-SET6 trainees now includes a section devoted to the identification of poor or unsatisfactory performance. Supervisors are provided with guidance as to the process and documentation required in this regard (refer to assessment report)
    - Orthopaedic Surgery, Paediatric Surgery and Urology have placed more emphasis on their quarterly in-training assessments
      - Orthopaedic Surgery have linked their quarterly in-training reports to syllabus outcomes
      - Paediatric Surgery require quarterly reviews of trainee progress in competencies with feedback to supervisors and trainers for needs assessment and individually structured learning program
      - In Urology trainees from SET1 – SET5 are required to submit 3 monthly in-training assessment reports. Trainees in their final year (SET6) are required to submit 6 monthly in-training assessment reports.

  These changes are in-line with the discussions at the SET review in April 2010 and the move towards:
  a. competency based training
  b. a comprehensive and intergrated set of formative assessment processes reflecting the educational objectives of the program
  c. increased use of formative assessment to monitor the progress of trainees and provide trainees with regular feedback, especially in the early years of their training, and
  d. closer alignment of assessment and the curriculum

- Some specialties have made changes to their work-place-based assessment processes
  - Orthopaedic DOPS, CBD and Mini-CEX assessments are being directly linked to defined syllabus outcomes.
  - In Paediatric Surgery the Measure of Operative Understanding and Expertise (PBAs) have been increased to one per month during last four years of training

These changes are in-line with the discussions at the SET review in April 2010 and the move towards:

a. competency based training
b. a comprehensive and intergrated set of formative assessment processes reflecting the educational objectives of the program
c. increased use of formative assessment to monitor the progress of trainees and provide trainees with regular feedback , and
d. closer alignment of assessment and the curriculum

- Some specialties have made changes to their on-line learning and examinations
  - Orthopaedic Surgery has mapped their Elog learning requirements and reflection to individual modules and is currently mapping their Fellowship Exam to the revised syllabus.
  - In Paediatric Surgery the specialty specific examination of anatomy, pathology and physiology integrated in mid SET rather than end of training
  - Each year Paediatric Surgery also provides their examiners with their up-dated curriculum modules with lists of completed formative and competency assessments over the previous program period. This is to ensure that all areas of the curriculum are appropriately assessed, whether by the Fellowship examination, speciality specific examinations, critical assessment tasks, directed online studies, or other assessment tasks.

These changes are in-line with the discussions at the Fellowship Examination review in May 2010 and the move towards:

a. increased use of formative assessment to monitor the progress of trainees and provide trainees and their supervisors with regular feedback
b. a comprehensive and intergrated set of assessment processes reflecting the educational objectives of the program, and
c. closer alignment of assessment and the curriculum

- Changes to performance feedback
  - Most of the changes listed above in relation to in-training assessment reports and/or processes; work-place-based assessment processes; and on-line learning and examinations will ensure that trainees will receive more frequent and timely feedback
  - General Surgery has introduced a performance management pack which has been distributed to Regional Subcommittees. This has enabled a streamlined approach to performance management, providing support to supervisors so that the required processes are easy to follow, timely and fair for Trainees.

  The College supports these changes because they are in response to planned changes in the program and/or requests for additional support for supervisors.

- There has been no change to processes for identifying unsatisfactory performance by trainees, however some of the specialty boards have responded to concerns expressed by their supervisors around the need for clearer guidelines and/or structures.
  - The General Surgery Board are currently discussing the introduction of a Trainee Portfolio to be used at the start of term meetings. This is planned to promote discussion on past term and future term problems / planning. The Board is currently approaching the Trainees association RACSTA for their opinion.
  - The Orthopaedic Board have developed a flowchart and form letters to assist their supervisors
  - In Vascular Surgery, if a trainee's performance is assessed as unsatisfactory, a 360 degree assessment will be required. The 360 degree assessment is also available to supervisors if they have a satisfactory trainee but want to broaden the trainees awareness beyond technical skills

- There have been no changes to the processes of initial assessment of overseas-trained specialists.
  - However, the Boards of Paediatric Surgery and Urology have developed more detailed and comprehensive specialty specific assessment reports for assessing IMGs during their period of oversight directed to all areas of surgical competence and clinical interaction.

  The College supports these changes because they are in response to requests for additional support for supervisors.

  - The College now provides an opportunity for IMGs under assessment to apply for recognition of 'Exceptional Performance' which, if recognised could lead to a revised assessment of 'substantial comparability'. See Section 3.6 in the Assessment of the Clinical Practice of IMGs in Australia policy at: http://www.surgeons.org/AM/Template.cfm?Section=Search_Results&TEMPLATE=/CM/ContentDisplay.cfm&CONTENTID=29615

6. *The curriculum – monitoring and evaluation*

Guidance: Examples of significant changes:
- Changes to processes for monitoring and evaluation of curriculum content, teaching and learning activities, assessment, and program outcomes;
- Changes to methods to monitor trainees' and supervisors' opinion of the programs;
- Changes to the percentage of candidates passing summative assessments. If applicable, comment briefly on actions taken to respond to these changes.

- There have been no changes to College processes for monitoring and evaluating curriculum content, teaching and learning activities, assessment, and program outcomes since the Supplementary report submitted in June, 2010.
  - As indicated in sections 3, 4 & 5 above the specialty boards carry out regular reviews of their curriculum content, teaching and learning activities, and assessment processes. On the basis of these reviews the curriculum is up-dated to reflect changes in the profession and the development of new assessment and management techniques.
- Changes to methods to monitor trainees' opinion of the programs
  - The Neurosurgery training position evaluation form, completed by trainees at the end of each 6 month rotation, was modified to more closely align with the accreditation standards. The forms are being collected from all trainees at the end of each rotation
  - Otolaryngology Head and Neck Surgery have asked their trainees to fill out performance reports on rotations which are not felt to be up to standard and some of these have been placed on probation
  - The Board of Plastic Surgery has evaluation forms which are available for the trainees to fill out on-line after each clinical rotation at each hospital. This is for the trainee to evaluate the quality of training provided in each rotation
  - The Urology board is planning to introduce a Trainee's Forum comprising trainees from each region and SET level. This forum will enable trainees to provide feedback on all aspects of the program and will provide an avenue for them to propose recommendations for program enhancements.
  - A new trainee evaluation form has been developed by RACSTA. This will be available to be used across all of the surgical specialties from the end of 2010. To provide greater anonymity for the trainees this survey will be analysed within the College and the Specialty Boards will receive only the collated results.

  The College has encouraged the surgical specialties to develop processes of collecting regular feedback from their trainees. However, because the specialties evaluation forms are designed to provide information about the specific training posts, this poses a potential problem around anonymity for trainees in smaller posts and/or surgical specialties. The Board of SET has therefore supported the development of the RACSTA evaluation form because it will potentially provide different data from the specialty specific evaluation forms.
- Changes to methods to monitor supervisors' opinion of the programs
  - General Surgery has developed a survey to gauge the response of supervisors and trainees when implementing / considering implementing changes. Opinions were sought from supervisors on changes to formative assessments, and the possible introduction of an online trainee forum (to be used for study groups, information sessions, supervisor / trainee conversation / tutorial sessions)
  - The Urology board is in the process of conducting a survey of trainers and supervisors about their opinions and feedback regarding the SET program.

  The College recognises and supports the need for specialties to constantly monitor their programs and systematically seek feedback from their supervisors.
- Changes to the percentage of candidates passing summative assessments. If applicable, comment briefly on actions taken to respond to these changes
  - See Appendix 2, Tables 13 & 15 for statistics on the Annual pass rate of the Fellowship Examinations, and Tables 17-26 for the Annual and sessional pass rates of the early examinations (Clinical Examination; Generic Surgical Sciences Examination; and Specialty Specific Surgical Sciences Examination.

  The percentage annual pass rate (Table 15) shows some fluctuation between 2008 and 2009 in some of the specialties. In most specialties a higher proportion of candidates passed, although with such small numbers of candidates in most specialities proportional differences appear greater than they actually are. Candidate's performance in the Fellowship examination was one of the topics considered in the FEX review in May, 2010 and continue to be an important consideration in any proposed changes to that examination.

The percentage annual pass rates for the generic surgical sciences and clinical examinations have remained consistent over recent years.

Candidate performances and results in the specialty specific basic sciences examinations have been an area of concern since the introduction of that examination for trainees in Cardiothoracic Surgery; General Surgery; Neurosurgery; Urology and Vascular Surgery. This is one of the issues which the specialty boards have been asked to consider and to bring to the next BSET meeting in October (see the College response to Recommendation 21 in Section B of this report).

7. *Issues relating to trainees*

Guidance: Examples of significant changes:
- Changes to trainee selection procedures or the college's role in selection;
- Changes to mechanisms to inform trainees of the activities of decision-making committees;
- Changes to the college's capacity to provide training status information to trainees
- Changes to the college's process for dispute resolution;
- Changes to the proportion of training positions available compared to the number of applicants for positions. If applicable, please comment briefly on the reasons for any disparity and any actions taken by the college or others to address it.

- There has been no change to the College's role in selection since the RACS Supplementary Report to the AMC in June, 2010.
- Some specialties modified components of their selection tools for the 2010 round of selection. All of these changes were published on the College website in November 2009 two months prior to the opening of the first stage of selection and five months before the opening of the second stage of selection.
  - The Neurosurgery board made the following modifications to their selection scoring processes:
    - the minimum standard for interview for the selection process conducted during 2010 for the 2011 intake was modified to combine the scores on the referee report and the structured curriculum vitae rather than considering them independently
    - the weightings for the selection tools for the selection process conducted during 2010 for the 2011 intake were changed. The CV weighting was reduced from 20% to 15% and the Referee Report weighting was increased from 35% to 40%
    - the process for using Referee Reports was changed in 2010 for the 2011 intake: 5 reports were collected and all the scores were averaged. In years the reports with the highest and lowest scores were removed before averaging
    - the number of sections in the interview and the scoring scale were changed
  - Orthopaedic Surgery changed their interview by removing the anatomy test and changing the style of questioning to be more scenario based using lead and probe questions. They also provided increased training for their interviewers in response to the College revised interviewer training course
  - Paediatric Surgery has changed their pre-requisite experiences to include mandatory clinical experience of Paediatric Surgery

  All of these changes reflect decisions made at the meeting of BSET, October 2009.

  - The Urology interviews have been centralised for all shortlisted applicants since 2009. Applicants are interviewed by two separate panels comprising 3 interviewers. In 2010, the Board of Urology utilised the services of a professional employment consultancy to develop the interview and interviewer training workshop. It is envisaged that this arrangement will continue in future years.

- Some specialties have considered ways to address problems that have been identified within their specialty selection processes
  - General Surgery has introduced a Selection Workshop for General Surgery applicants, held in each region, to go through the selection process. This resulted in fewer mistakes on applications, fewer general enquiries on regulations and the application process. In 2010, the first year of the General Surgery dedicated online application was far less onerous administratively than the previous multi specialty approach as the questions were tailored specifically to the requirements of General Surgery.

  The College supports the need for specialties to constantly monitor their programs and systematically respond to identified needs.

  - The Board of Plastic and Reconstructive Surgery have decided to stabilise intake numbers of applicants over a period of five years. On a year to year basis the experienced marked difference in the number of trainees being accepted on to Plastic Surgery. In some years this was projected to be as high as thirty trainees and in others as low as nine. The years where high numbers of candidates were selected would see people relatively low on the national rankings being accepted into training and in other years where the intake numbers were very low, potentially good candidates were unsuccessful in

achieving selection. The board therefore has decided to aim for middle ground numbers between the lowest and highest amounts. This would mean not only stabilisation of number intake, but also in theory a stabilisation of the quality of applicants. It would also protect against good candidates being excluded in small intake years.

This decision has yet to be discussed at BSET.

- Changes to mechanisms to inform trainees of the activities of decision-making committees
  - General Surgery have up-dated their Training Handbook to explain Trainee requests and the role of Subcommittees and Board in decision making and timeframe for expected outcomes.
  - The Neurosurgery board continues to:
    - hold an annual trainee meeting (during the NSA Annual Scientific Meeting) where issues of concern and developments in the SET Program are discussed.
    - designate one session at each of the twice yearly training seminars (which form part of the SET Program) for discussion on general training issues with the Board Chair.
    - write to trainees when changes are made to the SET Program in Neurosurgery Handbook and includes a section in the NSA newsletter highlighting changes
  - The Paediatric Surgery board continue to run a mandatory annual registrar training seminar during which members of the Board meets with trainees individually and as a group for bilateral feedback on progress and trainee issues
  - All specialty boards continue to have trainee representatives on their boards

  The College supports initiatives by the boards to improve their communication with trainees.

- Changes to the college's capacity to provide training status information to trainees
  - Currently the boards are responsible for ensuring that trainees receive accurate information about their progress. Because of technical problems with the data system
    - The College is changing to an up-graded system
    - General Surgery are planning to introduce a new data base
    - Neurosurgery have also introducing an new data base
  - The planned changes to the College website which will be progressively introduced over the next few months include links to data systems which will provide an up-to-date progress report for each trainee at the time they log-in
- Changes to the college's process for dispute resolution

  There has been no change to the College appeals processes

- Changes to the proportion of training positions available compared to the number of applicants for positions. If applicable, please comment briefly on the reasons for any disparity and any actions taken by the college or others to address it.
  - Although there has been an increase in the number of individuals applying for SET, there has been no change in the proportion of training positions available to the number of applicants for positions (see Appendix 2, Tables 4-8).
    - In 2008, 742 individuals made 1017 applications for selection across the nine specialities for 321 positions
    - In 2009, 798 individuals made 1108 applications for selection across the nine specialities for 331 positions
    - 1n 2010, 861 individuals made 1132 applications for selection across the nine specialties
  - As stated in the 2009 Annual report:

    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.

Please include a brief summary of any significant interactions with trainee associations and any significant issues raised by trainee associations.

The RACS Trainees Association (RACSTA) has now been running for almost 5 years. RACSTA has an independent board structure within the College, including an executive body. RACSTA representatives are now established in all specialties and states (and NZ), where they represent trainees on College Training and Regional boards (states and NZ).

In addition to these representations, members of the RACSTA executive group hold positions on all central College Boards relevant to training: principally the Board of Surgical Education and Training, and Education Board. RACSTA reports officially to Education Board, and has a close working relationship with the RACS Censor in Chief. RACSTA routinely participates in College workshops and discussions.

As of this year, the RACSTA Chair has also been constitutionally voted as a co-opted member of the College Council. This significant step means that Trainees are now represented at the highest governance level within the College. Adequate support is provided for the Trainee chair in fulfilling this significant responsibility.

A primary role of RACSTA is to inform trainees of the activities of decision-making committees, and to communicate trainee opinion back to these committees. Information distribution is primarily the responsibility the RACSTA specialty and regional representatives but is also carried by RACS and RACSTA via the College website and in College publications (email bulletins, Surgical News, the ANZ Journal of Surgery, regional newsletters and information booklets).

RACSTA has initiated a new conference, starting in 2010, to inform newly inducted SET trainees about the requirements and regulations of SET, and the functions of the College.

Significant issues presently being raised by RACSTA with the College include:

i) *Improved orientation procedures* for new trainees. Some trainees have struggled with understanding the requirements of the new SET program. As above, a new induction conference is therefore planned to resolve this.

ii) *Trainee term feedback of terms*. RACSTA has developed an on-line trainee term feedback tool, and it has been approved that this form (or a close variant of it) will be implemented in each of the specialties within the next 12 months. This tool provides trainees the opportunity to provide feedback about their supervision and training experiences in a supportive manner. Results will be audited by the training boards or training supervisors, by RACSTA and by the RACS Education & Research Division.

iii) *Working hours*: RACSTA has completed a major survey of trainee working hours and preferences / attitudes to working hours. The response rate was >55%. A peer-reviewed publication has been accepted for the ANZ Journal of Surgery and a second is under preparation. Further work is being done to develop a trainee position statement on trainee working hours. The College has been supportive of trainee interest in this issue.

iv) *Flexible training*: RACSTA has been working with RACS to improve access to flexible training. There is significant unmet demand, especially amongst female trainees. RACS has robust policies to support flexible training, but it is not easy for trainees to find accommodating training positions in the jurisdictions. RACSTA is piloting job-share matching systems, is investigating whether part-time training positions can be established, and is evaluating the barriers currently existing to flexible training at the jurisdictions.

Progress on these initiatives are regularly reported by RACSTA representative to the College education committees where their work receives strong support.

- The board of General Surgery has recently worked with RACSTA to resolve an issue where a Trainee who has taken 3 years research leave and an additional 3 years of maternity leave, required an extension to the maximum permissible time to complete SET. The Trainee has now been advised of approval of extended training time.
- The board of Vascular Surgery has been approached by some trainees regarding additional training following their successful completion of the FRACS examination as some do not feel ready to enter unsupervised clinical practice and would like to spend a year or two gaining additional experience. (The first trainees that will complete the full SET program in Vascular Surgery will finish their training in 2012 and the board recognises that different people learn at different speeds). The board has therefore asked the members of the Vascular community to consider employing Fellows of the Australasian College in 2013. The ANZSVS has begun advertising these posts on their website.

8. *Implementing the training program – delivery of educational resources*

Supervisors

Guidance: Examples of significant changes:
- Changes to the process by which supervisors are appointed;
- Changes to the roles of supervisors, assessors, trainers and/or mentors.

- There has been no change to the policy or process by which supervisors are appointed
- There has been no change to the roles of supervisors, assessors, trainers and/or mentors

Please include a brief summary of any activities to support supervisors, assessors, trainers and mentors, such as training activities or written manuals.

- Neurosurgery, Orthopaedic Surgery and Urology training boards have all arranged for SAT SET course to be provided at their Annual Scientific Meetings
- In General Surgery the board:
  - have introduced a quarterly newsletter for all General Surgery supervisors beginning in august 2010. The Newsletter highlights changes made to training regulations, College Policy, new procedures, courses available for professional development.
  - have introduced SET Selection Workshops in February / March 2010 and SET Orientation in November 2010. These meetings provide time for Supervisors and potential and new Trainees to meet and discuss training issues
  - a new Supervisor manual is in production. It is expected to be sent to all Supervisors at the start of term in 2011 and to each new Supervisor as appointed.
- In Neurosurgery the board:
  - continues to write to supervisors when changes are made to the SET Program in Neurosurgery Handbook and includes a section in the NSA newsletter highlighting changes
  - Updates the SET Program in Neurosurgery Handbook regularly. This handbook contains all information relevant to supervisors, trainees and training institution.
- The board of Paediatric surgery now require all their supervisors and trainers to complete the SAT SET courses
- The Urology board:
  - is developing more extensive documentation to provide supervisors and trainers regarding the diligence and expertise required in identifying poor performance.
  - Plans to hold an education forum at the USANZ ASM in 2011

The College strongly support the development of improved communication between the surgical training boards and the supervisors and trainers.

Resources

Guidance: Examples of significant changes:

- Changes to arrangements for monitoring the quality of clinical training;
- Changes to the process/policy or criteria/standards for the accreditation of training programs, institutions or training posts;
- Changes to access to outpatient and ambulatory experience;
- Changes to mechanisms for monitoring of rotations and posts;
- Changes to interaction with health services to ensure effective service-based training and to ensure that trainees can experience the breadth of the discipline.

- There has been no change to arrangements for monitoring the quality of clinical training other than those identified in section 6 & 7 above.
- There has been no change to the process/policy or generic criteria/standards for the accreditation of training programs, institutions or training posts
  - Some surgical specialties have decided to provide additional detailed criteria
    - Paediatric surgery have introduced detailed accreditation evaluation reports.
    - The Urology board has developed a urology specific accreditation documentation for SET1 and SET2 posts. This documentation compliments the pre-existing accreditation material for SET3-SET6 posts.
    - The Urology board continues to identify and accredit urology specific SET1 and SET2 posts as well as working with the Board in General Surgery to co-accredit posts that can be occupied by either a urology or general surgical trainee.
- There has been very little change to access to outpatient and ambulatory experience (see the response to this question in relation to NSW in Section B). In response to this problem:
  - The OHNS Board has insisted on trainees having access to at least 2 supervised teaching outpatient clinics every week. There needs to be the opportunity to assess new patient presentations in these clinics. Trainees have been directed to fill out performance reports on rotations which are not felt to be up to standard and have been placed on probation
  - Accreditation of posts in Paediatric surgery is now dependent on access to outpatient and ambulatory experience
- There has been no change to mechanisms for monitoring of rotations and posts other than those identified in section 6 & 7 above
- There has been little change to interaction with health services to ensure effective service-based training and to ensure that trainees can experience the breadth of the discipline.
  - Specialty boards and the College continue to seek opportunities to increase the number of training posts
  - The College held a meeting in August to discuss possible ways for trainees to gain access to training in private posts. These discussions are continuing.

See Appendix 5: Table 27 for the complete Table of training posts accredited in 2009.

9. *Continuing professional development*

Guidance: Examples of significant changes:
- Changes to policy or principles relating to continuing professional development;
- Changes to categories of activity recognised for continuing professional development;
- Changes to processes for endorsement of educational activities/meetings;
- Changes to evaluate professional development programs;
- Changes to processes for retraining of fellows who have been absent from practice;
- Changes to processes for remediation of fellows identified as under performing.

The CPD Program framework remained essentially unchanged in 2009. The program is recorded in a credit point system (rather than hours) to enable weighting for educational value and continues to have an emphasis on active learning, recognising the value of activities such as peer review of practice; surgical/clinical attachments; patient feedback surveys; interactive workshops/small group learning activities and learning and development plans.

The notable changes to the 2010 -2012 CPD Program are:
- a requirement to participate in the Australian and New Zealand Audit of Surgical Mortality if a surgeon is in operative based practice, has a surgical death and an audit of surgical mortality is available in the surgeon's hospital
- an increase in the number of Fellows randomly selected to verify their CPD returns, from 2.5% to 3.5%
- a focus on verifying one component of the CPD Program rather than a full 'audit' of an annual return

There have been no changes to the categories of activities recognised for CPD. There have been no major changes to the College's process for endorsement of educational activities/meetings.

Activities aimed at improving participation in CPD Program include:
- Upgrades to CPD Online system. Calendar feature allows for easy entry of meetings which are repeated on a regular basis.
- Specialty Society and Association representatives on the Professional Development and Standards Board are issued with a list of their members who are non-participant or non-compliant in the CPD Program. The representatives contact the Fellows individually to seek their participation and/or compliance. This process occurs in June and October of each year.
- Structured administrative processes as part of the annual CPD cycle, including three reminder letters and a letter from the College President.

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
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 /CAR	Cardiothoracic Surgery
GS /GEN	General Surgery
NS /NEU	Neurosurgery
OS /ORT	Orthopaedic Surgery
OHNS /OHN	Otolaryngology Head & Neck Surgery
PS /PEA	Paediatric Surgery
P&RS/ PLA	Plastic & Reconstructive Surgery
U/ URO	Urology
VS/ VAS	Vascular Surgery

Appendix 2 Statistics requested in section B

	Statistics	Table(s)	Page
a.	The number of trainees entering each college training program	4-8	
b.	The number of trainees who completed training in each program	15-16	
c.	The number of trainees undertaking each college training program	9-10	
d.	Each summative assessment activity (e.g. Part 1 and Part 2 exams) and the number and percentage of candidates sitting and passing each time they were held	Fellowship Exam 11-14 Early Examinations 17-26	
e.	The number and proportion of college fellows participating in the college's continuing professional development programs	3	

Table 3: 2009 CPD participation and compliance

Number of Fellows required to participate in CPD	3,721 Fellows
Number and proportion who submitted a return	3,094 (83% of Fellows)
Number and proportion who complied with annual requirements	3,017 (98% of those who made a return)

Information about the College CPD program is available on-line at:
http://www.surgeons.org/Content/NavigationMenu/FellowshipandStandards/CPDRecertification/default.htm#require

Table 4: 2009 SET Applications by Specialty and Location

	ACT	NSW	NT	QLD	SA	TAS	VIC	WA	**AUS**	NZ	O/S	**Total**
Cardiothoracic	0	11	0	5	1	0	12	3	**32**	9	0	**41**
General Surgery	5	104	2	63	14	4	82	18	**292**	47	0	**339**
Neurosurgery	1	23	0	7	3	3	17	5	**59**	7	0	**66**
Orthopaedic	4	51	0	45	18	3	49	13	**183**	32	0	**215**
Otolaryngology Head & Neck	1	33	0	26	8	2	25	6	**101**	15	0	**116**
Paediatric	0	9	0	4	2	0	3	2	**20**	5	1	**26**
Plastic & Reconstructive	1	39	0	20	5	4	37	6	**112**	16	0	**128**
Urology	0	29	0	26	6	2	30	6	**99**	15	0	**114**
Vascular Surgery	0	20	0	11	5	0	11	7	**54**	9	0	**63**
Total	**12**	**319**	**2**	**207**	**62**	**18**	**266**	**66**	**952**	**155**	**1**	**1108**

Table 5: 2010 SET Applications by Specialty and Location

	ACT	NSW	NT	QLD	SA	TAS	VIC	WA	**AUS**	NZ	O/S	**Total**
Cardiothoracic	1	6	0	3	1	0	9	3	**23**	8	0	**31**
General Surgery	8	107	8	64	22	6	110	20	**345**	53	1	**399**
Neurosurgery	2	23	0	11	2	1	23	3	**65**	2	1	**68**
Orthopaedic	3	60	0	37	17	1	52	15	**185**	36	0	**221**
Otolaryngology Head & Neck	1	32	2	21	5	4	32	6	**103**	8	0	**111**
Paediatric	2	9	1	4	2	0	4	2	**24**	3	1	**28**
Plastic & Reconstructive	3	38	0	9	5	1	41	5	**102**	12	0	**114**
Urology	2	27	2	20	4	4	24	9	**92**	17	0	**109**
Vascular Surgery	3	15	1	7	2	0	9	6	**43**	8	0	**51**
Total	**25**	**317**	**14**	**176**	**60**	**17**	**304**	**69**	**982**	**147**	**3**	**1132**

Note: the numbers in both of the above tables include applicants who submitted applications to more than one specialty — see Tables XX for numbers of applicants and type.

Table 6: 2009 Individuals who submitted an application to SET — by number and type

Number of applications	BST1	BST2	BST3	BST4	SET	SET deferred	IMG	Person	Fellow	Total
1			30	16	68		3	447	2	**566**
2			10	2	10			148		**170**
3			3	2	1			44	1	**51**
4 or more				1				10		**11**
Total			**43**	**21**	**79**		**3**	**649**	**3**	**798**

Table 7: 2010 Individuals who submitted an application to SET — by number and type

Number of applications	BST1	BST2	BST3	BST4	SET	SET deferred	IMG	Person	Total
1				10	64	2	1	561	**638**
2				2	5			177	**184**
3				1	1			29	**31**
4								8	**8**
Total				**13**	**70**	**2**	**1**	**775**	**861**

Table 8: 2009 & 2010 SET Accepted Offers by Specialty

	2009	2010
Cardiothoracic Surgery	3	9
General Surgery - Aus	98	88
General Surgery - NZ	18	15
Neurosurgery	14	12
Otolaryngology Head and Neck Surgery - Aus	14	5
Otolaryngology Head and Neck Surgery - NZ	6	5
Orthopaedic Surgery - Aus	46	50
Orthopaedic Surgery - NZ	13	11
Paediatric Surgery	6	8
Plastic and Reconstructive Surgery - Aus	18	16
Plastic and Reconstructive Surgery - NZ	6	2
Urology	20	23
Vascular Surgery	8	8
Total	**270**	**254**

Note:

1. The number of available posts in each specialty varies from year to year because of:
   - The number of trainees completing their training
   - The number of accredited posts (this can be increased with the identification of new posts, or decreased with the disaccreditation of posts)
2. The 2010 acceptance figures do not include potential second and third round offers for General Surgery (Australia)
3. For 2010, the number of available posts in Otolaryngology Head and Neck Surgery in Australia is smaller than usual because of the transition from first year training in General Surgery.

Table 9: 2009 Total SET Trainees by Specialty and Status

Status		Gender	CAR	GEN	NEU	ORT	OTO	PAE	PLA	URO	VAS	Total
Active	Clinical	Male	29	295	26	254	51	13	61	90	40	**859**
		Female	4	130	8	17	39	12	24	24	12	**270**
		Total	**33**	**425**	**34**	**271**	**90**	**25**	**85**	**114**	**52**	**1129**
	Accredited Research	Male	3	2	13	0	3	0	2	4	0	**27**
		Female	1	2	3	0	0	0	0	0	0	**6**
		Total	**4**	**4**	**16**	**0**	**3**	**0**	**2**	**4**	**0**	**33**
	Part Time	Male	0	0	0	0	0	0	0	0	0	**0**
		Female	0	1	0	0	0	0	0	0	0	**1**
		Total	**0**	**1**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**1**
	Probationary	Male	1	13	2	0	0	0	0	1	0	**17**
		Female	0	2	0	0	0	0	0	0	0	**2**
		Total	**1**	**15**	**2**	**0**	**0**	**0**	**0**	**1**	**0**	**19**
	Exam Pending	Male	3	3	0	2	0	0	0	0	0	**8**
		Female	0	0	0	0	0	0	0	0	0	**0**
		Total	**3**	**3**	**0**	**2**	**0**	**0**	**0**	**0**	**0**	**8**
Inactive	Approved Interruption to training	Male	1	16	3	0	4	0	2	4	1	**31**
		Female	0	14	2	1	3	1	1	1	0	**23**
		Total	**1**	**30**	**5**	**1**	**7**	**1**	**3**	**5**	**1**	**54**
	Deferred	Male	0	4	0	0	2	0	0	3	2	**11**
		Female	0	1	0	0	0	0	1	1	0	**3**
		Total	**0**	**5**	**0**	**0**	**2**	**0**	**1**	**4**	**2**	**14**
	Suspended	Male	0	0	0	0	0	0	0	1	0	**1**
		Female	0	0	0	0	0	0	0	0	0	**0**
		Total	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**1**	**0**	**1**
Left Program	Terminated	Male	0	4	1	1	0	0	0	1	0	**7**
		Female	0	1	0	0	0	0	0	0	0	**1**
		Total	**0**	**5**	**1**	**1**	**0**	**0**	**0**	**1**	**0**	**8**
	Withdrawn	Male	0	16	3	0	2	0	3	1	1	**26**
		Female	0	20	0	0	3	2	0	0	0	**25**
		Total	**0**	**36**	**3**	**0**	**5**	**2**	**3**	**1**	**1**	**51**
	Deceased	Male	0	2	0	0	1	0	0	0	0	**3**
		Female	0	0	0	0	0	0	0	0	0	**0**
		Total	**0**	**2**	**0**	**0**	**1**	**0**	**0**	**0**	**0**	**3**

Table 9: 2009 Total SET Trainees by Specialty and Status (cont)

Fellowship status	Accepted Fellowship	Male	3	38	6	56	9	0	6	10	9	**137**
		Female	0	19	1	3	5	0	3	3	1	**35**
		Total	**3**	**57**	**7**	**59**	**14**	**0**	**9**	**13**	**10**	**172**
	Eligible - in process	Male	2	12	3	27	8	1	1	4	6	**64**
		Female	0	3	0	0	4	0	2	1	0	**10**
		Total	**2**	**15**	**3**	**27**	**12**	**1**	**3**	**5**	**6**	**74**
	Eligible - no application	Male	0	0	1	0	1	0	0	0	0	**2**
		Female	0	0	0	1	0	0	0	0	0	**1**
		Total	**0**	**0**	**1**	**1**	**1**	**0**	**0**	**0**	**0**	**3**
Total Active		Male	36	313	41	256	54	13	63	95	40	**911**
		Female	5	135	11	17	39	12	24	24	12	**279**
		Total	**41**	**448**	**52**	**273**	**93**	**25**	**87**	**119**	**52**	**1190**

Table 10: 2010 Number and Percentage of Active SET Trainees by Specialty and Location - January to April

		Australia		New Zealand		Overseas		Combined	
		No.	%	No.	%	No.	%	No.	%
Cardiothoracic	Male	30	3.0%	4	2.1%	0	0.0%	34	2.8%
	Female	5	0.5%	0	0.0%	0	0.0%	5	0.4%
	Total	**35**	**3.5%**	**4**	**2.1%**	**0**	**0.0%**	**39**	**3.2%**
General Surgery	Male	272	26.9%	43	22.4%	0	0.0%	315	25.8%
	Female	123	12.1%	25	13.0%	0	0.0%	148	12.1%
	Total	**395**	**39.0%**	**68**	**35.4%**	**0**	**0.0%**	**463**	**37.9%**
Neurosurgery	Male	40	3.9%	5	2.6%	0	0.0%	45	3.7%
	Female	10	1.0%	1	0.5%	1	6.3%	12	1.0%
	Total	**50**	**4.9%**	**6**	**3.1%**	**1**	**6.3%**	**57**	**4.7%**
Orthopaedic	Male	200	19.7%	53	27.6%	1	6.3%	254	20.8%
	Female	17	1.7%	3	1.6%	1	6.3%	21	1.7%
	Total	**217**	**21.4%**	**56**	**29.2%**	**2**	**12.5%**	**275**	**22.5%**
Otolaryngology Head & Neck	Male	52	5.1%	4	2.1%	0	0.0%	56	4.6%
	Female	30	3.0%	11	5.7%	0	0.0%	41	3.4%
	Total	**82**	**8.1%**	**15**	**7.8%**	**0**	**0.0%**	**97**	**7.9%**
Paediatric	Male	11	1.1%	2	1.0%	0	0.0%	13	1.1%
	Female	10	1.0%	1	0.5%	0	0.0%	11	0.9%
	Total	**21**	**2.1%**	**3**	**1.6%**	**0**	**0.0%**	**24**	**2.0%**
Plastic & Reconstructive	Male	59	5.8%	13	6.8%	0	0.0%	72	5.9%
	Female	21	2.1%	7	3.6%	0	0.0%	28	2.3%
	Total	**80**	**7.9%**	**20**	**10.4%**	**0**	**0.0%**	**100**	**8.2%**
Urology	Male	72	7.1%	13	6.8%	8	50.0%	93	7.6%
	Female	21	2.1%	3	1.6%	1	6.3%	25	2.0%
	Total	**93**	**9.2%**	**16**	**8.3%**	**9**	**56.3%**	**118**	**9.7%**
Vascular Surgery	Male	33	3.3%	3	1.6%	1	6.3%	37	3.0%
	Female	7	0.7%	1	0.5%	3	18.8%	11	0.9%
	Total	**40**	**3.9%**	**4**	**2.1%**	**4**	**25.0%**	**48**	**3.9%**
Total	Male	769	75.9%	140	72.9%	10	62.5%	919	75.3%
	Female	244	24.1%	52	27.1%	6	37.5%	302	24.7%
	Total	**1013**	**100.0%**	**192**	**100.0%**	**16**	**100.0%**	**1221**	**100.0%**

Table 11: May 2009 Individual Fellowship Exam Pass Rates (number passed & % pass of all sitting)

	ACT	NSW	NT	QLD	SA	TAS	VIC	WA	Total AU	NZ	O/Seas Unknown	Total Passed	Total Sitting	% Passed
Cardiothoracic							**1** 100%		**1** 50%			**1**	**2**	**50%**
General		**16** 76%		**5** 63%	**1** 100%		**15** 68%	**3** 50%	**40** 68%	**4** 67%	**4** 100%	**48**	**69**	**70%**
Neurosurgery		**2** 67%					**3** 100%	**1** 100%	**6** 67%			**6**	**9**	**67%**
Orthopaedic		**10** 67%		**12** 75%	**4** 80%		**11** 85%	**5** 83%	**42** 74%	**11** 100%	**1** 100%	**54**	**69**	**78%**
Otolaryngology Head & Neck		**4** 67%		**3** 100%	**1** 100%		**5** 83%		**13** 72%			**13**	**21**	**62%**
Paediatric		**1** 100%							**1** 33%			**1**	**4**	**25%**
Plastic & Reconstructive		**1** 50%		**1** 100%			**2** 50%	**2** 100%	**6** 67%	**1** 50%	**1** 50%	**8**	**13**	**62%**
Urology		**5** 100%		**5** 100%	**2** 100%		**2** 100%	**2** 100%	**16** 94%		**1** 100%	**17**	**19**	**89%**
Vascular		**1** 100%		**2** 100%			**1** 100%		**4** 100%			**4**	**5**	**80%**
Total Total % passed		**40** 74%		**28** 80%	**8** 80%		**40** 75%	**13** 65%	**129** 72%	**16** 70%	**7** 70%	**152** 72%	**211**	

Table 12: October 2009 Individual Fellowship Exam Pass Rates (number passed & % pass of all sitting)

	ACT	NSW	NT	QLD	SA	TAS	VIC	WA	Total AU	NZ	O/Seas / Unknown	Total Passed	Total Sitting	% Passed
Cardiothoracic					**1** 100%	**1** 100%			**2** 67%			**2**	**3**	**67%**
General	**1** 100%	**8** 53%		**5** 71%	**1** 50%		**7** 64%	**2** 50%	**24** 57%	**2** 100%		**26**	**44**	**59%**
Neurosurgery		**3** 100%			**1** 100%				**4** 100%		**1** 100%	**5**	**5**	**100%**
Orthopaedic	**1** 50%	**5** 83%		**3** 75%	**1** 100%		**2** 100%	**1** 100%	**13** 72%			**13**	**18**	**72%**
Otolaryngology Head & Neck		**3** 100%					**1** 100%	**1** 50%	**5** 83%	**1** 33%	**1** 100%	**7**	**10**	**70%**
Paediatric							**1** 100%	**1** 100%	**2** 100%		**1** 100%	**3**	**3**	**100%**
Plastic & Reconstructive					**1** 100%		**2** 100%	**1** 100%	**4**	**2** 57%	**2** 100%	**8** 67%	**12**	**67%**
Urology	**1** 100%								**1** 50%	**3** 100%		**4**	**5**	**80%**
Vascular		**1** 50%							**1** 33%	**2** 67%		**3**	**6**	**50%**
Total Total % passed	**3** 75%	**20** 65%		**8** 62%	**5** 83%	**1** 33%	**13** 68%	**6** 67%	**56** 64%	**10** 77%	**5** 83%	**71** 67%	**106**	

Table 13: 2009 Annual Pass Rates Fellowship Exam (number passed & % pass of all sitting)

	ACT	NSW	NT	QLD	SA	TAS	VIC	WA	Total AU	NZ	O/Seas/ No Address	Total Passed	Total Sitting	% Passed
Cardiothoracic	**0**	**0**	**0**	**0**	**1**	**1**	**1**	**0**	**3**	**0**	**0**	**3**	**4**	**75%**
General	**1**	**24**	**0**	**10**	**2**	**0**	**22**	**5**	**64**	**6**	**4**	**74**	**96**	**77%**
Neurosurgery	**0**	**5**	**0**	**0**	**1**	**0**	**3**	**1**	**10**	**0**	**1**	**11**	**14**	**79%**
Orthopaedic	**1**	**15**	**0**	**15**	**5**	**0**	**13**	**6**	**55**	**11**	**1**	**67**	**76**	**88%**
Otolaryngology Head & Neck	**0**	**7**	**0**	**3**	**1**	**0**	**6**	**1**	**18**	**1**	**1**	**20**	**23**	**87%**
Paediatric	**0**	**1**	**0**	**0**	**0**	**0**	**1**	**1**	**3**	**0**	**1**	**4**	**4**	**100%**
Plastic & Reconstructive	**0**	**1**	**0**	**1**	**1**	**0**	**4**	**3**	**10**	**3**	**3**	**16**	**20**	**80%**
Urology	**1**	**5**	**0**	**5**	**2**	**0**	**2**	**2**	**17**	**3**	**1**	**21**	**22**	**95%**
Vascular	**0**	**2**	**0**	**2**	**0**	**0**	**1**	**0**	**5**	**2**	**0**	**7**	**10**	**70%**
Total	**3**	**60**	**0**	**36**	**13**	**1**	**53**	**19**	**185**	**26**	**12**	**223**	**269**	
Total % passed	**60%**	**82%**		**82%**	**93%**	**20%**	**88%**	**83%**	**100%**	**87%**	**92%**	**83%**	**100%**	

Note: A candidate who sat more than once in the same year is counted only once.

Table 14: May 2010 Individual Fellowship Exam Pass Rates (number passed & % pass of all sitting)

	ACT	NSW	NT	QLD	SA	TAS	VIC	WA	Total AU	NZ	Total passed	Total sitting	% Passed
Cardiothoracic	0	1	0	2	0	0	1	0	4	2	6	9	67%
		50%		100%			50%		57%	100%			
General	1	14	1	7	3	0	13	1	40	6	46	71	65%
	100%	74%	100%	64%	50%		54%	33%	62%	100%			
Neurosurgery	0	2	0	0	0	0	0	1	3	0	3	8	38%
		40%						100%	43%				
Orthopaedic	0	14	0	7	3	0	12	3	39	12	51	70	73%
		78%		64%	60%		71%	75%	68%	92%			
Otolaryngology Head & Neck	0	6	0	2	1	0	3	2	14	2	16	25	64%
		67%		100%	50%		50%	100%	64%	67%			
Paediatric	0	2	0	0	0	0	1	0	3	0	3	3	100%
		100%					100%		100%				
Plastic & Reconstructive	0	3	0	3	1	0	3	1	11	0	11	17	65%
		60%		100%	50%		100%	50%	73%				
Urology	0	3	0	4	1	0	7	2	17	2	19	24	79%
		60%		57%	100%		100%	100%	77%	100%			
Vascular	0	2	0	3	0	0	2	0	7	1	8	10	80%
		67%		100%			100%		78%	100%			
Total	1	47	1	28	9	0	42	10	138	25	163	237	
Total % passed	50%	69%	50%	72%	50%		68%	71%	67%	86%	69%		

Note: The second sitting of the Fellowship Examination is in late September, therefore the 2010 Annual pass rates are not yet available.

Table 15: 2008 - 2009 Annual Pass Rates Fellowship Exam

	2008			2009		
	Total Sitting	**Total Passed**	**% Passed**	**Total Sitting**	**Total Passed**	**% Passed**
Cardiothoracic	5	4	**80%**	4	3	**75%**
General	88	68	**77%**	96	74	**77%**
Neurosurgery	11	8	**73%**	14	11	**79%**
Orthopaedic	76	58	**76%**	76	67	**88%**
Otolaryngology Head & Neck	20	18	**90%**	23	20	**87%**
Paediatric	5	5	**100%**	4	4	**100%**
Plastic & Reconstructive	14	10	**71%**	20	16	**80%**
Urology	22	18	**82%**	22	21	**95%**
Vascular	13	10	**80%**	10	7	**70%**
Total	**254**	**199**		**269**	**223**	

Note: A candidate who sat more than once in the same year is counted only once.

Table 16: 2009 Trainees (and IMGs) Admitted to Fellowship

	Trainee	IMG	**Total**
Cardiothoracic	4	2	**6**
General Surgery	59	17	**76**
Neurosurgery	8	2	**10**
Orthopaedic	64	15	**79**
Otolaryngology Head & Neck	16	1	**17**
Paediatric	1	2	**3**
Plastic & Reconstructive	9	1	**10**
Urology	13	2	**15**
Vascular Surgery	9	1	**10**
Total	**183**	**43**	**226**

Table 17: 2010 Trainees (and IMGs) Admitted to Fellowship

	Trainee	IMG	**Total**
Cardiothoracic	0	2	**2**
General Surgery	41	13	**54**
Neurosurgery	7	2	**9**
Orthopaedic	43	3	**46**
Otolaryngology Head & Neck	15	2	**17**
Paediatric	3	1	**4**
Plastic & Reconstructive	9	1	**10**
Urology	10	3	**13**
Vascular Surgery	2	1	**3**
Total	**130**	**28**	**158**

Note: the statistics for Table 17 above relate only to the May Fellowship Examination; a second round of FEX is being conducted in September, 2010

Clinical Examinations — 2009 and 2010

The overall pass rate for the 2009 and 2010 clinical exam was 86.25%

Table 17: February 2009

A total of 35 candidates presented
31 Candidates passed, giving a pass rate for this examination of 89%

Specialty	No. Clinical Candidates	Passed (%)
BST	2	50%
Cardiothoracic	0	0
General Surgery	21	85.7%
Neurosurgery	0	0
OH&N	3	100%
Orthopaedic Surgery	4	100%
Paediatric Surgery	0	0
Plastic and Reconstructive Surgery	1	100%
Urology	3	100%
Vascular Surgery	1	100%

Table 18: June 2009

A total of 104 candidates presented
84 candidates passed, giving a pass rate for this examination of 81%.

Specialty	No. Clinical Candidates	Passed (%)
BST	4	100
Cardiothoracic	3	67
General Surgery	63	76
Neurosurgery	6	67
OH&N	6	83
Orthopaedic Surgery	7	100
Paediatric Surgery	-	-
Plastic and Reconstructive Surgery	-	-
Urology	8	100
Vascular Surgery	6	100

Table 19: February 2010

A total of 68 candidates presented 13th February 2010
59 Candidates passed, giving a pass rate for this examination of 86.8%

Specialty	No. Clinical Exam Candidates	Passed (%)
BST	2	50%
Cardiothoracic	1	100%
General Surgery	32	84.4%
Neurosurgery	5	80%
OH&N	5	100%
Orthopaedic Surgery	17	94.1%
Paediatric Surgery	1	100%
Plastic and Reconstructive Surgery	1	100%
Urology	3	100%
Vascular Surgery	1	0%

Table 20: June 2010

A total of 142 candidates presented 28th May 2010
127 Candidates passed, giving a pass rate for this examination of 89.4%

Specialty	No. Clinical Exam Candidates	Passed (%)
BST	4	50%
Cardiothoracic	-	-
General Surgery	81	93.8%
Neurosurgery	7	85.7%
OH&N	5	100%
Orthopaedic Surgery	25	96%
Paediatric Surgery	3	100%
Plastic and Reconstructive Surgery	5	60%
Urology	7	71.4%
Vascular Surgery	5	60%

Surgical Sciences (SSE) Generic Examinations for 2009 and 2010

Overall pass rate for the 2009 and 2010 SSE generic exam was 82.62%

Table 21: February 2009

A total of 25 candidates presented
15 Candidates passed, giving a pass rate for this examination of 60%

Specialty	No. Generic Exam Candidates	Passed (%)
BST	-	-
Cardiothoracic	-	-
General Surgery	14	50%
Neurosurgery	-	-
OH&N	1	100%
Orthopaedic Surgery	5	80%
Paediatric Surgery	-	-
Plastic and Reconstructive Surgery	-	-
Urology	2	50%
Vascular Surgery	3	66.7%

Table 22: June 2009

A total of 107 candidates presented
91 Candidates passed, giving a pass rate for this examination of 85.05%.

Specialty	No. Generic Exam Candidates	Passed (%)
BST	2	50%
Cardiothoracic	3	100%
General Surgery	69	85.5%
Neurosurgery	7	85.7%
OH&N	8	87.5%
Orthopaedic Surgery	6	50%
Paediatric Surgery	-	-
Plastic and Reconstructive Surgery	-	-
Urology	6	100%
Vascular Surgery	6	100%

Table 23: February 2010

A total of 57 candidates presented
50 Candidates passed, giving a pass rate for this examination of 87.7%

Specialty	No. Generic Exam Candidates	Passed (%)
BST	-	-
Cardiothoracic	1	100%
General Surgery	21	85.71%
Neurosurgery	2	50%
OH&N	3	100%
Orthopaedic Surgery	23	95.65%
Paediatric Surgery	1	0%
Plastic and Reconstructive Surgery	1	100%
Urology	4	100%
Vascular Surgery	1	100%

Table 24: June 2010

A total of 139 candidates presented
115 Candidates passed, giving a pass rate for this examination of 82.73%.

Specialty	No. Generic Exam Candidates	Passed (%)
BST	1	100%
Cardiothoracic	-	-
General Surgery	82	84.1%
Neurosurgery	8	87.5%
OH&N	7	85.7%
Orthopaedic Surgery	23	82.6%
Paediatric Surgery	4	50%
Plastic and Reconstructive Surgery	4	75%
Urology	6	83.3%
Vascular Surgery	4	75%

Table 25: SURGICAL SCIENCE EXAMINATION (SSE) – Specialty Specific Examination

	Feb-09			Jun-09			Feb-10			Jun-10			
Specialty	*Cands Sat*	*Passed*	*% Pass*	*Cands Sat*	*Passed*	*% Pass*	*Cands Sat*	*Passed*	*% Pass*	*Cands Sat*	*Passed*	*% Pass*	***Combined % Pass***
Cardiothoracic	*1*	*1*	*100*	*3*	*3*	*100*	*1*	*0*	*0*	*1*	*0*	*0*	***66.7***
General Surgery	*25*	*13*	*52*	*83*	*54*	*65.1*	*30*	*14*	*46.7*	*91*	*40*	*44*	***52.8***
Neurosurgery	*1*	*0*	*0*	*10*	*6*	*60*	*5*	*2*	*40*	*11*	*3*	*27.3*	***40.7***
OH&N	*1*	*1*	*100*	*7*	*2*	*28.6*	*7*	*7*	*100*	*7*	*1*	*14.3*	***50***
Urology	*4*	*4*	*100*	*6*	*6*	*100*	*4*	*3*	*75*	*7*	*5*	*71.4*	***85.7***
Vascular	*3*	*1*	*33*	*8*	*6*	*75*	*3*	*1*	*33*	*6*	*4*	*66.7*	***60***

Table 26: Orthopaedic Basic Sciences (OPBS); Paediatric Anatomy, Paediatric Pathology, and Plastic & Reconstructive Surgery Science Principles (PRSSP) Examinations

	Feb-09			May-09			June-09			October-09			
Specialty	*Cands Sat*	*Passed*	*% Pass*	*Cands Sat*	*Passed*	*% Pass*	*Cands Sat*	*Passed*	*% Pass*	*Cands Sat*	*Passed*	*% Pass*	***Combined % Pass***
OPBS	**56**	**37**	**66.1**	*NA*	*NA*	*NA*	*NA*	*NA*	*NA*	**70**	**60**	**85.71**	***77***
Paediatric Anatomy	*NA*	*NA*	*NA*	**4**	**2**	**50**	*NA*	*NA*	*NA*	**3**	**3**	**100**	***71.4***
Paediatric Pathology	*NA*	*NA*	*NA*	*NA*	*NA*	*NA*	**4**	**3**	**75**	**4**	**4**	**100**	***87.5***
PRSSP	*NA*	*NA*	*NA*	*NA*	*NA*	*NA*	*NA*	*NA*	*NA*	**23**	**23**	**100**	***100***

Please Note: - The OPBS, PRSSP and Paediatric Pathology Examination have not as yet been conducted for 2010 as this will occur in October.
- Paediatrics has only conducted its written examination at the present time. The Clinical Component will be conducted in September, therefore 2010 results are not as yet available for that examination.

Appendix 3 College Governance Map

Appendix 4

An outline of the final year (year 6) of Urology training

Since 1995, the Board of Urology and the Royal Australasian College of Surgeons has required Urology trainees to undertake a 'provisional' fellowship year following their final year of dedicated urology training and prior to final presentation of the FRACS (Urology). The 'provisional' fellowship year followed the final (3rd) year of dedicated urology training in which the FRACS (Urology) examination was undertaken. Where required, the FRACS examination could also be undertaken during the 'provisional' fellowship year. The 'provisional' fellowship year was always regarded as the final year of accredited urology training and trainees were not eligible to receive the FRACS (Urology) until they had satisfactorily completed this final year. At that time, the Board of Urology had a limited role in evaluating and overseeing trainees during the 'provisional' fellowship year.

In 2003, the bi-national selection process was introduced and with it a documented process for approving and accrediting the 'provisional' fellowship year was introduced. In 2007, the Board of Urology developed a set of guidelines and a more formalised process for the prospective approval of 'provisional' fellowship plans. The word 'provisional' was interpreted to mean 'provisional to the FRACS (Urology)' as opposed to a 'Provisional Fellowship'. Unfortunately, the term Fellowship as it applies to posts (Fellow) and the qualification (FRACS) will continue to be a source of potential confusion.

When the SET program commenced in 2008, urology training became a 6 year program (from SET1-SET6) and the 'provisional' fellowship year was renamed SET6 (Senior Registrar/Provisional Fellow). The use of the terminology '***Provisional Fellow***' was continued to assist trainees who were applying for overseas posts. This terminology is thought to allow easier access to such posts rather than the more correct SET 6 *pre*-Fellowship Senior Registrar designation. The 'provisional fellowship' year was, and still is regarded as an accredited year of training and the FRACS (Urology) is only awarded following satisfactory completion of all SET6 requirements.

The current SET6 guidelines stipulate that a SET6 post must provide exposure to a **breadth** of general urology, with an **element** of a sub-specialty. Additionally, the post must provide at least 20% of independent decision making/unsupervised operative surgery.

Trainees must obtain prospective approval of their SET6 post from the Board of Urology. In considering SET6 applications, the Board of Urology assesses whether the nominated post will provide the particular trainee with the required **general urology exposure** to complement their training. As such, a SET6 post may be appropriate for one trainee but not for another. Passing the fellowship examination does not mean that all trainees have attained an equal level of clinical skill – a point missed by some. Factors considered will include experience gained during SET3-SET5 and any competency areas that may require further development/exposure during SET6.

Appendix 5 Hospital accreditations presented to BSET for approval in 2009

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.

Table 27: Hospitals accredited (or reaccredited) for training in 2009

Specialty	State	Hospital	No. Posts Accredited	SET Level	Years Post Accredited
Cardiothoracic	**NSW**	John Hunter Hospital	1	SET1	5
			1	SET2P	5
		Liverpool Hospital	1	SET1	5
			1	SET2P	5
General Surgery	**ACT**	Calvary Private Hospital ACT	1	SET2P	4
		Canberra Hospital	1	SET1	4
	NSW	Auburn Hospital	1	SET1	4
			1	SET2P	4
		Bankstown - Lidcombe Hospital	1	SET1	4
			1	SET2P	4
		Bathurst Base Hospital	1	SET1	4
			1	SET2P	4
		Bega District Hospital	1	SET1	4
			1	SET2P	4
		Blacktown Hospital	1	SET1	4
			3	SET2P	4
		Broken Hill Health Service	1	SET1	4
		Canterbury Hospital & Community Health Service	1	SET1	4
			2	SET2P	4
		Dubbo Base Hospital	1	SET1	4
			2	SET2P	4
		Fairfield Health Service	1	SET1	4
			2	SET2P	4
		Goulburn Base Hospital	1	SET2P	4
		Hawkesbury District Health Service Ltd	1	SET2P	4
		Hornsby Ku-ring-gai Hospital	2	SET2P	4
		Hurstville Private Pty Ltd	1	SET1	4
		Lismore Base Hospital	1	SET1	4
			3	SET2P	4
		Liverpool Hospital	1	SET1	4
		Maitland Hospital	1	SET1	4
			1	SET2P	4
		Manly Hospital & Community Health Services	1	SET1	4
			1	SET2P	4
		Manning Base Hospital	1	SET1	4
			1	SET2P	4
		Mona Vale Hospital	1	SET1	4
			1	SET2P	4
		Mt Druitt Hospital	2	SET1	1
			1	SET2P	1
		Nepean Hospital	1	SET1	4
		Newcastle Mater Misericordiae Hospital	1	SET1	4

		Orange Base Hospital	2	SET1	4
			1	SET2P	4
		Port Macquarie Base Hospital	1	SET1	4
			2	SET2P	4
		Royal Prince Alfred Hospital	2	SET1	4
		Ryde Hospital & Community Health Services	1	SET1	4
		Shoalhaven District Memorial Hospital	1	SET1	4
			1	SET2P	4
		St Vincent's Private Hospital Lismore	1	SET2P	4
		Sutherland Hospital Caringbah & Community Health Service	2	SET2P	4
		Tamworth Base Hospital	1	SET1	4
			2	SET2P	4
		Tweed Hospital	1	SET1	4
			2	SET2P	4
		Westmead Hospital	1	SET1	
		Wollongong Hospital	1	SET1	4
			3	SET2P	4
	NT	Royal Darwin Hospital	1	SET1	1
			1	SET2P	1
	QLD	Cairns Base Hospital	2	SET1	1
			2	SET2P	1
	SA	Port Augusta Hospital	1	SET2P	5
	VIC	Austin Health	1	SET1	1
			1	SET1	1
		Box Hill Hospital	1	SET1	1
		Cabrini Medical Centre	2	SET1	1
		St John of God (Geelong)	1	SET2P	1
		St John of God (Warrnambool)	1	SET1	1
		Werribee Mercy Hospital	1	SET2P	1
	WA	St John of God (Bunbury)	1	SET1	1
		St John of God (Geraldton)	1	SET1	2
		St John of God (Geraldton)	1	SET1	1
		St John of God (Subiaco)	2	SET1	1
Neurosurgery	**NSW**	Dalcross Private Hospital	1	SET2P	1
		John Hunter Hospital	2	SET2P	1
		St George Hospital	1	SET2P	1
			1	SET1	1
	SA	Flinders Medical Centre	1	SET2P	6 months
		Women's & Children's Hospital (Australian Craniofacial Unit)	2	SET2P	6 months
	New Zealand	Wellington Hospital	1	SET2P	1
			1	SET1	1
	NSW	Macquarie University Private Hospital	1	SET2P	1
Otolaryngology Head and Neck Surgery	**NSW**	Gosford Hospital	2	SET2P	5
		John Hunter Hospital	2	SET2P	5

		The Children's Hospital At Westmead	2	SET2P	5
	WA	Fremantle Hospital & Health Service	1	SET2P	5
Orthopaedics	**ACT**	Canberra Hospital	1	SET1-5	4
	NSW	Maitland Hospital	1	SET1-5	1
	Overseas	Shriners Hospital for Children	2	SET2P	5
	QLD	Cairns Base Hospital	2	SET1-5	5
		Gold Coast Hospital	4	SET1-5	3
		Greenslopes Private Hospital	2	SET1-5	5
		Ipswich Hospital	2	SET1-5	5
		Mater Misericordiae Hospital Brisbane	4	SET1-5	2
		Nambour Hospital	2	SET1-5	1
		Prince Charles Hospital	3	SET1-5	5
		Princess Alexandra Hospital & Health Service District	5	SET1-5	1
		Queen Elizabeth II Hospital & Health Service District	3	SET1-5	5
		Redcliffe Hospital	2	SET1-5	5
		Royal Brisbane and Women's Hospital	5	SET1-5	4
		Royal Children's Hospital (QLD)	2	SET1-5	5
		Toowoomba Hospital	2	SET1-5	5
		Townsville Health Service District	2	SET1-5	1
	SA	Sportsmed SA Hospital	1	SET1-5	5
	VIC	Ballarat Base Hospital Campus	1	SET2P	2
		Epworth Hospital	1	SET1-5	3
		Royal Melbourne Hospital - Ludwig Institute	2	SET1-5	3
		Sandringham & District Memorial Hospital	1	SET1-5	3
		Western Health Network (Williamstown Campus)	1	SET1-5	1
	WA	Royal Perth Hospital	1	SET1-5	1
Plastic and Reconstructive Surgery	**New Zealand**	Christchurch Hospital	1	SET2P	1
		Middlemore Hospital (NZ)	1	SET2P	5
		Waikato Hospital	1	SET2P	1
	NSW	Auburn Hospital	1	SET1	5
	QLD	Gold Coast Hospital	1	SET1	5
		Greenslopes Private Hospital	1	SET2P	5
		Mater Misericordiae Hospital Brisbane	1	CMF +2	5
			1	SET1	5
			1	SET2P	5
		Princess Alexandra Hospital & Health Service District	3	SET2P	5
		Royal Brisbane and Women's Hospital	3	SET2P	5
		Royal Children's Hospital (QLD)	1	SET1	5
	VIC	Alfred Hospital	2	SET1	5
		Maroondah Hospital	1	SET1	5

	WA	Sir Charles Gairdner Hospital	1	SET1	5
Urology	**New Zealand**	Auckland Hospital	1	SET1	1
		Hawkes Bay Hospital	1	SET1	1
		Palmerston North Hospital	1	SET2P	1
		Taranaki Base Hospital	1	SET1	1
		Wellington	2	SET2P	1
	NSW	Campbelltown Hospital	1	SET2P	2
		Lake Macquarie Private Hospital	1	SET2P	5
		Liverpool Hospital	1	SET2P	1
		Royal North Shore Hospital	1	SET2P	5
		Sydney Adventist Hospital	1	SET2P	1
		Wagga Wagga Base Hospital	1	SET2P	1
	QLD	Launceston General Hospital	1	SET2P	1
	VIC	Box Hill Hospital	1	SET2P	1
		Western Hospital Footscray	1	SET2P	1
Vascular Surgery	**ACT**	Canberra Hospital	1	SET2P	2
	NSW	Gosford Hospital	1	SET2P	5
		John Hunter Hospital	1	SET2P	2
			1	SET2P	4
		Liverpool Hospital	2	SET2P	5
		Royal North Shore Hospital	1	SET2P	5
		St George Hospital	1	SET2P	2
		St Vincent's Hospital Sydney	1	SET2P	4
		Westmead Hospital	2	SET2P	1
	QLD	Townsville Health Service District	1	SET2P	3
	VIC	Austin Health	1	SET2P	5
		Frankston Hospital	1	SET2P	2
		Geelong Hospital	1	SET2P	5
		St Vincent's Hospital Melbourne	1	SET2P	1