ROYAL AUSTRALASIAN COLLEGE OF SURGEONS

AMC COMPREHENSIVE REPORT 2011

COLLEGE DETAILS

Name: Royal Australasian College of Surgeons

Address: College of Surgeons' Gardens
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MELBOURNE, VIC 3000

Date of last AMC assessment: 2007

Periodic reports since last AMC assessment: 2008, 2009, 2010

Reaccreditation due: December 2011

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STANDARD 1: CONTEXT IN WHICH THE EDUCATION AND TRAINING PROGRAM IS DELIVERED

1.1 Governance

1.1.1. The training organisation's governance structures and its education and training, assessment and continuing professional development functions are defined.
1.1.2. The governance structures describe the composition and terms of reference for each committee, and allow all relevant groups to be represented in decision-making.
1.1.3. The training organisation's internal structures give priority to its educational role relative to other activities.

A. Strengths

- **Council** maintains its role as the Senior Governance Committee of the College (RACS) which determines the strategic direction of the organisation, approves all policies where RACS activities is involved and handles key concerns (see attached diagram). The President (Mr Ian Civil MBE) is also the Chair of Council. The senior boards in the four portfolios of RACS (Education, Fellowship and Standards, Relationships and Advocacy, Resources) oversight in greater detail the implementation of strategy, the development and delivery of key initiatives and support the day to day delivery of RACS activities through Fellows and Staff.
  Weblink to Council Nomination and Voting Procedures for Office Bearers policy
- RACS formally adopted a revised Constitution from May 2010. Educationally, the key change associated with this was the formal co-option of the Chair of the Trainees Association (RACSTA) onto Council with full voting rights (except for the ability to stand for or vote on Office Bearer positions). The increased involvement and prominence of the voice of Trainees has been a strongly supported position across RACS and Specialty Societies over the past ten years. Given the time commitments on Trainees RACS is particularly indebted to them for their active involvement. The current Chair of the Association is Dr Greg O'Grady who is a General Surgery Trainee from New Zealand. Weblink to College Constitution
- The involvement of the various Specialties in the Governance of RACS has continued to be strengthened over the last ten years with the Specialty representatives now being full members of Council. There is active involvement of the Council Specialty Representatives with the thirteen Specialty Societies. However it is acknowledged that the communication and the involvement in decision making between these groups needs to be further enhanced. This is particularly at the senior Office Bearer level of all organisations. A number of strategies including review of the current Surgical Leaders Forum and involvement in society annual scientific meetings are being identified and implemented. Weblink to Election and Co-option to Council policy
- RACS has a clearly defined committee structure which ensures that the planning, implementation and reviewing of the training and professional development programs are supported within the overall college structure under the governance of Council.
  Weblink to the Map of the RACS Committee Structure
- All of the boards and committees have terms of reference which make provision for representation by the surgical specialties; Trainees, jurisdictions and a community advisor (EB), for example: Weblink to Governance Guidelines for Councillors
  Weblink to Education Board Terms of Reference
  Weblink to Board of Surgical Education and Training Terms of Reference
  Weblink to Professional Development and Standards Board Terms of Reference

B. Challenges

- The regulatory environment that surrounds the education of health professionals is becoming increasingly complex with multiple governmental bodies pursuing their specific agendas at a state, regional or national / bi-national level. This requires increased resourcing with subsequent expense to both Fellows and Trainees. Governance oversight is also increasingly detailed and complex which challenges the time available from Fellows who contribute in a pro-bono manner. Government bodies provide limited if any support for the direct costs of providing training or the

indirect cost of the regulators yet demand timelines and responses that are not consistent with current structures.
- Blending the Societies increasing desire for greater autonomy with the overall role of the College as the umbrella organisation for all of surgery will provide challenges to existing governance structures, particularly in regard to the delivery of surgical education.

C. Development plans over the next five years

- RACS is committed to the development of a competency based surgical education and training program that is based on CanMEDS. The ongoing implementation of that and slow movement away from a time based program is the key educational commitment. The delivery and assessment of this is moving rapidly to become IT facilitated or partially e-learning based. RACS is providing substantial funds to improve its IT infrastructure and oversight by Fellows of the College with both skills and interest in this area.
- Internationally one of the major themes being addressed is Professionalism and Skills relating to Teamwork and Communication / Collaboration. RACS, in conjunction with overseas Colleges and Educational Bodies continues to progress these issues (see Appendix 2).

D. Factors that could impact on the achievement of goals and objectives over the next five years

- There are a number of national or bi-national initiatives that have possible impact on RACS. The programs of Health Workforce Australia as an example require ongoing input and monitoring due to the tensions created by initiatives addressing all of health concerns predominantly at the undergraduate level.
- The increasing cost of regulation, program development and delivery is of ongoing concern where these costs are not recognised by Government, or the Health Sector
- Surgical training requires dedicated and accredited training posts for the educational activities to be delivered. All of these require surgical activity to provide the appropriate amount of experience. Without substantial increase in surgical activity in the public sector greater access will be required of the private sector. The private sector needs commitment for infrastructure and dedicated training positions for this to be successful. That requires ongoing government funding beyond the model that is currently being implemented by the Department of Health
- The biggest risk to RACS based training is the decreased appeal of pro-bono based training. Due to the increased regulation and supervisory requirements it is critical that these activities are recognised by protected time for the surgeons. Without this the additional pro-bono contribution is not sustainable.

E. How the College has responded to issues raised as a result of other national or state/ regional policy developments or national or state/ regional enquiries

- The College continues to interact with all state and national / bi-national agencies either directly by involvement of Fellows or by submission / correspondence. There are numerous enquiries relating to workforce, education, regulation and surgical service efficiency. RACS continues to provide input into as many as is possible.

1.2 Program Management

1.2.1 The training organisation has established a committee or committees with the responsibility, authority and capacity to direct the following key functions:
- *planning, implementing and reviewing the training program(s) and setting relevant policy and procedures*
- *setting and implementing policy and procedures relating to the assessment of overseas-trained specialists*
- *setting and implementing policy on continuing professional development and reviewing the effectiveness of continuing professional development activities.*

1.2.2. The training organisation's education and training activities are supported by appropriate resources including sufficient administrative and technical staff.

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

Completed

A. Strengths

- Education Board (EB) is responsible to Council for the management, monitoring, coordination and administration of all of the educational activities within RACS.
  Weblink to Education Board and Committees policies
  - The Board of Surgical Education and Training (BSET); and the Court of Examiners (Fellowship Examination) report to Education Board.
  - International Medical Graduate (IMG) assessment recommendations are made to BSET.
    Weblink to the Assessment of IMG
- The **Education Board** (EB) 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 RACS educational programs continues to evolve. The greatest dynamic is between the Education Board /Council with the Appeals Committee and the overall College Governance structure with the nine Specialties / thirteen Specialty Societies that are involved with delivering the training program.
- The **Appeals Committee** is structured in line with the recommendations of both the Australian Medical Council (AMC) and the Australian Competition and Consumer Commission (ACCC). It has two Fellows of RACS and three other members who have substantial legal / judicial / ombudsman experience or training. They are the Committee that can review decisions that are made concerning Trainees, International Medical Graduates and Fellows. They are not involved with the determination of policy which is the role of Council but with the decisions and the procedural fairness that supported the decisions arising from the implementation of policy. Obviously this is a "high stakes" situation and Trainees / International Medical Graduates now often engage legal representation at an early stage of their contested interaction with RACS. The changed role of legal representation is being actively reviewed currently to ensure that all views can be fully heard in this forum. Weblink to Appeals Mechanism Policy
- The **Court of Examiners** has been very active over the past twenty four months. This is chaired by Professor Spencer Beasley. There has been an active review of the support for our assessment processes. Educational programs for Examiners have been identified from the College of Surgeons in Edinburgh and are now being developed for local and ongoing implementation. Closer interaction is being achieved between the Courts of Examiners and the Training Boards to ensure appropriate mapping of curricula for assessment purposes. Finally the Information Technology support and administrative support is being reviewed to ensure the Courts of Examiners have the systems and capacity to deal with the larger number of Trainees now presenting for examination (see Section 5.1 parts A & C).
- The **Board of Surgical Education and Training** (BSET) is chaired by Mr Simon Williams. The activities oversighted by BSET are largely delivered by the nine training boards or utilises their members for associated activities such as the assessment of International Medical Graduates. SET as the formal educational program of RACS continues to be defined by the Memoranda of Understanding and Service Agreements between RACS and the thirteen specialty societies. It is recognised that these central documents have been in place for ten years and review of them to better reflect the greater involvement of the Specialty Societies in delivering the programs and greater rigor in the educational requirements is now appropriate. As already highlighted there has been progressive involvement between the Boards at the Summative Assessment level. Involvement with the early examinations has seen greater clarity on the material being examined and made more specialty aligned. Involvement with the Fellowship examination has allowed the appropriate mapping and blue-printing of examination material. RACS has previously put significant effort into ensuring the requirements for selection, the overall training programs and assessment programs have been similarly structured. This was at the recommendation of the AMC following previous reviews. Following specific advice from the AMC that this is no longer required, RACS is reviewing this approach to enable greater flexibility by the Training Boards.
- With BSET as the dominant driver, RACS has been the facilitator of a number of work-shops to identify better approaches and greater opportunities for the delivery of training in the private

sector. This has seen substantial interaction with the Specialty Societies, Government bodies such as Health Workforce Australia, Health Workforce New Zealand and Departments of Health, as well as the Private Hospitals. RACS regards the progressive involvement of the private sector in both Australia and New Zealand as critical for the sustainability of surgical training and for expansion in the number of training posts in the coming decade.

- The Professional Development and Standards Board (PDSB) is responsible to Council for providing the policy framework to ensure maintenance of competence of Fellows and provision of high quality surgical care to patients.

  Weblink to Professional Development and Standards Board and Committee policies

  Weblink to CPD and Recertification procedures

- The **Post Fellowship Education and Training Committee** (Chaired by Dr Hugh Martin, AM) has continued its activity of formal accreditation of courses or training programs that are occurring in the Post Fellowship area. A further Spinal Program is being reviewed as is the Colo-rectal program that has been associated with RACS for a number of years. This Committee also oversights the interaction between RACS and a number of multi-college committees that accredit training of specific procedures. As Government agencies becomes increasingly involved with funding programs that require single screening procedures such as colonoscopy RACS remains concerned that the training for these remains fully available for surgical training to ensure skills are available not only in screening programs but also in Rural / Remote areas.
- The Senior governance committee in the Fellowship portfolio is **Professional Development and Standards Board** (PDSB). This is chaired by Professor Michael Grigg. The Professional Standards Committee (Chaired by Mr Graeme Campbell) continues to oversight the Continuing Professional Development (CPD) program. The introduction of the national registration process with compulsory CPD has produced greater awareness of the requirements of the program, the necessity to ensure meaningful audit is achieved and the streamlining of all the associated systems.
- The Dean and/or the Chair of the BSET have made a commitment to attend the meetings of each of the nine surgical specialty training boards (each board meets three times per year) to advise them of program development and to respond to questions from the members of those boards
- Additional staff have been appointed to support the work of the Academy of Surgical Educators
  - The Vascular Surgery training board has appointed an additional member of staff to support Trainees.
- A significant allocation of RACS annual budget is allocated each year to 'New Key Initiatives'. The development and/or improvement of many of the training and professional development programs are funded through this process.

B. Challenges

None identified

C. Development plans over the next five years

- RACS is placing significant investment to provide a revitalised web presence and provide access to on-line learning (see Section 2.2 part C)
- The requirement for more capacity in the on-line learning area (see Section 2.2 part C) will require not only new infrastructure in the form of hardware and software, but also in the educational staff profile. The creation of a position of e-earning manager has occurred. It is anticipated that further organisational change will be required to fully support these on-line initiatives.

D. Factors that could impact on the achievement of goals and objectives over the next five years

- See Section 1.1 part D

E. How the College has responded to issues raised as a result of other national or state/ regional policy developments or national or state/ regional enquiries

None identified.

1.3 Educational Expertise and Exchange

1.3.1. The training organisation uses educational expertise in the development, management and continuous improvement of its education, training, assessment and continuing professional development activities.

1.3.2. The training organisation collaborates with other educational institutions and compares its curriculum, training program and assessment with that of other relevant programs

A. Strengths

- Professor Bruce Barraclough continues in the role of Dean of Education. Under his leadership a number of education and training initiatives are being progressed:
  - Major links with a number of universities and some of the other post-graduate medical colleges are continuing to be developed with the intention of expanding opportunities for surgical education and educational capacity (see Appendix 2).
    - The College believes the surgeons that are trained through our programs are of world standard. As a corollary to that it is believed our nine training programs are amongst the best training programs in the world. The College needs to advance these statements by being able to confirm them. It needs to belong not only to the network of surgical educational bodies but also other international groups.
  - Regular meetings are held with all College management staff involved in education and training to ensure a cohesive approach to all the educational initiatives, debriefings, and updates on key relationships of College related groups.
  - Arrangements have been made for the Dean (or senior member of Council) to regularly attend meetings of the Specialty Societies and the specialty training boards to provide an additional communication link between RACS and those organisations.
- The **Academy of Surgical Educators Board** is chaired by Professor Vince Cousins with the Advisory Committee of the Academy chaired by the Dean of Education (Professor Bruce Barraclough AO). Weblink to Academy of Surgical Educators Board Terms of Reference

Weblink to Academy of Surgical Educators Advisory Committee Terms of Reference

Having now been formally established membership opportunities are being actively advertised. The purpose of the Academy at this point is predominantly focused on the strategy of our educational programs, looking at issue of e-learning, support and training for Surgical Educators and the progression of curricula around the competency of professionalism. The increased resourcing of the Academy will enable this strategic review and identification of the activities that should be prioritised for delivery by the current College structures such as the Skills Committee.

- There are two key examples of this.
  - Firstly, the current emphasis on e-learning by the Academy has led to the identification of educational opportunities with the linking or accrediting of on line training. This requires the development of a key group of Fellows to provide leadership and clinician input. As the emphasis is on "blended learning" opportunities particularly in our skills area, the **Skills Education Committee** chaired by Mr Phil Truskett will have carriage of the e-learning accreditation requirements. Previously RACS has reported how we have been actively working with Educational providers to accredit their courses particularly in basic clinical sciences like Anatomy, Physiology, Pathology and Biochemistry. This is continuing but will now importantly develop and undertake the accreditation of online learning material.
  - Secondly, **Surgical Teachers Education Program Committee** (STEP) as a sub-committee of the **Professional Development Committee** (Chaired by Professor Marianne Vonau OAM) has now been established to provide better co-ordination of the various educational activities supporting our Surgical Educators. It is recognised that the Academy is the group focused on the key strategies with STEP providing specific oversight of courses such as SATSET which is also being reviewed to enable a blended approach of face to face and on line delivery. It is

the membership of STEP that will be progressively engaged with our external partners who are developing formal educational programs like Masters of Surgical Education.

- RACS has developed an extensive network of working relations with Universities and other post-graduate medical colleges in Australasia and internationally (see Appendix 2) for the purposes of:
  - o Sharing on-line surgical education and training material
  - o Accessing educational and training resources relating to the non-technical competencies
  - o Reviewing our programs from an international 'world standard'
- RACS has developed a process for accreditation of courses which are suitable for Trainees. A range of courses offered by RACS, specialty boards and universities have already been submitted for accreditation. Weblink to Course accreditation

B. Challenges

- See Section 1.1 part B

C. Development plans over the next five years

- See Section 1.1 part C

D. Factors that could impact on the achievement of goals and objectives over the next five years

- See Section 1.1 part D

E. How the College has responded to issues raised as a result of other national or state/ regional policy developments or national or state/ regional enquiries

- See Section 1.1 part E

1.4 Interaction with the Health Sector

1.4.1. The training organisation seeks to maintain constructive working relationships with relevant health departments and government, non-government and community agencies to promote the education, training and ongoing professional development of medical specialists.

1.4.2. The training organisation works with healthcare institutions to enable clinicians employed by them to contribute to high quality teaching and supervision, and to foster peer review and professional development.

Recommendation 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.

Recommendation 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.

Recommendation 6: Where jurisdictions have developed clear service expansion plans (e.g. new or expanded hospitals) accompanied by specific allocation of additional recurrent funding, the College 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.

- RACS continues to interact with the Health Sector at all levels of government across two nations being National, Commonwealth and State based. In some areas this is actively encouraged and

RACS is both formally and informally involved in educational and workforce initiatives. This consultative process has substantially increased recently with the advent of National Bodies such as Australian Health Practitioner Regulation Agency, Medical Board of Australia, Health Workforce Australia and ongoing review of New Zealand Committees such as the Health Committee, New Zealand. These bodies undertake substantial consultation with stakeholders usually by detailed submission, involvement with workshops and presentation to committees. RACS remains actively involved and attempts to broadly disseminate its views / positions to not only its membership but also other stakeholders. All of this material is routinely available on the RACS web-site.

- RACS continues to involve jurisdictional representatives on a number of committees and in particular the selection committee processes for Trainees, and the interview committees for International Medical Graduates. RACS is highly appreciative of their involvement and is disappointed by the more recent withdrawal of the jurisdictional representatives by their respective Departments of Health. RACS is a strong believer in the active engagement with all our stakeholders.

A. Strengths

- RACS regularly reports on the results of the selection processes as part of its Annual *Activities Report* Weblink to Activities Reports (for 2010 this information is on pages 25-29)
- In each region RACS has a regional committee which has responsibility for responding to, and reporting to Council on, workforce and advocacy issues.
  Weblink to the Board of Regional Chairs (BRC)
- Representatives of RACS interact with representatives of the Ministries of Health at both state and federal government level, as well as jurisdictional representatives, in different forums and on a broad range of issues. For example:
  - Health Workforce Australia and RACS continue to have regular meetings to advocate funding for post graduate training and to ensure the initiatives being put into place for the undergraduate and all of health responses are consistent with post graduate requirements
  - AHPRA / Medical Board of Australia has had substantial problems implementing its national database and national systems. RACS continues to interact regularly to seek improvements. Importantly the assessment of International Medical Graduates is now a formal sub-contracted role from AHPRA. RACS continues to meet with AHPRA to try and gain further understanding about the legal requirements / contractual arrangements
  - In the latter part of 2010 RACS conducted two workshops (one in Melbourne and one in Wellington NZ) on Training in the Private Sector. The workshops were attended by representatives of specialty training boards; specialty societies; Private Hospitals; Government representatives; medical associations and other colleges. The purpose of the meetings was to develop a range of possible models that could be utilised on the provision of surgical training in the private sector.
  - RACS has entered into a contract with the Australian federal government Department of Health and Aging (DHA) Specialist Training Program (STP) which provides funding for additional training posts in the private sector.
    - 0ver 50 posts have now been funded through this initiative.
- Through its regional committees RACS works closely with the State Ministers of Health, government departments and jurisdictional structures. All of the regional committees (NSW; ACT; Tas; Vic; Qland; SA, WA and NZ) except NT have at least two regular scheduled meetings per year, as well as meetings 2-3 times per year to discuss specific issues relevant to surgery and/or workforce. The NT regional committee has issue specific meetings.
- Besides these meetings, members of the regional committees represent RACS on a wide range of regional committees (for examples, see Appendix 3).
  - Queensland Health together with RACS have instituted an annual two day seminar (2010 and 2011).
- The Surgical Leaders Forum (initiated in 1999) is now scheduled to occur four times a year (at the ASC and in Council Week). It is considered to be a valuable information resource providing

an opportunity for members of Council, Presidents and CEOs of Specialty Societies of Australia and New Zealand, and senior College staff, to keep up-to-date on national health and hospital issues. It has become established practice that at each forum representatives of government (both state and federal) and high level health related organisations advise College members on the changing health environment (see Appendix 4) and are available for discussion and questioning.

- Each year at RACS Annual Scientific Congress (ASC) a session is allocated for the presentation and discussion of current national and/or international, health issues. At each congress at least one invited guest speaker has been a government member or community representative (see Appendix 5).
- In almost all of the surgical specialties contact between the specialty training boards and jurisdictional representatives has been reduced since the introduction of SET. The key reason for this is that the jurisdictions have withdrawn funding for their representatives to attend specialty training board meetings. The jurisdictional representatives (JRs) contribution at those meetings was much appreciated and is missed.
    - JRs continue to attend and participate in meetings of the training boards of Orthopaedic Surgery and Plastic & Reconstructive Surgery
- Specialty training boards continue to invite jurisdictional representation to participate in their selection and the accreditation / reaccreditation of hospital posts for training. Unfortunately, the infrequent acceptance of these invitations means that JRs participation in these events has fallen to an unacceptable level.
- Specialty training boards consult with JRs in each region about the identification of new training positions and about workforce issues.
- One area where JRs continue to participate on a regular basis is in the interviewing of International Medical Graduates which are now scheduled by RACS six times per year.

B. Challenges

- RACS and specialty training boards would like to increase the involvement of JRs in their various meetings. However, without a commitment of funding from the jurisdictions this is unlikely to occur.
- In 2009 RACS reviewed the way in which funding was allocated to cover the cost of the accreditation and reaccreditation of hospital posts. It was deemed appropriate that this expense ought to be paid by the relevant hospital, rather than from Trainee fees. This proposal has met with some resistance from some of the jurisdictions.
- The DHA Specialist Training Program (STP) plan to expand training settings beyond traditional public teaching hospitals offers both opportunities and challenges. The challenges include:
    - For each surgical specialty there are limitations on training posts (as there is on the provision of clinical services) resulting from the kinds of equipment required in theatre, and case numbers.
    - The concept of Trainees working in private settings, and providing service to, and being trained on, private patients challenges well-established assumptions on which private health insurance is based.
- As outlined in the 2010 AMC Annual Report RACS continues to emphasis to jurisdictional representatives (especially in NSW) how important it is for Trainees to have access to outpatients and ambulatory patients.
    - This requirement is defined within the training post accreditation criteria, however the specialty training boards are reluctant to penalise hospitals which are unable to offer that access because it would ultimately reduce the number of Trainees who could be selected into the training program

C. Development plans over the next five years

- RACS and the surgical specialties will continue to interact with the Health Sector at all levels of government across two nations being National, Commonwealth and State based.

- RACS committees and boards will continue to invite jurasdictional representation, despite the current lack of funding made available for this activity
- Representatives of RACS will continue to be leaders on committees relating to surgical issues (see Appendix 3 for examples).

D. Factors that could impact on the achievement of goals and objectives over the next five years

- Lack of funding (see part B above).

E. How RACS has responded to issues raised as a result of other national or state/ regional policy developments or national or state/ regional enquiries

None identified.

1.5 Continuous Renewal

1.5.1. The training organisation reviews and updates structures, functions and policies relating to education, training and continuing professional development to rectify deficiencies and to meet changing needs.

A. Achievements

- The revised Constitution is an example of the way in which RACS response to changing needs (see Section 1.1. part A).
- RACS achieved official certification from the International Organization for Standardization (ISO) in May 2010. The ISO 9001:2008 certification acknowledges RACS' commitment to quality management, continuous improvement and customer satisfaction. The certification:
  - is based on external evaluation of RACS management and administration structures, policies and procedures
  - requires annual verification
- The establishment of the Academy of Surgical Educators (see Section 1.3 part A)
- Revised STEP committee (see Section 1.3 part A)

B. Challenges

None identified

C. Development plans over the next five years

- RACS will continue to maintain ISO accreditation.

D. Factors that could impact on the achievement of goals and objectives over the next five years

None identified

E. How the College has responded to issues raised as a result of other national or state/ regional policy developments or national or state/ regional enquiries

None identified.

STANDARD 2: THE OUTCOMES OF THE TRAINING PROGRAM

2.1 Purpose of the Training Organisation

2.1.1. The purpose of the training organisation includes setting and promoting high standards of medical practice, training, research, continuing professional development, and social and community responsibilities.

2.2.2. In defining its purpose, the training organisation has consulted fellows and trainees and relevant groups of interest.

As stated in the RACS Strategic Plan:

The vision remains true to the purposes for which RACS was founded in 1927

Goals of RACS include:

Guarantee Continuing Provision of High Quality Training by:

- Ensuring that high quality surgical education and training programs which lead to FRACS are delivered by RACS and affiliated societies or RACS accredited education providers.
- Ensuring that FRACS continues to stand for competence and quality in surgical care

Promote Health and Well-being for the Community by

- Being the leading advocate for the surgical health and well-being of patients, including participation in global health advocacy.

Weblink to College Strategic Plan

A. Achievements

Whilst the vision and goal remain the same, the context and requirements of training have changed significantly. To meet these changes, since the 2007 accreditation RACS has:

- Engaged with representatives of state and federal government and jurisdictional representatives, in a range of different forums (see Section 1.4 part A)
- Worked with the Commonwealth DHA through the STP to expand training posts and positions into regional and rural areas, and private settings – currently RACS has accredited over 50 additional positions through this program.
- Through the work of expert working groups, and with broad consultation with key stakeholders, RACS has developed and published performance standards and guidelines as well as a range of other documents relating to health care and surgical safety. These include:
  - the Surgical Competence and Performance Guide for Fellows
    - RACS published the Surgical Competence and Performance Guide in 2008. This is now being updated and the working party undertaking this work is being oversighted by PDSB. The new edition of this booklet will include the development of a Multi-Source Feedback (MSF) tool and also a generic In-Training Assessment (ITA) tool.

    Weblink to Surgical Competence and Performance Guide
  - the revised Code of Conduct

    Weblink to Code of Conduct
    - The Code of Conduct was initially published in 2006 and a major revision has been undertaken to align our document with the Code of Conduct as published by the AMC and also with the College pledge that is a commitment by all new Fellows.
  - a number of 'Position Papers' on key issues relating to safety and quality of surgical care

    Weblink to Position Papers
  - submissions to a number of national medical and government inquiries and reviews

    Weblink to College Advocacy
  - the modified WHO Surgical Safety Checklist

    Weblink to the Surgical Safety Checklist

    Weblink to the Checklist Implementation Manual

  All of these documents are available on the RACS website for public access

B. Challenges

- See Sections 8.1 and 8.2 re maintaining high quality supervision and training posts.
- See Sections 9.2 and 9.3 re continuing professional development

C. Development plans over the next five years

- RACS is currently revising the statements of competence for Trainees (see Section 2.2 part C)
- RACS is developing and trialling a Performance Assessment and Feedback Tool, based on the Surgical Competence and Performance Guide. It is intended that this tool could be used by surgeons for self-assessment as well by surgical units for a 360^0 assessment process.
  Weblink to the Surgical Competence and Performance Guide
- See Section 5.3 part C re plans for Fellowship Examinations
- See Section 3.3 part C re plans for reviewing the current research requirements

D. Factors that could impact on the achievement of goals and objectives over the next five years

- Continued pressure from local hospital administrators to increase throughput of surgical cases without recognising the need to train junior staff who by necessity are slower than consultants.
- Government and administrative closures and restrictions in various hospitals due to rationalisation of services particularly within 'hospital regions or groups'.
  - Hospital closures of bed and operating theatre sessions to decrease costs by decreasing case throughput.
  - Limited capacity to identify additional training posts
  - Maintaining the case-loads in existing posts to ensure their viability for training
  - Inadequate backup supports including Intensive Care/High Dependency Units, specialist nursing and ancillary staff.
- The employment of physician assistants and nurse practitioners who potentially compete with Trainees for available patient case load and investigative procedures.
- The increasing number of university medical graduates in Australia is expected to put pressure on the amount of access that junior doctors have to clinical experiences which prepare them for surgical training (see Section 3.5 for the RACS response to this).
- Because of all of the above factors it is difficult to anticipate potential changes in the medical workplace that may occur and the extent to which those changes could impact on supervision and the quality of training posts.
- At this stage RACS is unsure of the potential impact that the 'National Health Workforce (NHW) Innovation and Reform Strategic Framework for Action' will have on medical careers and /or on specialist training programs.

E. How the College has responded to issues raised as a result of other national or state/ regional policy developments or national or state/ regional enquiries

- RACS has contributed to the NHW consultation process and will maintain a watching brief on the development of that process.
- Members of RACS contribute in national and international organisations for the improvement of health care and surgical safety. For example:
  - The Dean of RACS, Prof Bruce Barraclough was Chair of the Australian Council for Safety and Quality in Health Care from its inception in 2000 until 2006; he has also been the President of The International Society for Quality in Health Care. Currently he is Chair of the World Health Organization (WHO) committee developing curricula guides for medical and other health professionals in safety and quality.

- Fellows contributed to the development and trialling of the WHO Surgical Safety Checklist which is now endorsed by over 300 organisations worldwide. RACS has approved a revised Australia and New Zealand edition of the Surgical Safety Checklist.

- Since 1994, RACS's International Development Program has worked with the Australian Government's overseas aid program, AusAID, to deliver specialist medical services and training in Timor Leste; Papua New Guinea and the Pacific islands.
- The International Development Program also provides awards, fellowships, grants and scholarships to surgeons to fund training opportunities and facilitate professional contact with medical personnel. Weblink to International Development Program
- RACS NZ National Board and staff have very good links to a group of Pacific surgeons including working with the Pacific Islands Surgeons Association (PISA) to assist in organising its biennial conference.
  - Fellows' attendance at the PISA conferences gains them CPD points.
  - Professional links developed from those conferences have led to regular use of training placements in NZ, and in Australia, for surgical Trainees from the Fiji School of Medicine postgraduate surgical training program.
- Indigenous heath Issues (see Section 2.2 parts A, B & C)
- STP program (see Section 1.4 part C and 2.1 part B)
- RACS Fellows have established a strong tradition in providing support for disasters within the region. This is evidenced in a range of ways including the:
  - Trauma Committee Weblink to the Trauma Committee
  - Two trauma courses Early Management of Severe Trauma (EMST) and Definitive Surgical Trauma Care course (DSTC)
  - Disaster Preparedness Working party, and
  - Surgical Leaders' Forum, May 2011 where all of the speakers addressed issues relating to surgeons' response to disaster (see Appendix 4).
- In 2007 RACS published a position paper on Safe hours Weblink to Safe Hours Position Paper
- More recently:
  - RACSTA have surveyed Trainees to collect data on their work patterns and perspectives on the issue. Their findings were reported to BSET and other RACS committees.
  - RACS New Zealand National Board have published an article in their quarterly newsletter Weblink to NZ National Board June, 2010 newsletter

2.2 Graduate Outcomes

2.2.1. The training organisation has defined graduate outcomes for each training program including any sub-specialty programs. These outcomes are based on the nature of the discipline and the practitioners' role in the delivery of health care. The outcomes are related to community need.

2.2.2. The outcomes address the broad roles of practitioners in the discipline as well as technical and clinical expertise.

2.2.3. The training organisation makes information on graduate outcomes publicly available.

2.2.4. Successful completion of the program of study must be certified by a diploma or other formal award.

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

Recommendation 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.

Recommendation 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.

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

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

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

A. Achievements

- Trainees who successfully complete of all of the requirements of training become Fellows of RACS (FRACS). Weblink to the Admission to Fellowship policy
- RACS publishes the number of Trainees and IMGs obtaining Fellowship (by specialty and location) in the Annual *Activities Report*. Weblink to Activities Reports (2010 refer to pages 59-61)
- Since 2003 RACS has had a statement of graduate outcomes which applies to all of the surgical specialties and is published, for public assess, on the RACS website as the 'Definition of Surgical Competence' Weblink to College Statement of Competence
  - The definition is based on the seven competencies as defined in the CanMEDS framework, plus Technical Expertise, and Judgement – Clinical Decision Making. Thus, they encompass all of the varying roles and relationships which surgeons are required to fulfil to meet community needs.
    - The definition of competence in both Communication, and Judgement – Clinical Decision Making includes being sensitive to the physical, social, cultural, and psychological needs of their patients and their families.
  - The nine surgical competencies constitute the framework of overall graduate outcomes for the curriculum for each of the nine surgical specialties.
  - The surgical competence statement has been used by each of the nine surgical specialties as the basis on which they developed their in-training assessment forms.
  - The surgical competence statement is used by each of the surgical specialties as a framework for planning and blueprinting their formative and summative assessment processes.
  - In the most recent revision of their curriculum modules General Surgery has integrated three competency areas (Medical and Technical Expertise and Judgement – Clinical Decision Making) as well as structuring their training requirements to reflect progression through the training program (see further information in Section 3.2 Part A).
- See Appendix 6 for the updated 'Timetable for the planned move to competency-based training' for the activities which have been completed, those which are currently being developed, and those which are on-going.
- Most of the surgical specialties (Cardiothoracic Surgery (CS), General Surgery (GS), Neurosurgery (NS), Orthopaedic Surgery (OS), Otolaryngology Head and Neck Surgery (OHNS), Paediatric Surgery (PS), Urology (U), and Vascular Surgery (VS) assess cultural competence (in awareness of; management of patients; and communication with) in their in-training assessment forms. Trainees are assessed against these requirements at least every three months throughout their training program.
  - The NZ OS Trainees Mini-CEX assesses if the Trainee "*adjusts manner of communication with patients for cultural and linguistic differences and emotional status*". SET 1 Trainees are assessed on this 4 times in their first year, SET 2-4 Trainees are assessed twice per year.
- The Surgical Competence and Performance Guide clearly identifies expectations that Fellows will be culturally competent and able to respond to cultural and community needs.
  Weblink to Surgical Competence and Performance Guide (refer particularly to pages 16 &18)
- As part of its developing program to address cultural competence RACS has introduced a three-day course, the 'Process Communication Model', into their suite of Professional Development

programs. The course is designed to improve participants' understanding of their own preferred communication channel and how they manage stress, as a basis for understanding others (colleagues, patients and their families). Weblink to Process Communication Model

- In 2011 RACS has been successful in securing funding for two Australian Indigenous health projects under the Commonwealth government Rural Health Continuity Education (RHCE) Program.
  - The Indigenous Health and Cultural Competency Online Portal, is a collaborative project with the Royal Australasian College of Physicians and the Australasian College of Dermatologists. The project will create a portal to link and/or house and hence provide easy access to available professional development opportunities for the Medical Colleges pertaining to Indigenous specific cultural competency and cultural safety training.
  - The Australian Indigenous Health eLearning Modules aim to improve surgeons' understanding of Indigenous cultural issues which impact on their Indigenous patients' health care outcomes.
  - The learning module will build on the Australian Indigenous On-line Health Program delivered by RACS in 2006 and 2009

  Both projects will run for three years and will be developed in consultation with Aboriginal and Torres Strait Islander (ATSI) communities to ensure that the resulting Indigenous health resources meet the aims and standards of the CPMC National Aboriginal and Torres Strait islander Curriculum Framework and comply with AMC expectations in regarding to ATSI cultural competency and cultural safety.
- RACS has an Indigenous Health Position Statement and has incorporated Indigenous health priorities into its strategic plan. Both of these instruments are subject to periodic review and evaluation. Weblink to Indigenous Health Position Statement
- RACS also has an Indigenous Health Committee with the responsibility to guide and assist RACS achieve its objectives in Indigenous health in both Australia and New Zealand. Weblink to Indigenous Health Committee Terms of Reference

B. Challenges

- The issue of some 'programs' (surgical specialties) wishing to evolve separately was discussed with representatives of the AMC (Jill Sewell, Chair, AMC Education Accreditation Committee (SEAC) and Robin Mortimer, Deputy President AMC (by teleconference)) at a meeting at RACS on February 4, 2011.
  - RACS is aware that one of the surgical specialties — Orthopaedic Surgery — has sought advice from the AMC as it is considering becoming accredited as a separate entity.
    - Currently there is no clearly defined direction and until advised otherwise RACS will continue to oversee the Orthopaedic Surgery training program including their curriculum, assessment and selection processes under the terms of the Memorandum of Understanding and the Board of Surgical Education and Training (BSET).
- RACS has not yet been able to meet its commitment to recruit Indigenous doctors to be trained as surgeons. To address this issue RACS:
  - Launched its program in 2010 to promote surgery as a career in indigenous communities and in that year invited two Indigenous doctors to attend the Annual Scientific Congress.
  - Contributed a surgical expo at the Australian Indigenous Doctors' Association (AIDA) annual symposium.
  - Is collaborating with the AIDA to develop strategies to promote and recruit ATSI doctors into surgical training.
  - The Indigenous Health Committee is developing a similar program for Māori medical students and doctors in collaboration with TeORA
- Since the introduction of the nine surgical competencies RACS has been responsible for developing information and learning resources for what have been referred to as the six 'non-technical' competencies — whilst each of the nine surgical specialties has developed material (modules; logbooks; courses) for their Trainees in the technical competencies (Technical and Medical Expertise and Judgement – Clinical Decision making).

  - In 2010 RACS undertook a blueprinting process, using a 9X9 matrix (nine competencies X nine surgical specialties) to ascertain the extent to which learning resources were being provided for Trainees across the spectrum of training and competencies. From this process it is evident that more training resources are required in most competency areas (except Technical Expertise).
    - See below for development plans to meet this challenge.

- Whilst the surgical competence statement defines the required levels of performance and expertise for Trainees at the end of their training, and the Surgical Competence and Performance Guide has been published for Fellows, it is evident that standards of competence to reflect progression through training are also needed.
  - See below for development plans to meet this challenge.
- With the growing use of web-based training resources, access and navigation to different areas of RACS and specialty websites has become increasingly more difficult.
  - See below for development plans to meet this challenge.
- Although RACS has 'community representatives' on its key boards and committees (including Council) it has found it difficult to identify an appropriate representative group of health consumers and/or patients to consult with.
  - At the meeting between RACS and representatives of the AMC (Jill Sewell, Chair, AMC Education Accreditation Committee (SEAC) and Robin Mortimer, Deputy President AMC (by teleconference)) on February 4, 2011 RACS identified that they had difficulty identifying appropriate representation from this sector.
    - RACS is still awaiting advice from the AMC

C. Development plans over the next five years

- The development of standards of competence to reflect progression through training across all nine competencies began in 2010 and it is anticipated that the standards will be ready to send out for wide consultation in the second half of 2011.
  - The definition of these standards for all nine competencies has required the conscientious, explicit, and judicious identification of current information from systematic research on the definition and assessment of *competence*, integrated with senior surgeons' concrete, clinical expertise.
    - From extensive research and consultation with other Colleges in Australia and overseas (Canada and UK), the definition of progress through the development of competence has not yet been achieve by any other medical training organisation.
  - Once the standards have been reviewed through consultation they will be made available for the specialty boards to use.
- RACS is currently developing a Professional Development (PD) activity for the Surgical Teachers Education Program (STEP) faculty[1], to be implemented in 2012. The aim is to maintain the knowledge and skills of the STEP faculty in current medical education learning and teaching techniques. The STEP faculty provides facilitators for the *Surgical Teachers Course* (STC) as well as *Supervisors and Trainers for SET* (SAT SET), *Selection Interviewer Training for SET* (SIT SET), and *Keeping Trainees on Track* (KTOT) courses.
- The STC is a two day professional development workshop for surgical teachers. The STC faculty has annually reviewed the course curriculum based on evaluations provided by participants and faculty members. The course will now be given a major revision by an external medical educator to ensure that the original objectives and outcomes are still being met and continue to be relevant to today's teaching and learning environment.
- The blueprinting process and the research into the development of standards for progression has highlighted the importance of the work done by RACS in 2009-10 in developing new courses, designed to integrate several of the 'non-technical' competencies, for both Trainees and Fellows. There are four new courses which are current progressing through different stages of development and roll-out:

[1] 'Faculty' is the term RACS uses to describe trainers and surgeon-directors of courses and workshops.

- The *Training in Professional Skills* (TIPS) course developed from a project funded in 2009 by the Australian Society for Simulation in Health Care (ASSH) for RACS to work in association with St Vincent's Hospital and Monash University's Centre for Medical and Health Sciences Education (CMHSE). The two-day course is designed to provide training in communication skills, judgement and decision making and professionalism to Trainees in SET 3-4, across all surgical specialties. This year (2011) three courses will be run.
  - It is not intended to offer the course to all mid-SET Trainees in the immediate future. Roll-out of the course will depend upon availability of faculty and appropriate facilities.
- KTOT is a half-day course designed for supervisors and trainers as a follow-on from the SAT SET course. After being trialled in 2010 and running a Train-the-Trainer course in 2011, KTOT was launched at the 2011 Annual Scientific Congress (ASC). Focusing on the competencies of Scholar and Teacher, and Professionalism, the key skills are designed to assist supervisors work with Trainees who lack skills as adult, independent learners (goal-setting; self-assessment; insight) and to improve supervisors' skills in giving feedback.
  - On-line resources will provide training in the same skills for Trainees
- With the support of the Royal College of Surgeons of Edinburgh (RCSEd) and the University of Aberdeen, in 2011 RACS ran a two day Train-the-trainer *Non-technical Skills for Surgeons* (NOTSS) course. This course was developed in Scotland with joint funding by RCSE and the NHS Education of Scotland to provide training in skills relevant to working in theatre (related to the competencies of Communication; Judgement – Decision Making; and Leadership) as well as how to observe and rate observable behaviours in theatre. Web link to NOTSS
  - RACS is currently revising this course to be delivered as a one-day course which will be initially presented in association with the annual conference of the Provincial Surgeons of Australia (PSA) in July 2011.
  - It is intended that this one-day course will be made available as a professional development activity for Fellows. OHNS have indicated that they would like to run this course at their 2012 ASM.
- The General Surgery Australia (GAS) has developed a two-day course *Management of Surgical Emergencies* (MOSES) which is currently in the pilot phase. It is designed for Trainees in SET3-4, focusing mainly on the competence of Judgement- Clinical Decision Making.

- The Otolaryngology Head and Neck Surgery (OHNS) training board has a particular interest in indigenous health care and is working with the Indigenous Health Committee to develop an indigenous health strand for their curriculum.
- It is planned that the new College website incorporating the Knowledge Hub will be launched in the second half of this year (2011). The Knowledge Hub is designed to provide:
  - Seamless user experience so that Trainees and Fellows can move between the RACS website and other websites without addition sign-in requirements
  - Recognising that RACS is one of many sources of surgical expertise, the website will draw on other resources from around the world, for example, Colleges of Surgery in the UK.
- To improve accessibility and potentially to reduce the pressure on faculty resources, RACS is adapting existing courses, or components of courses to be provided on-line:
  - The SAT SET Course continues to be highly successful with over 2000 participants having completed the course, and a further nine courses being offered in 2011. Components of this course are being prepared to be offered on-line.
    - Research on the value and impact of SAT SET was carried out independently and published in the ANZ Journal of Surgery Weblink to Journal of Surgery research paper
  - *Selection Interviewer Training for SET* (SIT SET) course (see Section 7.1 part A)
  - See Section 4 parts A & C re development of courses for Trainees
  - KTOT (see above)
- RACS plans to provide on-line training to the Fellowship in relation to the content and implications for surgical practice of the revised Code of conduct. Weblink to Code of Conduct

- Besides the material developed under the two Australian Indigenous health projects, RACS will continue to identify resources for cultural competence on the website. For example:
  - Links to the Australian National Health and Research Council (NHRC) documents on Cultural Competence in Health
  - Links to the Medical Council of New Zealand Statements on "Cultural Competence" and "Best practice when providing care to Māori patients and their whānau"; and its resource booklets *Best health outcomes for Māori :Practice implications*, and *Best health outcomes for Pacific Peoples: Practice implications*.
  - Use case-studies and other information produced by indigenous groups as components for on-line assessment activities.
  - Up-date the on-line Health Advocacy module.
- Te Ohu Rata o Aotearoa (Te ORA): Māori Medical Practitioners Association of Aotearoa/New Zealand is invited to attend the College's Indigenous Health Committee.
- Representatives of RACS have met with the Te Ohu Rata o Aotearoa: Māori Medical Practitioners Association of Aotearoa / New Zealand (Te ORA) on several occasions to discuss RACS support for their initiatives and potential College initiatives that may encourage Maori doctors to consider a career in surgery. Funding for these would be sought from the Foundation for Surgery and potential initiatives could include:
  - Summer Scholarships for Māori medical students
  - RACS attendance at the Te ORA conference to promote a surgical career, and
  - A RACS award for a presentation at that conference.
- See Section 5.3 part C re Fellowship Examinations.

D. Factors that could impact on the achievement of goals and objectives over the next five years

- The availability of faculty and the cost of developing and maintaining good quality training resources is always a consideration. For this reason RACS will continue to seek to identify appropriate resources (face-to-face and on-line) produced by other medical education providers and, if needed develop relationships with those organisations.

E. How the College has responded to issues raised as a result of other national or state/ regional policy developments or national or state/ regional enquiries

- See Section 2.1 part E

STANDARD 3: CURRICULUM CONTENT

3.1 Curriculum Framework

3.1.1. For each of its education and training programs, the training organisation has a framework for the curriculum organised according to the overall graduate outcomes. The framework is publically available.

- Since its publication in 2003 the RACS statement of graduate outcomes, the *Definition of Surgical Competence* has become the curriculum framework all of the surgical specialties. It is available for public assess on the RACS website.
  - See Section 2.2 part A

3.2 Curriculum Structure, Composition and Duration

3.2.1. For each component or stage, the curriculum specifies the educational objectives and outcomes, details the nature and range of clinical experience required to meet these objectives, and outlines the syllabus of knowledge, skills and professional qualities to be acquired.

3.2.2. Successful completion of the training program must be certified by a diploma or other formal award

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

Recommendation 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.

Completed

A. Achievements

- As stated in the *Timetable for the planned move to competency-based training* provided to the AMC in 2007:-

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

- Through BSET, RACS, and specialty training boards, have together made substantial progress (see Appendix 6 for the up-dated timetable, plus information in the following sections of this report).
  - A significant achievement has been in the clearer identification of progression through the training program. SET is a single training program with no specified components or stages. However, at the two-day SET review workshop held in April 2010 (see 2010 Annual Report) it was agreed that as part of the move to CBT it was necessary to more clearly define the requirements for progression.
    - As outlined in 2.2 some of surgical specialties have already revised their training modules to reflect this progression (GS, OS, and PS) whilst all of the others are planning to do so (C, NS, OHNS, U, and VS) and Plastic and Reconstructive Surgery (P&RS)..
      Weblink to General Surgery modules (access to this weblink requires a password)
    - As outlined in Section 2.2 the development of standards of competence to reflect progression is expected to be completed this year (2011).
  - All of the specialty training boards have introduced work-place-based (WPB) assessment to assess Trainees on a range of competencies (see Section 5.1 part A).
- There have been changes to some of the specialty training programs – in each case these changes have more clearly defined the training pathway for Trainees and, at the same time,

made it possible for the relevant specialty training board to apply more stringent governance of all aspects of training.

  - As reported in the RACS 2010 Annual Report (Table 2, page 4) U and PS are now the only specialties that require their Trainees to commence training in General Surgery training posts.

- College educational staff were involved in the workshop of the Network of Medical College Educators on *Work-Place-Based Assessment* in November, 2010.
- Fellows and senior staff from RACS were involved in the CPMC Intercollege workshop on Supervision in April, 2010.
- In March 2011 Senior Fellows and College staff participated in a three day seminar on Medical Education with the Royal Australasian College of Physicians (RACP) and the Royal College of Physicians and Surgeons of Canada (RCPSC). This relationship is planned to continue for future collaborative development (see below).
- Each year in October, RACS holds a meeting attended by the educational officers from each of the surgical specialties and RACS education staff.

B. Challenges

Competency based training relies on early and frequent WPB assessment. To ensure that supervisors understand this process RACS has developed and delivered training programs for supervisors and trainers (see the following section and also Section 8).

- The challenge is to both ensure that the supervisors and trainers have sufficient time to observe the Trainees and provide feedback on their performance, and that Trainees are assessed frequently enough to ensure validity and reliability of the assessments.
  - Currently there is little agreement in the findings of WPB assessment research regarding the number of rating opportunities and/or raters required to achieve a valid and reliable assessment.
    - There is however some agreement that increasing the number of rating opportunities, as well as the number of raters, is likely to improve reliability.
  - There is also debate about the extent to which there is any direct correlation between the use of the tools and improved performance. There is however some agreement that:
    - using a structured WPB assessment tool can facilitate better feedback to Trainees, which in turn can improve performance, and that
    - supervisors / trainers need training in the use of WPB assessment tools
  - There is some indication in the literature that assessing Trainees on a range of different WPB assessment tools (Direct Observation of Procedural Skills (DOPS); mini-Clinical Examinations (mini-CEX), Case-based Discussion (CBD), and Procedure Based Assessment (PBA) is likely to be more reliable than assessment on any single tool.
  - Although the need for recognition of the importance of the teaching role and of allocated time for consultants to effectively carry out that role is written in RACS accreditation documents as a requirement for the accreditation of training posts, only a small number of jurisdictions fulfil that requirement, the majority do not.
  - Until the jurisdictions recognise and make provision for appropriate teaching and assessment time it will be difficult for the training boards to increase their WPB assessment requirements to an appropriate level.

C. Development plans over the next five years

- RACS will continue to provide training for supervisors and trainers with courses (SAT SET and KTOT) and review whether there is a need for additional courses (e.g. NOTSS).
- RACS will continue to monitor the research on WPB assessment tools and to inform the specialty training boards of findings. If future research provides a consensus on the any of the tools then the current processes will be reconsidered.

- The tri-partite collaboration between RACS, RCPSC and the RACP on Medical Education is planned to continue with discussions at the RCPSC annual conference in September 2011 and a meeting at RACS early next year (2012).

D. Factors that could impact on the achievement of goals and objectives over the next five years

- The pressure on time for supervisors to effectively do WPB means that RACS will not push for higher numbers of WPB assessments to be carried out. It will also continue to advocate the use of WPB assessment as formative (rather than summative) assessment tools and the need for multiple raters.
- Any change to the availability of supervisors and trainers to support the training program could have a substantial impact on RACS plan to enhance training through WPB assessment.

E. How the College has responded to issues raised as a result of other national or state/ regional policy developments or national or state/ regional enquiries

- RACS supports the proposals put forward at the CPMC Intercollege workshop on Supervision in April, 2010 that there be:
  - a united approach to supervision across all of the colleges
  - protected time for education / training.

3.3 Research in the Training Program

3.3.1. The training program includes formal learning about research methodology, critical appraisal of literature, scientific data and evidence-based practice, and encourages the trainee to participate in research.

3.3.2. The training program allows appropriate candidates to enter research training during specialist education and to receive appropriate credit towards completion of specialist training.

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

A. Achievements

- Participation in research is a mandatory requirement in SET training for all surgical specialties. It is included because it is seen as assisting Trainees to develop the necessary experiences and skills to be able to critically appraise new trends in surgery and contribute to the development, dissemination, application and translation of new medical knowledge and practices.
- Participation in research has also been identified as having the potential to contribute to Trainee's development across a range of competencies including:- scholar and teacher, medical expertise, communication, and professionalism.
- As part of the SET Program the current research requirement is the completion of an investigative project prior to sitting the Fellowship Examination. This has not changed.
  Weblink to the Research during Surgical Education and Training policy
- Whilst all of the training boards require their Trainees to meet at least the minimum research requirements as defined in the policy some of the training boards have additional requirements:
  - CS; GS; OHNS; and OS encourage Trainees to undertake a period of full-time supervised surgical research sometime during their training.
  - CS Trainees are required to complete a publishable standard original thesis of 10,000 words by the end of SET 4
    - This research requirement was introduced for Trainees selected onto cardiothoracic surgery training in 2008 (commencing SET 1 or SET 2 in 2009)
    - Trainees must author two journal articles for publication

- OS; P&RS and VS have used section 3.1.2 of the RACS policy on research to rate different forms of publication on a scale of 1-3 points, requiring Trainees to complete at least five (5) points prior to presentation for the FEX.
  Weblink to Vascular Surgery Training Regulations (refer to Section 5)
- NS continue to require all of their Trainees to take a one year (SET4) full-time research post.
- GS have changed their Recognition of Prior Learning (RPL) requirements for the research component and the way in which Trainees can meet the research requirements.
  Weblink to General Surgery Training regulations (see section 4.5 and Appendix 3)
- OHNS provide some of their Trainees with additional support to undertake full-time research through the provision of scholarships offered by the Garnett Passe and Rodney Williams Foundation. These research scholarships are administered and directed by the Regional Training Subcommittee Chairs of OHNS in each mainland capital city within Australia.

B. Challenges

- In the past specialty training boards have strongly encourage research amongst Trainees, both in clinical posts and in full-time research posts. However the introduction of SET is seen by the Urology training board as reducing training time for core clinical training and have decided that they will longer allow full-time research as part of the training program.

C. Development plans over the next five years

- At the Section of Academic Surgery (SAS) Committee meeting held in May 2011, it was agreed that a working group would be formed, comprising Professor John Windsor (SAS Chair), Richard Hanney and a representative from RACSTA, to work on more clearly defining the educational objectives and research requirements during training. The working group will report back to the Section on this task.
  - The Committee has reviewed a discussion paper from Bruce Waxman entitled *Educational Objectives – Research* and an earlier paper by Adrian Anthony (Feb 2010) on the requirements of research in SET (pertaining to General Surgery) has also been considered.
  - John Windsor spoke to the June BSET meeting and received support for the proposed working group.

- In addition, Prof Windsor has been invited to attend the 10 June meeting of BSET, which will facilitate a further discussion on the importance of research during training with the Chairs of the specialty boards. Ahead of this meeting, some work will be done to investigate research requirements in other overseas Colleges, which may also inform this discussion.
  Weblink to the Section of Academic Surgery

D. Factors that could impact on the achievement of goals and objectives over the next five years

None identified

E. How the College has responded to issues raised as a result of other national or state/ regional policy developments or national or state/ regional enquiries

None identified

3.4 Flexible Training

3.4.1. The program structure and training requirements recognise part-time, interrupted and other flexible forms of training.

3.4.2. There are opportunities for trainees to pursue studies of choice, consistent with training program outcomes, which are underpinned by policies on the recognition of prior learning. These policies recognise demonstrated competencies achieved in other relevant training programs both here and overseas, and give trainees appropriate credit towards the requirements of the training program.

Recommendation 14: Report to the AMC on the impact of SET on the availability of flexible training opportunities

The introduction of SET has had no impact on the availability of flexible training opportunities.

- There are limited opportunities for part-time training due to the nature of the employment contracts offered by the hospitals.
- The process for applying to the training boards for deferring the commencement of training, or interrupting training has not changed.
    - Each year some selected Trainees apply for and are given recognition of prior experience. This depends on their level of clinical experience, the courses they have done, and/or whether they have passed the generic early examinations (or their equivalents).

A. Achievements

- RACS has a policy which enables Trainees to apply to vary their training by deferring the commencement of their training; interrupting their training; or to undertake part-time training. Weblink to Trainee Registration and Variation Policy
    - There have been a small number of successful examples of flexible training in each rotation.
    - As can be seen from the Table *Total SET Trainees by Specialty and Status in 2010*, on page 31 of the 2010 College *Activities Report*, there is a small proportion of Trainees who vary their training each year, and that this proportion changes from year to year. Weblink to Activities Reports
- In 2010 the Royal Australasian College of Surgeons Trainees' Association (RACSTA) conducted an extensive survey regarding flexible training opportunities and followed that up with a working party review of the challenges and barriers which exist, and to identify opportunities for improvement.
- RACS has a policy which enables Trainees to apply for Recognition of Prior Learning or Credit Transfer. Weblink to Recognition of Prior Learning Policy
- P&RS and VS have previously offered opportunities for Trainees to take some of their training in overseas posts. For a range of reasons (accreditation of posts; practicality of organising the placement) this is becoming more difficult to maintain.

B. Challenges

- RACSTA extensively surveyed their members and found a significant gap between the demand for and supply of flexible training opportunities.
- One conclusion from the RACSTA survey is that the problem lies not with RACS policy, which is robust and readily allows for flexible training without issue. The greatest barrier is the practical opportunities to actually work part-time in the jurisdictions, where jobs are usually organized on a full-time basis. Some success has been made with offering 'packaged solutions' to the jurisdictions, i.e. getting two Trainees who want to job share to apply for a single job. In our experience this approach is looked on favourably by the training boards and can be effective; however, in smaller specialties it is difficult to find someone to job share with in the same city. To have children, most Trainees currently take full time leave then return to full time work, or possibly do a period of research.
- RACSTA has lobbied the specialty boards to identify specific training positions that might be suitable for flexible training, with some progress, most recently in Urology. This strategy should help facilitate and enable Trainees to work flexibly by offering precedents and routine pathways.
- Some of the specialty training boards have expressed concern that Trainees taking interruption to training can leave training posts vacant. Given the pressure on using every available training post this is seen as waste of scarce resources.
- There is some concern about the unintended consequences for Trainees who take flexible training or some kind of interruption to their training.

C. Development plans over the next five years

- RACS, through the specialty training boards and regional offices, will continue to request that the jurisdictions identify opportunities for flexible training.
- In future, private training rotations may offer new opportunities for part-time positions.

D. Factors that could impact on the achievement of goals and objectives over the next five years

- Barriers still exist regarding trainer and supervisor / surgeon attitudes, e.g. that continuity of care is compromised (this is potentially true and there is therefore a need to improve handover practices), or that training quality suffers when the intensity drops and is spread out over more time (this might need to be reviewed).
- Trainees themselves may feel fear that their training will regress if they do not work full time. Improving awareness and empowering Trainees to consider and apply for flexible training is the most critical aspect to progress. Change will not happen until Trainees start applying and pushing the system to change.

E. How the College has responded to issues raised as a result of other national or state/ regional policy developments or national or state/ regional enquiries

- See Section 2.1 part C re access to appropriate training positions, and part C re safe hours

3.5 The Continuum of Learning

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

A. Achievements

- Over recent years RACS has had a designated area of the website with information for potential applicants. This site which is available from the homepage, provides information on:
  - The pathway from medical school through selection and surgical training
  - Videos of senior surgeons providing advice about training and the profession of surgery
  - An e-mail address for personal enquiries Weblink to Becoming a Surgeon
- Medical graduates can register their interest in participating in each of the RACS courses [*Australian and New Zealand Surgical Skills Education and Training* (ASSET); *Care of the Critically Ill Surgical Patient* (CCrISP); *Early Management of Severe Trauma* (EMST); and *Critical Literature Evaluation and Research* (CLEAR)] as soon as they graduate for university.
- Under the leadership of the Skills Education Committee (SEC), RACS has recently completed a draft document defining the generic 'elementary skills' which medical students and junior medical doctors need to develop prior to beginning training in surgery.
  - Currently the document is being considered by the specialty training boards. They have the opportunity to add specialty specific skills prior to its publication later in 2011.
- The lowest level of progression in the standards of competence document (see Section 2.2 part C) describes characteristic behaviours at the pre-vocational level.
- RACS has established communication links with medical schools and pre-vocational training providers. For example:
  - Since its inception in October 2010, Prof Bruce Barraclough has had meetings with the Chief Executive of the NSW Clinical Education and Training Institute (CETI) (formerly IMET).
  - RACS Fellows – in their role as academic surgeons in medical schools – have supported the establishment of surgery clubs for medical students.

- In 2010 RACS contributed to the consultation process of the *Learning and Teaching Academic Standards* (LTAS) project, administered through the Australian Learning and Teaching Council (ALTC) which is revising the 'threshold learning outcomes' for Health, Medicine and Veterinary Science university degrees for all Australian universities.

B. Challenges

- The introduction of SET has enabled junior medical doctors to apply for selection from PGY2 (and beyond). This had led to concerns that some of the selected Trainees have not developed sufficient elementary skills to make the best use of their early training rotations.
- The increasing number of university medical graduates is expected to have a negative impact on the depth of clinical experience which junior doctors will have and the impact which this may have on their preparation for surgical training.

C. Development plans over the next five years

- It is planned that the 'elementary skills' document will be published on the RACS website as well as being more broadly publicised through Surgical News and other publications.
- RACS has developed a promotion display to provide information at specialty Annual Scientific Meetings (ASMs) and for medical students seeking information on a surgical career. It is intended that this display will be presented by senior RACS Fellows and staff.

D. Factors that could impact on the achievement of goals and objectives over the next five years

None identified

E. How the College has responded to issues raised as a result of other national or state/ regional policy developments or national or state/ regional enquiries

- The development of the 'elementary skills' document is a response to both the early selection of Trainees into specialty surgical training and the Australian Government policy of increasing the number of places in medical degree courses. This anticipated rapid increase in medical graduates is expected to place enormous pressure on both the number of intern training positions, and the quality / depth of those training experiences.
  - It is hoped that when the document is published, universities and skills training centres will see the opportunity of providing targeted training for people who intend to apply for surgical training.

STANDARD 4: TEACHING AND LEARNING METHODS

4.1.1. The training is practice-based involving the trainees' personal participation in relevant aspects of the health services and, for clinical specialties, direct patient care.
4.1.2. The training program includes appropriately integrated practical and theoretical instruction.
4.1.3. The training process ensures an increasing degree of independent responsibility as skills, knowledge and experience grow.

The training programs, in each surgical specialty, are comprised of a combination of many elements.

- The core to each program is clinical experience.
  - During the five or six years of the training program (depending on the specialty) Trainees are allocated by the relevant specialty training board to training rotations in surgical units which are accredited as training posts (see Section 8.2). Training rotations are almost always six months in duration (except in SET1 when they may be 3 months). In each rotation clinical experiences include:
    - ward rounds, handovers, multidisciplinary team meetings and, where possible, outpatient clinics
    - attendance at operating sessions where the Trainee is taught the relevant competencies
    - on-call duties to assess and manage acute surgical pathologies
    - participation in a clinical audit processes
  - Each specialty training board carefully monitors each Trainee's logbook to ensure that they are gaining sufficient case-load experience, and that their skills and knowledge are improving so that they are gradually increasing the proportion of procedures that they are able to perform without direct supervision.
  - The training boards also carefully monitor the training experiences of each Trainee across each year of training, and each training post, to ensure that they receive the widest possible experience across the breadth as well as the depth of the surgical specialty.
    - Each year the training boards allocate Trainees to training posts based on their prior training experiences and Trainee's preferences
    - GS has developed a formula to identify the composition of clinical experiences which predominate in each training post. This enables GS to allocate Trainees to posts to ensure they receive experience in the breadth of GS training
    - U has developed guidelines for training positions in the private sector which include the need for full disclosure to the patient and an approval template for operative consent.
  - Whilst in training posts, Trainees are employed by the hospitals.
- Supervisors and trainers are responsible to ensure that each Trainee receives individual training as well as the kinds of clinical experiences which will enable them to develop the necessary skills and knowledge to increase their level of independent responsibility and fulfil the requirements of training.
  - Trainees record their clinical experiences in their logbooks. The logbooks are monitored by the training boards to gauge the number of procedures that each Trainee has recorded.
- All Trainees are provided with practical and theoretical instruction in a range of courses.
  - All specialties require their Trainees to have completed three of the RACS courses:- ASSET; CCrISP; and EMST. GS, U, and OS (NZ) also require their Trainees to complete CLEAR.
    Weblink to Skills Training
  - The two largest specialties (GS and OS) provide weekly tutorials for their Trainees in each region; these specialties also provide courses on their 'Trainee Day(s)' associated with their Annual Scientific Meeting (ASM).
  - P&RS has introduced a number of new training courses / workshops in each regional area in topics such as anatomy.
  - All specialties provide courses on their 'Trainee Day(s)' associated with their ASMs.
    - Courses address a range of competencies

        - In response to feedback from Trainees and to reduce the stress on Trainees, NS have reduced the number of seminars which Trainees are required to attend, and moved some of the RACS courses later into the program.
    - PS require their Trainees in mid – late SET to complete four on-line assessments per year.
    - PS have mandated that all of their Trainees must attend the SAT SET course or a modified 'Trainee' version of this course.
- VS have an exchange program with posts in the UK – Trainees are encouraged to take up an overseas post to experience different health care systems.
- Trainees knowledge and skills are progressively assessed in a number of ways:
    - During each rotation each Trainee is assessed across the nine RACS competencies in the mid-term and end-of-term assessments.
    - They are assessed with one or more work- based assessment tools (see Sections 3.2 parts A & C and 5.1 part A).
    - There are formal examinations at various stages of training (see Section 5.1 part A).
    - Trainees in some of the specialties (OS; PS; & VS) are also assessed on-line (see Section 5.1 part A).

A. Achievements

- WPB Assessment (see Section 3.2 parts A & C).
- Revised modules (see Section 3.2 part A – curriculum structure).
- Additional courses addressing the non-technical competencies (see Section 2.2 parts A & C).
- Provision of an interactive on-line learning resource to enhance Trainees three dimensional knowledge of anatomy Weblink to anat@media (access to this resource requires a password)
- Most surgical specialties provide their Trainees with examination preparation courses prior to them sitting the Fellowship Examinations. These courses are also available for IMGs who are required to successfully complete that examination as part of their assessment.
- RACS and some of the specialty training boards (OS; P&RS; & U) provide Trainee orientation programs.
    - The two day College induction program was developed in collaboration with RACSTA
    - P&RS introduced a specific SET1 course for the first year entrants to Plastic Surgery training. The course concentrates on the more basic skills and knowledge required to start training in P&RS
    - The Urology Trainee Week is an intensive one week program comprising practice exams and vivas, together with an interactive program comprising clinical and non-clinical sessions.
    - Urology requires their SET2 Trainees to attend the *Introductory Skills Workshop* when they are about to enter their first year of clinical Urology training (usually SET 3).

B. Challenges

- The number of RACS courses offered per year, and the number of people on the waiting lists for these courses continue to grow. This increasing demand is placing a great deal of pressure on availability of faculty to run the courses. For example:
    - In 2010 the RACS provided 17 ASSET courses with 317 participants and 340 faculty (in 2009 there were 14 courses; 260 participants and 309 faculty) yet the waiting list continues to exceed 2,000 (see page 12). Weblink to Activities Reports
- The pressure on faculty is exacerbated by the increase in the number of courses being offered – for Trainees and for Fellows
- The pro-bono model on which education and training is currently based is potentially a limiting factor on the amount of time that supervisors and faculty are able to provide.

- Time and leave requirements can limit the number of courses that Trainees can attend.
- The VS exchange posts may be withdrawn from the program due to the increasing complexity of the process

C. Development plans over the next five years

- As part of its planned revision of the ASSET course the ASSET committee has planned to develop a 'blended learning' approach to provide some components of the program on-line (pre-course and post-course) whilst retaining the intensively interactive skills training as a face-to-face workshop.
  - The course is being re-designed in 2011; the new course is planned to be rolled-out in 2012
  - It is anticipated that the on-line components will reduce the duration of the face-to-face component and reduce the load on faculty, making it possible to increase the number of courses offered.
- The EMST Committee has a five year plan to refine their course and reduce the time of applicants on the waitlist. They also plan to:
  - revise the *Instructor Course* selection process to facilitate more surgical representation and decrease obstacles to becoming an instructor
  - extend their active engagement with Advanced Trauma Life Support (ATLS) International and the American College of Surgeons (ACS).
- The CCrISP Committee has a five year plan to increase faculty from 176 in 2011 to 300 by 2016. The Committee also intends to:
  - Reduce the time that applicants are on the waiting list
  - Improve course delivery by establishing on-line pre-course learning
  - Establish and maintain a strong relationship with CCrISP, RCS England
  - Support multidisciplinary interaction between RACS and other specialty colleges
- The surgical specialty training boards are planning to enhance the learning resources available for their Trainees. For example:
  - Urology plans to:
    - Replace a compulsory anatomy course for SET5 Trainees with a range of local section / regional based skills workshops addressing medical and technical expertise and non-technical competencies.
    - Develop an internet-based case discussion forum to incorporate short topic discussions and written questions as part of the Trainee learning and assessment program.
    - Establish a web-based repository into which Trainees, trainers and supervisors can upload interesting case information for discussion and for future educational exercises with particular interest in storage of imaging studies.
    - Review the general surgical skills needed to progress through Urology SET and to consider whether these skills could be attained in one year in high volume uro-oncology units, potentially reducing Urology's reliance on GS posts and/or reducing the duration of training.
  - Vascular Surgery plans to:
    - Monitor the ultrasound training and requirements which are currently mandated in the Vascular Surgery program
    - Encourage Trainees to attend more College meetings and workshops
    - Incorporate College workshops into the ASMs

D. Factors that could impact on the achievement of goals and objectives over the next five years

- The costs associated with developing and maintaining on-line learning resources (software and hardware)
- The potential reduction of sponsorship funding to support the running of courses (both essential resources and cost for faculty and participants).
- The pro-bono model potentially limits the input of Fellows to meet the increasing demands of supervision, assessment, and courses as well as involvement in training boards.

- In some regions the number of face-to-face courses which Trainees can participate in is limited by the amount of leave they can take from their employment.

E. How the College has responded to issues raised as a result of other national or state/ regional policy developments or national or state/ regional enquiries

- See Section 2.2 parts A & C re competencies (including cultural competence); indigenous health; planned development of resources for non-technical competences; and supervisor training.

STANDARD 5: ASSESSMENT

5.1 Assessment Approach

5.1.1. The assessment program, which includes both summative and formative assessments, reflects comprehensively the educational objectives of the training program.
5.1.2. The training organisation uses a range of assessment formats that are appropriately aligned to the components of the training program.
5.1.3. The training organisation has policies relating to disadvantage and special consideration in assessment, including making reasonable adjustments for trainees with a disability

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

Recommendation 16: ~~Research thoroughly the strengths, weaknesses, practicalities and generalizability 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.~~ The AMC notes that since the 2007 assessment, considerable literature has been written on these tools. The AMC considers that this recommendation is no longer appropriate. It asks that in future reports the College advise the AMC on it is using the available research findings in making decisions about the assessment tools it employs.

A. Achievements

- RACS has a policy defining the processes for the assessment of clinical training.
  Weblink to Assessment of Clinical Training policy
- RACS has policies defining the conduct of each of the examinations.
  Weblink to Examination and Assessment policies
- RACS has a policy addressing the issue of Trainees who are ill, injured or impaired during training. Weblink to Ill, Injured and Impaired Trainees policy
- RACS has a policy outlining the process for Trainees to notify about, and apply for consideration for, special circumstances and disability.
  Weblink to SET Notification of special circumstances and disability policy
- RACS has a policy outlining the process for Trainees to apply for consideration of religious beliefs. Weblink to Religious Observance policy
- All of the surgical specialties have blueprinted their formative and summative assessment processes across their learning modules and the nine RACS competencies. In this way they have a clear picture of when, and in what way, each of the key learning requirements are most appropriately assessed. For example see:- Weblink to Paediatric Surgery Assessment Plan
- The use of WPB assessment has been implemented by all specialty training boards except for CS (they plan to introduce DOPS as part of the change in their program (2011 is the first year that CS have taken Trainees directly into their specialty, in previous years CS Trainees have spent their first year of training in GS posts).
  - The commencement of SET coincided with the introduction of DOPS and Mini-CEX to assess Trainees early in SET, mostly SET1. Since then, specialties have continued to use these processes in SET 1 and 2.
  - NS does not use DOPS or Mini-CEX. They require all Trainees to be assessed on a total of 'core workplace competencies' in the five years of clinical training.
  - PS has introduced assessment of specific key procedures - 4 times per year in SET1 and 2, and 12 times per year in SET3-6.
- Urology has revised their in-training-assessment form into two – one for SET1 and 2, and another for SET3-6.
- The anatomy component of the generic Surgical Sciences Examination (SSE) has been extensively reviewed; the new content and format will be introduced in 2012. The curriculum will now be more appropriate and better aligned with each specialty's specialty specific curricula.

- Three specialties have mandatory on-line formative assessments for components of their training program.
  - OS has integrated learning opportunities including focused journal articles, defined operative lists (linked to elog) practice case studies / MCQ & exams linked to individual modules.
  - PS require their trainees to complete eight Directed On-line Group Studies (DOGS) during their mid to late SET training.
  - VS have MCQs at the end of each of their training modules. Trainees are required to successfully complete all of these before applying for FEX.
- In 2010 all the surgical specialties were asked to review the content and the timing of their specialty specific SSE, in the light of proposed changes to the Fellowship Examination (FEX)
  - Several of the specialties (NS; OHNS; OS; P&RS; PS; and VS) have elected not to change their specialty specific examination. CS; GS; and U plan to move the examination to occur later in the program.
    - Urology plans to move the specialty specific surgical science examination to SET 3-4. This change will apply to Trainees who are appointed to commence training in 2012. The first examination will be conducted in 2015.
- Additional resources have been provided to improve the consistency and validity of FEX:
  - An Examiner Manual has been developed to provide guidance to each of the specialty courts on the preparation and conduct of the exam
  - A one-day Examiner Training program has been developed and trialled with senior examiners from each of the nine surgical specialties, and will be open to all new examiners in the second half of 2011.
  - A trial of an expanded close marking system is being used at the FEX in May 2011; if a success this system will be implemented by all specialties. This should further improve both the validity and reliability of the examination, and allow feedback on performance to all examiners.
  - The Chair of the Court or one of the Deputy Chairs attended each specialty court meeting in February / March 2011 to answer questions and provide guidance on:
    - improving alignment between the curriculum and the examination
    - improving the level of examination questions (against Bloom's taxonomy)
    - discussing proposed modification to the close marking system

B. Challenges

- The different rate of up-take of WPB assessment processes between the surgical specialties is dependent on a number of factors including the size of the specialty; their educational resources; and their training priorities.
- The greatest challenge to the successful and effective introduction of WPB assessment across all of the surgical specialties is lack of support for, and recognition of, the supervision / training role in the hospitals (see Section 3.2 part B).

C. Development plans over the next five years

- As a result of a review of the content of both the early generic SSE and the FEX in 2010-11 substantial changes are planned. These changes have been identified as necessary because the examinations need to reflect the compression of the training program in SET, and the closer alignment of the training programs to the competencies.
  - From 2012 the new generic SSE will have both a revised curriculum and a different format
    - Information about this examination will be published on the RACS website following approval by BSET and EB in June 2011. This is prior to the selection of Trainees who will commence in SET in 2012.
- The FEX Court is trialling a modified marking system (alongside its current system) in 2011. This system, adapted from that used by the UK Intercollegiate Court, provides for increased marking opportunities, related to specific competencies, within each exam component.

- Other planned changes to improve the transparency and consistency of the FEX are:
  - Introduction of clear descriptors defining the meaning of each level of the close marking system are being introduced in 2011.
  - A structured blueprinting process to map every examination question against specialty content X competency X exam component X level of cognitive difficulty (using Bloom's taxonomy). This process will also ensure that the specialty syllabus is covered appropriately and will improve the reliability of the exam. It will also ensure improved alignment with the other assessment processes of SET.
  - Redefining the FEX to focus specifically on the competencies of Medical Expertise; Clinical Decision Making and Professional Judgement.
    - Development of standardised marking descriptors for each of the competencies
  - Development of a process for the assessment of examiner performance and feedback
  - Better measurement of content validity, and inter- and intra-examiner bias, and improvements to reliability of FEX
  - Developing clearer guidelines around eligibility to sit the FEX.
  - Review of criteria and process for selection of examiners.
- It is anticipated that by 2013 all member of the FEX Court will have participated in the Examiner Training program.
- The Clinical Examination Committee, which has the responsibility for developing the generic Clinical Examination (CE) are currently trialling an alternative standard setting process – the Borderline Regression Method – and are planning to introduce this method from January 2012.

NOTE: the introduction of these changes to the marking system for the FEX and the standard setting for the CE will not be made until they have been carefully trialled and compared with the current processes.

- The NS training board are discussing the possibility of developing a competence assessment report for each of their proposed four SET levels (three plus research) which concentrate specifically on areas such as technical, medical, judgement, management/leadership, scholar/teacher and health advocacy, plus a professional performance assessment focusing on areas such as professionalism, communication and collaboration which would define the minimum standards for all SET levels.

D. Factors that could impact on the achievement of goals and objectives over the next five years

None identified

E. How the College has responded to issues raised as a result of other national or state/ regional policy developments or national or state/ regional enquiries

- In November, 2010 the Chair of the FEX Court, the two Deputy Chairs and the Manager of RACS Examinations Department, attended the Joint Committee of Intercollegiate Examinations (JCIE) examiner training to observe and review their training course and the way they carry out examiner performance evaluation, as well as other aspects of their examination processes.
  - The developments and planned changes outlined above reflect the findings from that visit.

5.2 Feedback and Performance

5.2.1. The training organisation has processes for early identification of trainees who are under performing and for determining programs of remedial work for them.

5.2.2. The training organisation facilitates regular feedback to trainees on performance to guide learning.

5.2.3. The training organisation provides feedback to supervisors of training on trainee performance, where appropriate

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

A. Achievements

- Since the inception of SET, RACS has had a policy on dismissal from surgical training which addresses the identification and management of underperforming Trainees
  Weblink to Dismissal from Surgical Training policy
- The SAT SET course was designed to train supervisors and trainers on the identification and management of underperforming Trainees (see Section 2.2 part C)
- The 2011 course KTOT has been designed to continue that training (see Section 2.2 part C)
- Some of the specialty training boards have developed additional resources for their supervisors
  - In 2010 GS 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.
  - GS have introduced Mini CEX, DOPS and 360^0 assessment throughout training for Trainees who are identified by their supervisors as 'borderline' or underperforming.
  - OS have introduced Mini CEX, CBD and 360^0 assessment for Trainees who are on a remedial plan.
  - VS have introduced 360^0 assessment for Trainees who are identified by their supervisors as 'borderline' and for Trainees who their supervisors believe will benefit from additional feedback on their performance on the spectrum of competencies.
  - OS and U have published additional guidelines and standardised documentation to assist their supervisors with identifying and managing underperforming Trainees
- The RACS policy defines the processes for the assessment of clinical training specifies processes through which Trainees receive regular feedback and the minimum frequency for those processes. Weblink to Assessment of Clinical Training policy
- RACS policies define the conduct of each of the examinations specify the way in which candidates will receive feedback on their examination performance.
  Weblink to Examination and Assessment policies
- The RACS policy on Fellowship Examination eligibility, review and feedback defines the circumstances under which supervisors and/or employers and/or medical registration authorities are advised of the poor performance of a Trainee or IMG in the Fellowship Examination.
  Weblink to the Fellowship Examination Eligibility, Review and Feedback policy

B. Challenges

- Supervisors have been reluctant to formally identify Trainees who are underperforming because:
  - They are aware of the extra burden of work which is required to oversee and manage an underperforming Trainee, and/or
  - They are unsure whether their expectations of Trainees at particular levels of training are the same as other supervisors' expectations, and/or
  - They think that, although the Trainee may not be progressing as expected, putting them on probation would not be appropriate, and/or
  - They avoid the uncomfortable situation of having to provide direct feedback of poor performance or difficulties with skill acquisition, and/or
  - They have a perception of medico-legal vulnerability.

C. Development plans over the next five years

- It is hoped that the identification of 'normal progress' through the training program by the definition of progressive standards for each of the RACS competencies (see Section 2.2) will lead to revision of in-training assessment processes so that it will be easier to identify the incompetent; the slow but satisfactory learner; the "normal" satisfactory learner; and the more advanced Trainee (as outlined in the RACS 2010 Annual Report).
  - It is intended that this development will address two of the three challenges identified above.
- OHNS plans to develop processes so that increased counselling is provided for underperforming Trainees and Trainees who fail the examinations.
- VS plans to improve the knowledge of their supervisors in this area by:
  - Requiring all their supervisors to attend a meeting with the training board annually, and
  - Requiring all their supervisors to attend a SAT SET Course

D. Factors that could impact on the achievement of goals and objectives over the next five years

- The proposed plan to identify the 'slow but satisfactory learner' and the 'more advanced learner' is expected to influence the duration of training. Particularly in the case of the 'slow learner' RACS will need to consider carefully the effect that this would have on the availability of training posts and the expectations of employers and medical workforce planners.
  - How long it will take RACS to develop reliable ways of distinguishing at an early stage of training the "slow learner" from the Trainee who will eventually not succeed.
  - RACS does not employ the Trainees and will continue to negotiate with the jurisdictions and other representatives of the health sector about the plans to more accurately identify Trainees' progress and, where necessary, either extend or reduce the duration of their training.
  - There is an assumption in the Australian 'National Health Workforce Innovation and Reform Strategic Framework for Action' consultancy documents that competency based training will inevitably lead to' increased training efficiency' i.e. that it will reduce the time that it takes to complete training.

E. How the College has responded to issues raised as a result of other national or state/ regional policy developments or national or state/ regional enquiries

- RACS supports the proposals put forward at the CPMC Intercollege workshop on Supervision in April, 2010 which acknowledged the need for a united approach to supervision across all of the colleges including specific training on dealing with underperforming Trainees
- RACS has concerns about the assumptions of 'increased training efficiency' underpinning the 'National Health Workforce Innovation and Reform Strategic Framework for Action' consultancy documents.

5.3 Assessment Quality

5.3.1. The training provider considers the reliability and validity of assessment methods, the educational impact of the assessment on trainee learning, and the feasibility of the assessment items. It introduces new assessment methods where required.

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

Completed

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

Completed

A. Achievements

- RACS applies a range of well researched standard setting approaches to ensure that examinations are valid and reliable.
  - Rasch scaling was introduced in 2005 for the Basic Sciences Examination (as reported in the 2007 AMC accreditation report). RACS continues to use this approach to analyse the results of the generic SSE to maintain the consistency of the pass standard over time.
    - The model used to define the pass standard is a modified version of the *Angoff Method*
  - The Borderline Group Method has been used for standard setting for the generic Clinical Examination since the inception of SET. However, with smaller numbers of candidates taking some of the examinations (i.e. less than 100) the Clinical Committee decided to trial the Borderline Regression Method in 2011 (in parallel with the current process).
  - Each of the specialty specific SSE which are run in parallel with the generic SSE (CS; GS; NS; OHNS; U and VS) also apply rigorous standard setting processes to maintain consistency, validity and reliability.
    - NS apply a modified Angoff method, prior to the exam, to judge the expected performance of a 'borderline candidate' for each question and pre-set the pass-mark.
    - The other five specialties use a Bookmark method after the exam, to identify the typical performance of the 'borderline candidate'.

B. Challenges

- Because of the diverse range of assessment approaches used in the FEX (seven separate segments comprising: writtens; clinical examinations and vivas), standard setting has been a challenge. See plans below for how this is being addressed.

C. Development plans over the next five years

- See Section 5.1 part C

D. Factors that could impact on the achievement of goals and objectives over the next five years

None identified

E. How the College has responded to issues raised as a result of other national or state/ regional policy developments or national or state/ regional enquiries

- See Section 5.1 part E

5.4 Assessment of Specialist Trained Overseas

5.4.1. The processes for assessing of specialists trained overseas are in accordance with the principles outlined by the AMC and the Committee of Presidents of Medical Colleges Joint Standing Committee on Overseas Trained Specialists (for Australia) or by the Medical Council of New Zealand (for New Zealand).

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

Completed

A. Achievements

- RACS has developed consistent policies and procedures for the assessment of International Medical Graduates (IMGs) in both Australia and New Zealand. These policies are published on the public section of the RACS website. Weblink to the International Medical Graduate policies
- RACS provides guidelines for IMG applicants, information about the specialist assessment processes and clinical assessment processes, as well as links to the AMC and MCNZ websites.

Weblink to Information for IMGs

- The Clinical Assessment of IMGs in **Australia** policy details the process for managing unsatisfactory performance by an IMG. It also identifies the process available for an IMG on a pathway to Fellowship by examination to apply for recognition of exceptional performance during clinical assessment. Recognition of such performance can result in an IMG being exempted from sitting the Fellowship Examination.
- The Australian IMG Assessment policies have been changed to require IMGs to accept or reject the recommended pathway to Fellowship. This was to alleviate misunderstandings regarding the status of an assessment. The change means that all parties are clear on the activities that need to be completed to achieve Fellowship of the College.
- In Australia, IMGs unhappy with the recommended pathway to Fellowship can request reconsideration of any RACS decision. A formal Appeals process, common to the training program, enables IMGs to challenge decisions. Weblink to Appeals Mechanism Policy
- The Clinical Assessment of IMGs in **New Zealand** policy defines the process for assessing IMGs who wish to obtain vocational scope registration in one of the nine surgical specialties. Weblink to the Vocational Assessment of International Medical Graduates in New Zealand policy
- The IMG assessment process in New Zealand conforms precisely with that defined by Medical Council of New Zealand (MCNZ). The RACS New Zealand office:
  - Provides comprehensive advice and recommendations on the IMG's qualifications, training and experience and whether this is at the level of a NZ trained specialist.
  - It has processes which enable it to:
    - Assess the IMG's qualifications, training and experience against the statutory standard, as equivalent to or as satisfactory as, that of an Australasian trained specialist holding the Fellowship qualification.
    - Notify the MCNZ in writing, if any significant concerns about competence become apparent during the assessment of QTE and thereafter.
    - Provide advice as to any differences between the IMG's qualifications, training and experience, and the prescribed qualification (Fellowship) and whether there are any deficiencies or gaps in training; whether subsequent experience has addressed these, and if not, what type of experience, supervised practice and assessment would address the deficiencies or gaps in training, to inform MCNZ in making a decision.
    - Advise the MCNZ of any requirements the doctor needs to complete to obtain vocational registration, together with comprehensive reasons.
    - Ensure reports meet administrative law obligations and principles by providing well reasoned advice directly supported by the paper documentation and information obtained at interview.
- In New Zealand, IMGs who are unhappy with their assessment can make appeals / requests of reconsideration to the MCNZ.
- RACS continues to publish data on the outcomes of IMG applications in the Annual *Activities Report*. Weblink to the Activities Reports (2010 see pages 18-24)

B. Challenges

- The College has constituted assessment panels to ensure that the representatives of the specialty in which the IMG is being assessed do not form a majority with a veto over decisions. This was done on the advice of the AMC and the ACCC to avoid perceptions of restricting the number of surgeons practicing in the community. At a meeting with the College the AMC indicated that it would accept majority membership by specialty representatives and would rely on the ACCC to investigate any complaints about non-competitive behaviour.

  Consequently RACS is reviewing the composition of IMG Assessment Panels to afford specialties the option of having a decisive majority. Non-specialty representatives will be retained to provide a diversity of views, and a process for oversighting majority decisions will also be incorporated.

- The College notes that interaction with the Joint Standing Committee on Overseas Trained Specialists (JSCOTS) has been almost non-existent in recent times. Since the then RACS Dean

of Education Prof. John Collins retired from JSCOTS the IMG Assessment Department of RACS has not been provided with updates on relevant activity.

C. Development plans over the next 5 years

- A working party is currently investigating options to improve the IMG assessment process. This working party is looking at opportunities to ensure that the clinical assessors are appropriately trained for their role, and that there are assessment activities such as Direct Observation of Procedural Skills (DOPS) and Mini-Clinical Examinations (Mini-CEX).
- RACS is also developing e-Learning offerings that will assist IMGs to achieve Fellowship (see Section 2.2 part C).
- Some of the specialty training boards have identified this as a priority area for development:
  - OHNS training board plan to increase their involvement with the oversight of IMGs.
  - PS will require IMG's assessed under article 19 from February 2011 to undertake some of the same formative assessment activities as Trainees (MOUSE; CATS; DOGS and RATS). Weblink to Paediatric Surgery Training regulations (refer to page 2)
  - U have developed different assessment reports for IMGs depending on whether their assessment requires them to sit the FEX, or not.

D. Factors that could impact on the achievement of goals and objectives over the next five years

None identified

E. How the College has responded to issues raised as a result of other national or state/ regional policy developments or national or state/ regional enquiries

- The College continues to review developments in IMG assessment in Australia and New Zealand and incorporates changes where appropriate.

STANDARD 6: MONOTORING AND EVALUATION

6.1 Ongoing Monitoring

6.1.1. The training organisation regularly evaluates and reviews its training programs. Its processes address curriculum content, quality of teaching and supervision, assessment and trainee progress.

6.1.2. Supervisors and trainers contribute to monitoring and to program development. Their feedback is systematically sought, analysed and used as part of the monitoring process.

6.1.3. Trainees contribute to monitoring and to program development. Their confidential feedback on the quality of supervision, training and clinical experience is systematically sought, analysed and used in the monitoring process. Trainee feedback is specifically sought on proposed changes to the training program to ensure that existing trainees are not unfairly disadvantaged by such changes.

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

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

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

A. Achievements

- RACS Education Development and Research Department (EDRD) has a designated member of staff to support and coordinate evaluation.
  - Following expressed concerns about 'early selection into training' in the 2010 SET review, EDRD analysed the performance of Trainees selected from PGY2 in the SSE and Clinical Examinations and in in-training assessments
    - Findings indicate that this cohort of Trainees performed well across all of those assessments, and significantly better than Trainees who were five or more years post-university prior to selection into SET.
- With the support of RACS, an EDRD staff member is studying SET Trainees' progress through training from selection to completion, for a PhD.
- PS has proposed an audit of selection processes over the last 10 years, relating success on the selection tools to success in the training program.
- Different components of training are evaluated by different committees and boards:
  - Each skills committee evaluates every skills course and the overall impact of that course
  - The generic SSE and CE and some of the specialty specific SSEs are monitored through the standard setting processes (see Section 5.3 part A)
  - The FEX is monitored by members of the Court (see Section 5.1 part A)
    - In 2010 the Court introduced an anonymous on-line evaluation process for all candidates
    - The outcomes in terms of individual attempts and pass rate; annual pass rate; and eventual pass rate (by specialty; region and status (Trainee; IMG) have been carefully monitored by RACS Examination Department and members of the FEX court. These statistics are reported annually.

      Weblink to Activities Reports (refer to pages 43-51 in the 2010 Report)
  - Each specialty training board is responsible for evaluating its own curriculum content, especially in relation to the competencies of Technical and Medical Expertise and Judgement – Clinical Decision Making (see Section 3.2 part A)
    - RACS is responsible for evaluating the curriculum content of the other six competencies – this evaluation has led to the planned development of the progression standards (see Section 2.2 parts A & C).

  - Each specialty training board is responsible for monitoring the progress of its Trainees throughout SET, reporting this to BSET, and in the Annual *Activities Reports.*
    Weblink to Activities Reports (refer to pages 30-42 in the 2010 Report)
    - Each of the training boards keeps long-term data to monitor Trainees' performance including completion rates, withdrawals, progression, probation and dismissal rates
    - In 2011 OHNS training board is performing an audit on the Trainees who were selected from PGY2.
    - PS training board has a designated member who monitors Trainees' use and progression on each of the formative assessment tools.

- Each of the specialty training boards (as well as the regional training boards in the larger specialties) is comprised of supervisors who bring first-hand knowledge of the training program as well as the training context.
  - Most of the specialties (GS; NS; OHNS; OS; PS; P&RS; & U) have designated meetings for supervisors at their ASMs. These meetings are both to provide information and to receive feedback on issues raised by the supervisors.
    - VS is planning to introduce an annual meeting of the training board and all VS supervisors.
    - VS is also planning to open its board meetings for interested parties to attend.
  - OS has developed and implemented surveys of supervisors and trainers to monitor their opinions on all aspects of the program.
  - In 2010 U conducted a survey of their supervisors and trainers.
- Evaluation of selection (see Section 7.1 part A)
- Most of the training boards require their Trainees to provide anonymous feedback on their training experience at the end of each rotation throughout training.
  - CS only requires Trainees to submit this evaluation for their first year of training.
  - U requires Trainees in SET1 and 2 to submit feedback on their rotations (in GS)
- Information collected through the training board Trainee evaluation processes is collated and provided to the panel of surgeons (and JR representatives) conducting the next round of accreditation for that specific training post.
- In addition, RACSTA have developed an on-line survey for all Trainees to provide anonymous feedback at the end of each rotation. The data from this survey will be analysed by the RACS Evaluation Coordinator in EDRD. The collated results will be provided back to the specialty training boards.
- All of the specialty training boards have Trainee meetings associated with their ASMs at which Trainees are encouraged to give feedback and to discuss issues
  - PS and VS have annual meetings with each individual Trainee.
- See Section 2.2 Part A re the evaluation of SAT SET

B. Challenges

- To maximise the sharing of the key findings from the range of monitoring and evaluation processes — especially those conducted by the specialties and specialty training boards.
- To ensure that the best possible use is made of the monitoring and evaluation processes by pitching the questions at the most appropriate level.
- See Section 2.2 part B re communication with external stakeholders.

C. Development plans over the next five years

- To encourage the specialty training boards to refer their planned surveys and reviews to the EDRD evaluation coordinator for advice on both the preparation and analysis of evaluation tools
- To encourage the specialty training boards to report to BSET on the findings of any of their evaluation processes

D. Factors that could impact on the achievement of goals and objectives over the next five years

None identified

E. How the College has responded to issues raised as a result of other national or state/ regional policy developments or national or state/ regional enquiries

None identified

6.2 Outcome Evaluation

6.2.1. The training organisation maintains records on the outputs of its training program, is developing methods to measure outcomes of training and is collecting qualitative information on outcomes.

6.2.2. Supervisors, trainees, health care administrators, other health care professionals and consumers contribute to evaluation processes.

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

A. Achievements

- See Section 6.1 part A re monitoring of progression of Trainees through the training program and the collection and maintenance of quantitative data.
- See Section 6.1 part A re involvement of Supervisors and Trainees in the evaluation processes.
- See Section 1.4 part A re interaction with the health sector.

B. Challenges

None identified

C. Development plans over the next five years

- Reasons that trainees leave their training before completion are recorded by each of the training boards.
  - GS has the highest number of trainees who leave training in their specialty (at the end of 2010 that was 10 out of ~400 trainees). However, almost all of those d so to take up training in another specialty.
  - The next highest number of exiting trainees (across all specialties) list personal and/or health reasons
- It is anticipated that in 2011 some of the first cohort of SET Trainees (those selected to commence training in SET2 in GS; OS; OHNS; P&RS; and VS in 2008) will complete their training.
  - An evaluation proposal for collecting qualitative data from SET graduates as well as former graduates of the Advanced Surgical Training program (AST) will be developed by EDRD and put to the October meeting of BSET.

D. Factors that could impact on the achievement of goals and objectives over the next five years

- See Section 2.1 part D

E. How the College has responded to issues raised as a result of other national or state/ regional policy developments or national or state/ regional enquiries

None identified

STANDARD 7: ISSUES RELATING TO TRAINEES

7.1 Admission Policy and Selection

7.1.1. A clear statement of principles underpins the selection process, including the principle of merit-based selection.

7.1.2. The processes for selection into the training program:

- *are based on the published criteria and the principles of the training organisation concerned*
- *are evaluated with respect to validity, reliability and feasibility*
- *are transparent, rigorous and fair*
- *are capable of standing up to external scrutiny*
- *include a formal process for review of decisions in relation to selection, and information on this process is outlined to candidates prior to the selection process.*

7.1.3. The training organisation documents and publishes its selection criteria. Its recommended weighting for various elements of the selection process, including previous experience in the discipline, is described. The marking system for the elements of the process is also described.

7.1.4. The training organisation publishes its requirements for mandatory experience, such as periods of rural training, and/or for rotation through a range of training sites. The criteria and process for seeking exemption from such requirements are made clear.

7.1.5. The training organisation monitors the consistent application of selection policies across training sites and/or regions.

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

A. Achievements

- It was agreed at the October meeting of BSET 2010 that there was no educational justification for those surgical specialties which have separate selection processes in Australia and New Zealand (GS; OHNS: OS; & P&RS) to have different selection criteria (where they existed).
- Following the selection workshop in 2009 all of the specialties have changed their interview processes to be more closely aligned to the agreed principle of selection for attributes suitable for training, rather than attained competencies (as reported in the RACS Report to the AMC 2009).
  Weblink to the 2009 RACS report
  - Each specialty has also changed their interview format to include interviews by multiple panels and multiple interviewers.
  - Several specialties (GS; NS; OHNS; & PS) are developing banks of interview scenarios addressing the desired attributes
- The Interviewer Training Course was completely revised in 2008 and the course — SAT SIT — is offered to each of the surgical specialties prior to their interviews.
  - The new course explains the process of selection for attributes and for potential for training, rather than acquired competence.
  - All of the principles on which the selection process is based are published in the manual for that course (see Appendix 7)
  - CS has mandated that all of their interviewers must do the SAT SIT course
  - OHNS have involved more of their supervisors in the selection process, and the majority of their interviewers have undergone interviewer training
- The selection criteria, mandatory requirements, and relevant policies including the Appeals policy, are published on-line
  Weblink to Selection requirements
  Weblink to Selection to SET policy
  Weblink to Registration for Selection into SET policy
  Weblink to Appeals Mechanism Policy

- Each surgical specialty publishes detailed information about its selection tools and the scoring processes in its *Selection Regulations* Weblink to Selection requirements (go to 'Specialty specific eligibility requirements for selection into the SET program')

- RACSTA made the following comment:
  - RACSTA has had a strong interest in selection processes, particularly with respect to consistency across specialties, transparency and fairness. Our view is that selection has improved substantially since the introduction of SET. Selection requirements are now clearly indicated and available via RACS website, and are closely followed by applicants. RACSTA has received very few complaints from Trainees in the last two years regarding selection fairness, which is in contrast to previous years.

- Each year since the inception of SET the selection processes have been evaluated in a number of different ways:
  - EDRD has conducted an evaluation on the selection processes of each surgical specialty and provided feedback to each training board on how their processes could be improved. Weblink to Selection Evaluation Procedure (access to this link requires a password)
  - Each specialty training board reviews their mandatory requirements, selection tools, scoring criteria and scoring processes prior to the October meeting of BSET where their plans are openly discussed and refined prior to approval by BSET; EB and Council before publication on RACS website for the following year.
  - NS conduct evaluation surveys with their selection applicants.
  - OHNS, OS and P&RS survey interviewers and interviewees to gather feedback on their perceptions of the interview processes and questions.

B. Challenges

- Concerns expressed by supervisors and training boards that Trainees being selected into the program do not have sufficient experience (see Section 3.5 part A for RACS response).
- **Concern expressed by the training boards that there is currently no recognition of the variance in attributes required for selection by the nine speciality training programs** RACS is concerned that there will be a significant increase in applicants which could make the current processes, requiring a great deal of attention paid to each individual application, difficult to maintain.
- The requirement for several selected consultants to provide references can be problematic and prone to subjectivity and luck elements rather than objectivity. Most recently (2010 selections), some applicants to P&RS were rejected interviews because the nominated consultants failed to return their referee reports – unfairly disadvantaging these Trainees through no fault of their own.
  - A more rigorous monitoring of referee reports was approved at October 2010 BSET.

C. Development plans over the next five years

- In response to both existing concerns relating to 'early selection' and the anticipated impact that the increase in medical graduates will have on opportunities for clinical experience, RACS has defined 'elementary skills' needed for training in surgery.
  - See Section 3.5 part A re the definition of 'elementary skills'.
  - PS is planning to define prerequisite technical and clinical competencies for selection into training
- U plans to run regionally-based standardised preliminary interviews to reduce cost and involve more local urologists in the selection process.

It is anticipated that some variances in the criteria for selection between the training boards may emerge. The Education Board will take a greater role in ensuring the educational validity of individual training board's criteria, rather than setting a singular selection criteria standard.

D. Factors that could impact on the achievement of goals and objectives over the next five years

None identified

E. How the College has responded to issues raised as a result of other national or state/ regional policy developments or national or state/ regional enquiries

- The timing of the SET selection cycle has been specifically planned in response to feedback from the jurisdictions that they wanted information about Trainee appointments prior to the time of year when they appoint people for the following year.
  - The timing of the SSE and CE has also been adjusted to fit this time-frame so the specialty training boards will know exactly how many training posts they will have available for new Trainees.

7.2 Trainee Participation in Training Organisation Governance

7.2.1. The training organisation has formal processes and structures that facilitate and support the involvement of trainees in the governance of their training.

A. Achievements

- All surgical Trainees are automatically members of RACSTA and as such have the right to vote for committee members.
- Members of the RACSTA committee are elected to represent all surgical specialties and regions.
  - Committee members are elected annually for a two year term.

Weblink to RACSTA Terms of Reference

- RACS has Trainee representation, with full voting rights, on all education and training boards and on Council.
  - Trainee representatives are all members of RACS Trainees Association — RACSTA

Weblink to RACSTA

- RACSTA made the following comment:

  RACSTA has grown and matured within its five years of existence. We now feel we are among the best-represented Trainees of any College group. RACSTA reps are active in all areas of training, education and college governance that we see as valuable, including specialty boards, BSET, education board, and now holding a voting role on Council. Other College stakeholders afford the RACSTA Board respect and we are satisfied that any concerns we have will be listened to and acted on. Overall, we feel our involvement in College affairs is excellent.

- RACSTA has administrative support within RACS structure
- See Section 6.1 part A re specialty specific Trainee meetings and Trainee evaluation of rotations

B. Challenges

None identified

C. Development plans over the next five years

- The contribution of Trainee representatives at all of the education and training board meetings is greatly valued. RACS intends to continue to support the development of RACSTA as an important representative group.

D. Factors that could impact on the achievement of goals and objectives over the next five years

None identified

E. How the College has responded to issues raised as a result of other national or state/ regional policy developments or national or state/ regional enquiries

None identified

7.3 Communication with Trainees

7.3.1. The training organisation has mechanisms to inform trainees about the activities of its decision-making committees, in addition to communication by the trainee organisation or trainee representatives.
7.3.2. The training organisation provides clear and easily accessible information about the training program, costs and requirements, and any proposed changes.
7.3.3. The training organisation provides timely and correct information to trainees about their training status to facilitate their progress through training requirements.

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

Completed

A. Achievements

- Following each meeting of Council and Council Executive, all Trainees (and Fellows) receive an email of *Council Highlights*, providing a summary of the key issues from that meeting. *Council Highlights* can also be viewed (with a password) on the RACS website.
- Information about SET program costs is published on the RACS website annually.
  Weblink to 2011 training fees
- Each specialty training board provides their Trainees with information about training requirements via their training regulations. Weblink to the Training area of RACS website
  (Note: Links to each of the specialty training areas is navigated via the left hand index (access to information on training requirements in OS and U requires a password)
  - Some surgical specialties (GS; OHNS; PS) also provide their Trainees with a training handbook
- Each specialty training board is responsible for providing accurate and timely information to their Trainees about their training status and progress through training.
  - Improved data-bases have enabled each of the training boards to accurately monitor Trainee progress and performance in their clinical experiences; required courses; examinations and research requirements and to advise them if any of the training components have not been met.
    - As part of the new RACS website it is intended that Trainees will be able to access their own records at any time.
  - RACS Examinations Department is responsible for formally advising Trainees of their results in the SSE, CE and FEX. Weblink to the Conduct of Examinations policies
- All specialty training boards have Trainee representation on their training boards. In addition:
  - In 2009 P&RS introduced an on-line newsletter for Trainees.
  - OS have improved communication between Trainees and their education manager via the e-learning centre.
  - See also Sections 4 re communication with Trainees via Trainee Day(s), meetings with Trainees and Trainee orientation programs.

B. Challenges

- RACSTA made the following comment:

  This is an ongoing area of work and has been identified by RACSTA as one of their priorities for 2011. Effective communication channels are Surgical News, Highlights emails (including RACSTA Highlights), RACS Journal, emails from specialty boards and RACSTA reps, and some newsletters from College branches, specialty societies and specialty boards. We see steady improvements over recent years, but there is still scope for improvement. The regeneration of RACS website offers reason for optimism. The personalisation of website interaction and introduction of community elements is seen as particularly beneficial, potentially enabling more clarity and effectiveness of communication in training-related matters.

C. Development plans over the next five years

- The re-development of the RACS website, with the capacity to personalise information is expected to significantly enhance communication between RACS and each individual Trainee.
  - See Section 2.2 part C re plans for RACS website
  - RACS also plans to put some of the presentations from RACS/RACSTA orientation seminar on-line.
- Some surgical specialties also plan to improve communication with their Trainees:
  - OHNS plans to increase early feedback to unsuccessful candidates regarding their performance in examinations and to increase transparency in the processes.
  - U plans to establish a Trainee Forum comprising representatives from all SET levels and regions. The Chair and Deputy Chair of the Trainee Forum will take on the role of Trainee representatives on the training board.

D. Factors that could impact on the achievement of goals and objectives over the next five years

None identified

E. How the College has responded to issues raised as a result of other national or state/ regional policy developments or national or state/ regional enquiries

7.4 Resolution of Training Problems and Disputes

7.4.1. The training organisation has processes to address confidentially problems with training supervision and requirements.
7.4.2. The training organisation has clear impartial pathways for timely resolution of training related disputes between trainees and supervisors or trainees and the organisation.
7.4.3. The training organisation has reconsideration, review and appeals processes that allow trainees to seek impartial review of training-related decisions, and makes its appeals policies publicly available.
7.4.4. The training organisation has a process for evaluating de-identified appeals and complaints to determine if there is a systems problem.

A. Achievements

- RACS has clear guidelines for the role of supervisors Weblink to Duties of Supervisors
- RACS provides training for supervisors in the SAT SET and KTOT courses (see Section 2.2 part C).
- In 2011 RACS published a Position Paper on bullying and harassment.

  Weblink to Bully and Harassment: Recognition, avoidance and management
- RACS has recently revising its Appeals Policy to make the initial steps in dispute resolution clearer.
- The Appeals mechanism is clearly defined Weblink to Appeals Mechanism Policy
- See Section 5.2 part A re underperforming Trainees
- See Section 6.1 part A re Trainee evaluation processes
- RACSTA has defined processes in place to enable Trainees to seek additional assistance and advice. See Section 7.2 part A
- RACSTA made the following comment:

  There is no doubt that Trainees are feeling much more empowered in this space in recent years, and willing to use the problems and disputes resolution processes. Trainees have substantial confidence in the independence, robustness, transparency and fairness of these processes. Several controversial

and high-profile cases within RACS, which have ruled in Trainees' favour (outcomes not necessarily agreed with by RACSTA) testify just how independent this process is. Trainees have representation on these panels, most recently the academic conduct committee (which convened for the first time) to resolve a Trainee disciplinary matter.

B. Challenges

- Trainees are becoming more litigious in their approach to what they identify as negative outcomes, regardless of whether there has been a breach of procedure, or not. RACS's approach has always been to resolve any problems of disputes through mediation where possible.

C. Development plans over the next five years

- OHNS plan to develop processes for early resolution of training disputes via counselling and remediation.

D. Factors that could impact on the achievement of goals and objectives over the next five years

None identified

E. How the College has responded to issues raised as a result of other national or state/ regional policy developments or national or state/ regional enquiries

- In a position paper in June 2009 the AMA identified bullying and harassment as significant problems in the medical sector. RACS has developed and published a position paper on this issue to guide Trainees and Fellows (see above).

STANDARD 8: IMPLEMENTING THE TRAINING PROGRAM – DELIVERY OF EDUCATIONAL RESOURCES

8.1 Supervisors, Assessors, Trainers and Mentors

8.1.1. The training provider has defined the responsibilities of hospital and community practitioners who contribute to the delivery of the program of study and the responsibilities of the training provider to these practitioners. It communicates its goals and objectives for specialist medical education to these practitioners.

8.1.2. The training provider has processes for selecting supervisors who have demonstrated appropriate capability for this role. It facilitates the training and professional development of supervisors and trainers.

8.1.3. The training provider routinely evaluates supervisor and trainer effectiveness including feedback from trainees.

8.1.4. The training organisation has processes for selecting assessors in written, oral and performance-based assessments who have demonstrated relevant capabilities.

8.1.5. The training organisation has processes to evaluate the effectiveness of its assessors/examiners including feedback from trainees, and to assist them in their professional development in this role.

Recommendation 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.*

Recommendation 28: Increase communication with supervisors and trainers about SET.

Completed

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

Completed

A. Achievements

- RACS has clear guidelines of the roles and responsibilities of supervisors, and on the appointment and tenure of a supervisor. Weblink to Duties of Supervisors

  Weblink to the Surgical Supervision policy

  Weblink to the Surgical Trainers policy
- RACS provides training for supervisors in the SAT SET and KTOT courses (see Section 2.2)
  - Several of the specialties (NS; PS; OS) have worked with RACS Professional Development Department to provide their supervisors with training in SAT SET at their ASMs
  - CS have mandated that all of their supervisors must do the SAT SET course.
  - In 2012 OHNS plans to offer NOTSS
- The specialty training boards have a range of ways in which they provide information about the training program to their supervisors and collect information from them:
  - See Section 6.1 part A on the way that supervisors are advised about, and involved in, defining and evaluating the specialty training program.
  - GS introduced a quarterly newsletter for all General Surgery supervisors in August 2010. This newsletter highlights changes made to training regulations, College Policy, new procedures, and courses available for professional development.
  - P&RS communicate with their supervisors via a regular on-line newsletters.
- See Section 3.2 part B re changes in the workload of supervisors.

  - In 2010 PS surveyed their supervisors and determined that only a small number of supervisors are compensated by their hospital for their time spent training and assessing Trainees.

- See Section 6.1 part A re processes for Trainees to provide feedback on their training experiences.
- Examiners, including the people who write the SSE and CE, are appointed because of their expertise.

Weblink to Examination and Assessment policies (see Terms of Reference for the various committees)

- See Section 5.1 part A re FEX examiner selection, training, and evaluation

B. Challenges

- Maintaining the involvement of supervisors and trainers (see Sections 1 and 4 about the pro-bono contribution of supervisors and trainers).
- Provision by the hospital employers of appropriate time to meet training responsibilities.
  - This requirement is defined within the training post accreditation criteria, however the specialty training boards are reluctant to penalise hospitals which do not meet this requirement because it would ultimately reduce the number of Trainees who could be selected into the training program.

C. Development plans over the next five years

- The new course for supervisors KTOT will be made available free of charge.
- See Section 2.2 part C for plans to make components of the courses for supervisors available on-line.

D. Factors that could impact on the achievement of goals and objectives over the next five years

- See Section 2.1 part D

E. How the College has responded to issues raised as a result of other national or state/ regional policy developments or national or state/ regional enquiries

- See Section 3.2 part E re CPMC workshop.

8.2 Clinical and Other Educational Resources

8.2.1. The training organisation has a process and criteria to select and recognise hospitals, sites and posts for training purposes. The accreditation standards of the training organisation are publicly available.

8.2.2. The training organisation specifies the clinical and/or other practical experience, infrastructure and educational support required of an accredited hospital/training position in terms of the outcomes for the training program. It implements clear processes to assess the quality and appropriateness of the experience and support offered to determine if these requirements are met.

8.2.3. The training organisation's accreditation requirements cover: orientation, clinical and/or other experience, appropriate supervision, structured educational programs, educational and infrastructure supports such as access to the internet, library, journals and other learning facilities, continuing medical education sessions accessible to the trainee, dedicated time for teaching and training and opportunities for informal teaching and training in the work environment.

8.2.4. The training organisation works with the health services to ensure that the capacity of the health care system is effectively used for service-based training, and that trainees can

experience the breadth of the discipline. It uses an appropriate variety of clinical settings, patients and clinical problems for training purposes, while respecting service functions.

A. Achievements

- Since 2005 RACS has had clearly defined criteria and processes for accreditation of new training posts and re-accreditation of existing posts.
  - The seven criteria cover: education facilities and systems required; quality of education, training and learning; surgical supervisors and staff; support services for Trainees; clinical load and theatre sessions; equipment and clinical support services; and clinical governance, quality and safety.
    - This information is published on-line and hospitals are encouraged to access this resource. Weblink to Training Post Accreditation
  - Some of the surgical specialties (NS; OHNS; OS; & U) have made minor modifications to RACS accreditation requirements. Their accreditation standards are also available on-line from their websites — NS; OHNS; OS; U;
  - VS has revised its approach to reaccreditation of hospitals and in some instances has completed paper-based inspections of hospitals (instead of visiting each site).
- The two training boards which continue to use General Surgery posts for early SET training (PS & U) have developed an agreement with GS that they will accredit the posts which they identify as meeting their training needs.
  - GS and U also co-accredit posts that can be occupied by a surgical Trainee in either specialty
- See Section 1.4 re interaction with the health sector.
- See Section 4 re the allocation of Trainees to training posts.

B. Challenges

- See Section 1.4 re interaction with the health sector.
- Other challenges include:
  - A small number of instances have occurred in which a potential new training post was identified, but funding was not approved by STP.

C. Development plans over the next five years

- See Section 1.4 part A re STP projects
- Some specialty training boards continue to review the way in which their training posts are utilised:
  - Based on a rigorous assessment and review of the SET6 (final year) of training and consultation with Trainees, trainers and the jurisdictions, the U training board plans to implement a more streamlined and robust program for that component of training. The Board has identified and will accredit ~ 20 posts within Australia and New Zealand specifically for SET6 Trainees to occupy from 2012 onwards.

D. Factors that could impact on the achievement of goals and objectives over the next five years

- See part D of Sections 1.4 and 2.1

E. How the College has responded to issues raised as a result of other national or state/ regional policy developments or national or state/ regional enquiries

- See Challenges above
- See Section 1.4 re interaction with the health sector.

STANDARD 9: CONTINUING PROFESSIONAL DEVELOPMENT

9.1 Continuing Professional Development Programs

9.1.1. The training provider's professional development programs are based on self-directed learning. The programs assist participants to maintain and develop knowledge, skills and attitudes essential for meeting the changing needs of patients and the health care delivery system, and for responding to scientific developments in medicine as well as changing societal expectations.

9.1.2. The training provider determines the formal structure of the CPD program in consultation with stakeholders, taking account of the requirements of relevant authorities such as the Medical Board of Australia and the Medical Council of New Zealand.

9.1.3. The process and criteria for assessing and recognising CPD providers and/or the individual CPD activities are based on educational quality, the use of appropriate educational methods and resources, and take into consideration feedback from participants.

9.1.4. The training provider documents the recognised CPD activities of participants in a systematic and transparent way, and monitors participation.

9.1.5. The training provider has mechanisms to allow doctors who are not its fellows to access relevant continuing professional development and other educational opportunities.

9.1.6. The training provider has processes to counsel fellows who do not participate in ongoing professional development programs.

A. Achievements

- The CPD Program enables Fellows to design their own learning plans. It encourages Fellows to develop knowledge and skills in a variety of areas across both technical and non-technical competencies. Fellows claim activities in the following categories:
    1. surgical audit and peer review,
    2. hospital credentialing
    3. clinical governance and evaluation of patient care,
    4. maintenance of clinical knowledge and skills,
    5. teaching and examination,
    6. research and publication**,** and
    7. other professional development activities (non-technical)

    Weblink to CPD program

    - Categories 4 and 7 include courses in communication, collaboration and teamwork, leadership and management, teaching and professionalism. Some of these courses address issues such as cultural diversity and needs.
        - See Section 2.2 – parts A and C re cultural competence
- In determining the program for each triennium RACS consults with specialty societies and regional boards when establishing the structure of the CPD Program. This ensures the program is relevant to all specialties and Fellows in a variety of locations. RACS has also held discussions with the Medical Board of Australia and the Medical Council of New Zealand on ensuring that the program meets their requirements. Weblink to Approved CME activities
- In order to ensure a high standard of educational value, all CPD activities are required to be assessed through the formal College Continuing Medical Education (CME) approval process before being included in the program.
    - The number of approved courses increased by 9% from 2009 to 2010.
- The CPD program does not have an annual minimum time requirement. Rather Fellows are required to meet some annual requirements and accrue points in other categories over the triennium (see page 4 in the CPD program booklet).
- RACS CPD program has a number of policies which define the approval of activities and participation requirements. Weblink to CPD and Recertification policies
- There is a clearly defined process of annual review and evaluation of participation and of encouraging and enabling those who have not met the requirements (see CPD program and the CPD program – participation and compliance policy)

- Compliance with the CPD program is being achieved by 94% of the Fellowship with an increasing proportion of Fellows making use of CPD Online.
- RACS publishes data on the participation of Fellows (by specialty and region) annually in the *Activities Reports*. Weblink to Activities Reports
- RACS staff and the Executive Directors for Surgical Affairs (in Australia and New Zealand) counsel Fellows who do not participate in the CPD Program or are having difficulty in meeting the requirements.
    - Specialty society representatives are also asked to assist their members to meet the requirements of the program, for example by conducting peer reviews of audit data.
- RACS offers a Maintenance of Professional Standards (MOPS) Program for doctors who are not Fellows to participate in continuing professional development. Weblink to MOPS
    - The numbers of IMGs and others who participate in the MOPS program are also reported in the annual *Activities Reports*.
- Doctors who are not RACS Fellows can also attend some educational activities organised by the Professional Development Department. Weblink to Professional Development activities

B. Challenges

- Achieving full compliance with the CPD Program (currently 94%).

C. Development plans over the next five years

- Improvements are being made to the CPD on-line system to facilitate increased participation by Fellows. This new system will enable Fellows to track their annual and triennial compliance, print their own statements and apply for exemptions where appropriate. It is anticipated that this will encourage participation and compliance.

D. Factors that could impact on the achievement of goals and objectives over the next five years

- Uptake of CPD Online system.
- Funding of Professional Development activities.

E. How the College has responded to issues raised as a result of other national or state/ regional policy developments or national or state/ regional enquiries

- RACS is working with the Australian Health Practitioner Regulation Agency (AHPRA) to investigate the impact of AHPRA requirements on retired and semi-retired surgeons who continue to teach, write referrals and prescriptions.

9.2 Retraining

9.2.1. The training provider has processes to respond to requests for retraining of its fellows.

A. Achievements

- The College has a process of retraining and reskilling surgeons. However the two terms are not synonymous.
    - Retraining applies to surgeons who previously possessed the skills in the areas where there are now deficiencies. These deficiencies may be technical or non-technical skills.
    - Reskilling requires the attainment of skills not previously possessed which may pertain to a new procedure or an alteration in devices used. This is particularly relevant to surgeons returning to practice after an absence, or those who have not kept up with surgical developments. This pertains mainly to technical skills and less commonly to non-technical areas.
- In both these areas RACS maintains a policy which is managed through the Offices of the Executive Directors for Surgical Affairs. Weblink to Re-Skilling and Re-Entry Program Guidelines

- The policy allows for an individualised approach to the surgeon. It relies on the surgeon involved to have some insight into the difficulties and then a program is arranged of graduated return to full independent practice – usually based on a progression of assisting an established surgeon, being assisted by an established surgeon and then return to independent surgical practice, with reporting of outcomes to a surgeon or a group until the activity is shown to be satisfactory.
- Should this process be not successful or certain procedures are not able to be performed satisfactorily, it is RACS recommendation that credentialing authorities provide credentialing with limitations to certain procedures, or all procedures except nominated procedures.
- Reskilling has a similar focus but is more difficult to achieve.

B. Challenges

- As RACS has no regulatory powers regarding registration or credentialing for practice within hospitals etc, we are limited in activity to requests from the Medical Board of Australia (MBA) or the Medical council of New Zealand (MCNZ) for re-training, or re-skilling; or in response to issues that arise out of review of the practice of individual surgeons which is often performed at the request of individual hospitals or District Health Boards (DHBs).
- On many occasions the difficulty that RACS faces relates to insight of the surgeon undertaking this process.
- It is difficult to find a position that is possible to achieve either re-skilling or re-training, with a willing supervisor, whilst at the same time not interfering with the training program of bright young surgical aspirants.
- It is also difficult if the surgeon is required to move from their place of employment.
    - The best situations are where surgeon supervisors are familiar with supervising Trainees and methods of assessment commonly used. Then the surgeon undergoing re-training or re-skilling is able to be assessed and benchmarked with the same rigor and with the same endpoint of a Trainee/ surgeon who is equipped for independent surgical practice.

C. Development plans over the next five years

None identified

D. Factors that could impact on the achievement of goals and objectives over the next five years

- Without support from the MBA, the MCNZ or DHBs, the jurisdictions, appropriate posts for re-training or re-skilling, and surgeon supervisors these programs will be difficult to maintain.

E. How the College has responded to issues raised as a result of other national or state/ regional policy developments or national or state/ regional enquiries

9.3 Remediation

9.3.1. The training provider has processes to respond to requests for remediation of its fellows who have been identified as under performing in a particular area.

A. Achievements

- Remediation and retraining are considered under the same heading. RACS regards remediation as the collegial obligation to our Fellows/Trainees/IMGs on a pathway to Fellowship.
- Remediation more often refers to failure or departure from acceptable practice involving the non - technical skills and behaviours of surgeons. Again there are difficulties, but courses and programs are available through the RACS Professional Development Department, concerning Communication, Dealing with the difficult patient, Surgical audit and Cultural awareness. In

addition surgeons are directed to appropriate courses run by outside providers relating to anger management, bullying and harassment.

- RACS maintains a policy which is managed through the Office of the Executive Director for Surgical Affairs. Weblink to Re-Skilling and Re-Entry Program Guidelines

B. Challenges

- See Section 9.2. Similar difficulties are experienced in this area and it presents RACS with the challenge of sourcing such re-training whilst providing appropriate supervision, an income stream, and at the same time not interfering with the experience gained in training programs for surgical Trainees who are aspiring to gain appropriate training and experience to serve the community.

C. Development plans over the next five years

- RACS is developing an assessment tool for measuring Competence and Performance based on behavioural markers. This is aimed to be used by surgeons and also by Trainees aspiring to be surgeons. This may avoid some departures from aspects of Competence and Performance by providing a measure and an ability to identify such trends early and so remediate behaviour before problems arise and need remediation (see Section 2.1 part C).

D. Factors that could impact on the achievement of goals and objectives over the next five years

- See Section 9.2

E. How the College has responded to issues raised as a result of other national or state/ regional policy developments or national or state/ regional enquiries

None identified

APPENDICES:

Appendix 1 List of Acronyms

ACCC	Australian Competition and Consumer Commission
ACS	American College of Surgeons
AHPRA	Australian Health Practitioner Regulation Agency
AIDA	Australian Indigenous Doctors' Association
ALTC	Australian Learning and Teaching Council
AMA	Australian Medical Association
AMC	Australian Medical Council
ASSET	Australian and New Zealand Surgical Skills Education and Training (course)
ASSH	Australian Society of Simulation in Healthcare
ASC	Annual Scientific Congress (College)
ASM	Annual Scientific Meeting (Specialties)
AST	Advanced Surgical Training
ATLS	Advanced Trauma Life Support
ATSI	Aboriginal and Torres Strait Islander
BRC	Board of Regional Chairs
BSET	Board of Surgical Education and Training
CBD	Case-Based Discussion
CBT	Competency-based training
CE	Clinical Examination
CETI	Clinical Education and Training Institute (NSW)
CCrISP	Care of the Critically Ill Surgical Patient (course)
CLEAR	Critical Literature Evaluation and Research (course)
CMHSE	Centre for Medical and Health Sciences Education
CPD	Continuing Professional Development
CPMC	Council of Presidents of Medical Colleges
DHA	Department of Health and Aging
DHBs	District Health Boards
DOPS	Direct Observation of Procedures
DSTC	Definitive Surgical Trauma Care (course)
EB	Education Board
EDRD	Education Development and Research Department
EMST	Early Management of Severe Trauma (course)
ESC	English-Speaking Countries
FEX	Fellowship Examination
FRACS	Fellow of the Royal Australasian College of Surgeons
IMG	International Medical Graduate
ISO	International Organization for Standardization
ITA	In-Training Assessment
JCIE	Joint Committee of Intercollegiate Examinations

JRs	Jurisdictional representatives
JSCOTS	Joint Standing Committee on Overseas Trained Specialists
LTAS	Learning and Teaching Academic Standards
MBA	Medical Board of Australia
MCNZ	Medical Council of New Zealand
Mini-CEX	Mini-Clinical Examinations
MOSES	Management of Surgical Emergencies
MSF	Multi-Source Feedback
KTOT	Keeping Trainees on Track
NHRC	National Health and Research Council
NHW	National Health Workforce
NMCE	Network of Medical College Educators
NOTSS	Non-technical Skills for Surgeons (course)
PBA	Procedure Based Assessment
PD	Professional Development
PDSB	Professional Development and Standards Board
PFET	Post Fellowship Education and Training
PISA	Pacific Islands Surgeons Association
PSA	Provincial Surgeons of Australia
RACP	Royal Australasian College of Physicians
RACS	Royal Australasian College of Surgeons
RACSTA	Royal Australasian College of Surgeons Trainees' Association
RHCE	Rural Health Continuity Education
RCPSC	Royal College of Physicians and Surgeons of Canada
RCS	Royal College of Surgeons
RCSEd	Royal College of Surgeons of Edinburgh
RPL	Recognition of Prior Learning
SAS	Section of Academic Surgery (
SAT SET	Supervisors and Trainers for SET (course)
SEC	Skills Education Committee
SET	Surgical Education and Training
SIT SET	Selection Interviewer Training for SET (course)
SSE	Surgical Sciences Examination
STEP	Surgical Teachers Education Program
STC	Surgical Teachers Course (course)
STP	Specialist Training Program
Te ORA	Te Ohu Rata o Aotearoa
TIPS	Training in Professional Skills (course)
WHO	World Health Organization
WPB	Work-place-based

Surgical Specialties

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

Appendix 2 Educational Expertise and Exchange

Collaborations with universities in Australasia

RACS has developed MOUs with, or in discussion with, a number of universities in Australasia,

Macquarie University
Monash University
University of Melbourne
University of Sydney
University of Western Sydney
University of Wollongong
University of New England
Otago University
RMIT University
University of Queensland
University of Adelaide
University of Western Australia

Relationships with other colleges (Australasia)

RACS representatives participate in post graduate medical networks such as:

- Council of Presidents of Medical Colleges (CPMC)
- Network of Medical College Educators (NMCE)

RACS is working on specific projects in collaboration with other post graduate medical Colleges

- College of Physicians
    - MSF tool
    - Tri-partite workshop in Sydney (see Section 3.2 part C)
- Australian Indigenous Health Projects is a collaboration between RACS, the Royal Australasian College of Physicians and the Australasian College of Dermatologists

Relationships with other colleges and/or universities (international)

RACS has developed MOUs with, or in discussion with, a number of overseas institutions including:

- University of Edinburgh
- Royal College of Surgeons of Edinburgh
    - NOTSS
    - Fellowship Examination
    - On-line courses
- College of Physicians and Surgeons of Canada
    - Tri-partite workshop in Sydney (see Section 3.2 part C)
- Royal College of Surgeons, England
- General Medical Council and London Deanery

Appendix 3 Examples of College representatives on external organisations

NSW REGIONAL OFFICE (as at 25 January 2011)

OUTSIDE BODIES	REPRESENTATIVE
Area of Need Advisory Committee	Robert Costa
Breast Cancer	Mr Norman C Janu Mr Hugh L Carmalt
Cancer Council NSW – Members Assembly	Ms Bev Lindley
Cancer Trials NSW Steering Committee Membership	Prof Philip Crowe
(CHASM)Collaborating Hospitals Audit of Surgical Mortality	Mr Joseph Lizzio Mr. Warren Hargreaves
CEC – Transfusion Medicine Advisory Committee (TMAC)	Mr Gary Fermanis
CEC – Blood Clinical and Scientific Advisory Committee (BCSAC)	Mr Gary Fermanis
GP Procedural Training Program Committee	Mr Gary Fermanis
Health Care Complaint Commission (HCCC)	Mr Joseph Lizzio
Law Society- Medico-Legal Liaison Committee	Mr Joseph Lizzio
Medical Indemnity and Expert Witnesses	Mr Joseph Lizzio
Motor Accidents Authority	Mr Neil A Berry
NSW Medical Board	Mr Anthony A. Eyers
NSW Melanoma Network Advisory Board	Mr Austin M Curtin
Nursing Issues	Dr Mary Langcake
Private Health Facilities Advisory Committee	Mr Robert Costa
Senior Surgeons' Group	Mr Robert Rae
Surgical Services Taskforce	Mr Joseph Lizzio
WorkCover - Whole Person Impairment (WPI) Co-coordinating Committee	Mr Neil A Berry

QUEENSLAND REGIONAL OFFICE

RACS Queensland Regional Office interfaces with the local Health jurisdiction on many fronts and has been extremely active in pursuing engagement with Queensland Health since the issue regarding Dr Patel came to light in 2005.

Though at first this engagement was ad hoc it has now become relatively structured and involves many planned large joint activities and other smaller types of meetings and interactions. Examples include:

- The Surgical Strategy Workshop is an all-day meeting held where RAGS and QHealth discuss issues of concern in surgery including surgical training and workforce issues. These meetings are

conducted in July and December each year and are attended by up to 8 representatives of the Queensland Regional Committee, Chairs of the Surgical Networks and QHealth officials.

- RACS is a member of the Queensland Committee of Medical Specialist Colleges formed in February 2010. This group meets quarterly, involves 10 medical colleges, and is attended by the Minister for Health and/or the Director General Queensland Health. Training is a paramount issue for this group.
- The Queensland Regional Committee has had detailed discussions with QHealth and its representatives through 2 projects funded by QHealth - one workforce based and one education and training based. $150,000 funding has been provided across 2 projects:
  - *Retention and Return of Surgeons to the Public Hospital System* undertaken owing to surgical dissatisfaction in the workplace in the immediate post- Patel era.
  - The *Overseas Trained Surgeon Upskilling and Mentoring* project was a recommendation from a 2009 Ministerial Taskforce on Specialist Training in Regional Areas.

  These projects have been jointly managed with the Medical Workforce Unit of Queensland Health and RACS Queensland Regional Office.
- The Queensland Regional Committee has had jurisdictional representatives attend its committee meeting to present and answer questions on matters of concern.
  - In 2010 Dr Michael Ward from the Health Quality Complaints Commission attended a monthly committee meeting and Dr Peter Steer, the CEO of the new Queensland Children's Hospital Project, also attended a meeting.
  - In 2011 it is anticipated that Dr Jeanette Young the Chief Health Officer will attend the June meeting of the Committee and Dr Peter Steer would be invited to attend a meeting in late 2011.
- A number of smaller meetings occurred in 2009 and 2010 with various QHealth officials on the following topics:

  Surgery Connect - developing business rules which would not adversely affect training

  Area of need - looking to place newly qualified surgeons

  Specialist Outpatient Services - issues related to training

  Queensland Audit of Surgical Mortality issues – ICU beds

  Project meetings - for the projects mentioned above

  Clinician Performance Support Service (CiiPSS)
- Through 2008-2011 RACS has been, or is continuing to be, a stakeholder representative on 15 Committees conducted by QHealth.

OUTSIDE BODIES (current)	**REPRESENTATIVE**
Physicians Assistants Steering Committee	Dr Bernard Whitfield
Specialist Outpatient Strategic Services	Dr Bernard Whitfield
Bowel Cancer Screening	Dr Damien Petersen
Queensland Children's Hospital Development	Dr R. Black
Surgery Strategic Group	Dr I Dickinson Dr R Stitz Dr J Quinn Dr R Lewandowski Dr M Stevens Dr M Smithers
OTS Mentoring and Upskilling Project Committee	Dr P Woodruff Dr M Stevens

Appendix 4 Guest Speakers at Surgical Leaders Forums (2009-2011)

2009

May	The Hon Peter Dutton MP, Federal Shadow Minister for Health and Ageing
June	Peter Holman, NSW Govt, Chairperson, Medical Services Committee Topic: Strengthening Departments of Surgery and for them to have clear communication with hospital and area administration
October	Prof Jim Bishop, Commonwealth Chief Medical Officer Dr B Rowbotham, President Royal College of Pathologists of Australasia Topic: Issues relating to proposed changes to pathology referral forms

2010

February	Dr Michael Walsh, CEO Cabrini Health Topic: Training in the private sector – hospital perspective
	Mr Mark Cormack CEO and The Hon Jim McGinty Chair Health Workforce Australia Topic: Health Workforce perspective
June	Mr Kim Snowball, Acting Director-General, WA Department of Health Topic : "Outcome" audit data and health quality improvement
	Dr Richard Lewandowski (Qld); Dr Jessica Yin (WA); Mr Michael Dobson (VIC) Topic: College interaction with State Health Departments
October	Professor Des Gorman, Executive Chairman, Health Workforce New Zealand Topic: Towards a sustainable and fit for purpose surgical workforce
	Ms Lynne Pezzullo, Director, Access Economics Topic: Australian Health Workforce – a political and economic perspective
	Dr Martin Van Der Weyden, Editor, Medical Journal of Australia Topic: An outsider's view of surgeons and surgery

2011

February	Professor Peter Procopis, Chair Medical Board of New South Wales Dr John Adams, Chair Medical Council of New Zealand Topic: Recruitment and employment of International Medial Graduates - Philosophy, regulations, options and processes
	Dr Christine Bennett, former Chair Health and Hospitals Reform Commission Topic: Community Expectations
	Dr Rod Fawcett, Director Medical Education and Training, Barwon Health Topic: Hospital Expectations

May 2011 Program

The theme was: *The readiness of Australian and New Zealand surgeons to respond to major disasters in our region*

	Chair: *Mr Ian Civil*
9.00 – 9.30 30 mins	**Disaster planning and the surgeons' role** Dr Ian Norton, Director Disaster Preparedness and Response, National Critical Care and Trauma Response Centre
9.30 – 9.50 20 mins 9.50 – 10.10 20 mins	**Queensland Floods and Cyclones – organisational challenges** Mr Barry O'Loughlin, Director of Surgery, Princess Alexandra Hospital, Brisbane Dr Pieter Prinsloo, Director of Surgery, Cairns Base Hospital
10.10 – 10.40 30 mins	**Christchurch Earthquake – actions and reactions** Mr Greg Robertson, Director of Surgery, Christchurch Hospital
11.00 – 11.20 20 mins 11.20 – 11.40 20 mins 11.40 – 12.10 30 mins	**Victorian Fires: What medical lessons were learned?** Mr Michael Weymouth, Plastic and burns surgeon, The Alfred Hospital, Melbourne **Tsunami Disasters and the Role of the Military** Dr Annette Holian, Deputy Director of Trauma Service, Royal Darwin Hospital **What do surgeons need to do to be "disaster ready"?** A/Prof Andrew Pearce, Clinical Director of Training and Standards, Medstar Emergency Medical Retrieval Service for South Australia
12.10 – 12.30 20 mins 12.30 – 13.00 30 mins	**Where do surgeons fit in Australia's overall disaster plan?** Prof Chris Baggoley, Acting Commonwealth Chief Medical Officer **What's different with man-made disasters and where surgeons fit in the big picture** Prof Karim Brohi, Professor of Trauma Sciences, Queen Mary School of Medicine and Dentistry, London

Appendix 5 Political representatives as Guest speakers at RACS ASC

2006

The Hon Tony Abbott (Australian Federal Government)
The Hon Craig Knowles (NSW government)

2007

The Hon Dr Sir Terepai Maoate KBE, (Deputy Prime Minister and Minister of Health, Cook Islands)
The Hon Dr Viliamu Ta'u Tangi, (Deputy Prime Minister and Minister for Health, Tonga)

2008 Conjoint ASC (RACS and the College of Surgeons of Hong Kong

Dr C.H. Leong, (Chair of Hospital Authority of HK; Member of the Executive Council of Hong Kong Government
Prof. Michael Gregg, (Chair, Ministerial Advisory Committee on Elective Surgery, Victoria)
Prof Jiefu Huang, (Vice Minister for Health, Beijing)

2009

The Hon Bill Pincus QC (Brisbane)

2010

The Hon Dr Kim Hames (Deputy Premier and Minister for Health and Indigenous Affairs, WA)

2011

Mr Anthony Morris QC (Brisbane)
The Hon Alexander Downer (former federal MP 1984-2008)
Lord Ara Darzi (former Health Minister in England)

Appendix 6 Timetable for the planned move to competency-based training

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

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

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

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

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

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

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

Importantly, on-going and meaningful consultation with the jurisdictions will be required to ensure that any potential effect on the current workforce system is recognised and managed. For example, when a Trainee fails to reach the required standard they need additional time and careful support from the supervisors. If they continue to underperform and are obliged to repeat a training period, this also entails additional resources. RACS and its specialties have experience in managing Trainees who may be underperforming however, the numbers may increase in this new system.

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

Activity	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016+	Contingences and external factors
Research of international developments and world-best practice											
Involvement of specialty Boards, Examination Courts and committees in writing, reviewing, and revising materials											
Further definition of RACS competencies following an evaluation of modules and identifying that they did not adequately reflect progression through training											Continued development depends upon: ▪ Development of curriculum and validated assessment tools ▪ Training of Supervisors ▪ Validation research demonstrating that these process enhance/facilitate training
Redefinition of specialty specific modules – technical expertise; medical expertise; judgement – clinical decision making											
Rewriting of generic modules — non-technical modules											Dependent on the further definition of the RACS competencies
Aligning revised competencies with in-training assessment											
Development of specialty specific assessment matrix aligned with competencies											
Possible introduction of additional tools such as 360^0 to assess performance											
Aligning competencies with FEX											
Alignment of SSE and CE with appropriate competencies											
Revision of the generic SSE											
Introduction of revised generic SSE											The introduction of revised examinations and/ or examination processes will be phased to ensure that: ▪ no candidate is potentially disadvantaged and ▪ all candidates receive appropriate advanced notification of the changes
Development / review of speciality specific SSE											
Introduction of revised speciality specific SSE											
Evaluation of FEX to ascertain the extent to which elements of the examination are being addressed earlier in the program											
Trial of revised marking scheme for FEX											
Possible introduction of revised marking scheme for FEX											
Development of the policy and procedures for the Recognition of Prior Learning											

Activity	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016+	Contingences and external factors
SAT SET program for supervisors – Phase 1											▪ The introduction of CBT is contingent upon having trainers and supervisors who are skilled in the assessment and evaluation of competencies. ▪ CBT requires increased supervisor/trainer time in the workplace ▪ Negotiation and collaboration with JRs is required to achieve recognition of designated time and/or paid supervision
Introduction of workplace-based assessment processes such as Mini-CEX; DOPS; CBD; PBA for Trainees This is ongoing as Trainees progress – introducing different assessment tools to all levels of training at appropriate intervals and frequency											
SAT SET program for supervisors – Phase 2 Keeping Trainees on Track (KTOT)											
On-going evaluation of SET training program to ascertain effectiveness of training and identify; ▪ Additional competency training programs required ▪ Principles on which training time may be varied ▪ Where there may be scope for shortening training period											
The development of web based educational materials to support training and encompass non-technical competencies											Dependent on the introduction of the new e-learning system (2011)
Development of face-to-face courses for Trainees in the 'non-technical competencies'											Continued development depends upon: ▪ Access to funding ▪ Availability of Trainers ▪ Validation research demonstrating that these experiences enhance/facilitate training and can transpose to the clinical setting
Negotiating and collaborating with Jurisdictions to manage the risk of any adverse impact on workforce requirements and effect on employment conditions eg salary scale determinations											Continued involvement of JRs in College committees
Evaluation of selection processes to ascertain alignment between selection attributes and training competencies											

Appendix 7 Section 1 of the Interviewer Training Manual

1. Principles underpinning the SET selection processes

There are a number of nationally and internationally agreed principles which inform and underpin the conduct of the Surgical Education and Training (SET) selection processes. These include:

- Australian Medical Council (AMC) and Medical Council of New Zealand (MCNZ) accreditation principles
- The 'Brennan Principles' — Trainee Selection in Australian Medical Colleges, January 1998
- Decisions agreed by the surgical specialties at a selection workshop in June 2007
- The outcome of discussions and the consensus reached on selection, presented at a plenary session of the 13th Ottawa International Conference on Clinical Competence (Ozzawa) held in Melbourne on 6-8 March, 2008.
- Decisions agreed by the surgical specialties at a selection workshop in April 2009

1.1 AMC and MCNZ accreditation principles

- Selection processes must be compliant with relevant Australian and New Zealand laws and the principles of natural justice and procedural fairness.
- Selection processes must be conducted on a national or bi-national basis in Australia and New Zealand.

1.2 The Brennan Principles

In 1998 the College endorsed the 'Best Practice Framework for Trainee Selection' that subsequently became known as the 'Brennan Principles' which continue to underpin the College Trainee selection processes as follows:

- Selection processes must be merit based, free of bias and, to the greatest possible extent, quantifiable.
- Selection processes must be open to external scrutiny and conducted in an accountable manner using documented processes.
- The opportunity to apply for selection must be publicised in a manner which creates awareness of opportunity for all eligible applicants.
- Criteria in all of the tools must be related to objectives of the training program and the desired attributes of graduates.
- There is a clear statement of principles underpinning selection which should include aims – i.e. to select the best candidates, as well as to ensure that the processes are both legal and accountable.
- Eligibility and selection criteria should be clearly stated and published. As far as possible these criteria must be objective and quantifiable.
- Advertising should ensure that all eligible candidates (national or binational) are aware of the selection processes
- Limits to the numbers of training positions, whether these are quotas, or relating to the number of training positions, should be explicit and openly declared.
- Applications for training positions should be written in a standardised proforma.
- Referees' reports should be written in a standardised proforma with a view to achieving objectivity, comparability and quantification.
- The selection committee should be large enough to carry out the task and have the confidence of the candidate, the profession and the community.

- The selection committee should also be prepared to be held accountable for their decisions and to have their decisions and processes reviewed in other forums.
- Selection criteria should be objective and quantifiable to the greatest possible extent, they must also be documented and published.
- The interview should be objective and free of bias.
- Selection committees should score and rank candidates using the tools described.
- Applicants should be given an honest and frank appraisal of their standing in the eyes of those conducting the selection process.
- Selection process should be capable of standing external scrutiny. The selection processes should be valid and reliable with formal, regular, inclusive review of the selection process and evaluation.
- Records of proceedings should be kept which are sufficient to enable non-participants in the original selection to accurately re-construct processes and decisions.
- There should be a formal process for appealing decisions.

1.3 Selection of Surgical Trainees for SET (Agreed June 14, 2007)

- Selection process to comply with the Brennan principles.
- Selection through open competition using a merit-based process.
- Standardised on line application form for all nine specialties.
- Eligibility criteria justified against educational and clinical requirements.
- Selection based on structured referees' reports, structured curriculum vitae and semi-structured interview.
- Each selection tool to be made up of a list of scorable items, which relate to the RACS nine competencies and are common for all nine specialties.
- Scoring methodology standardised for each item within each selection tool.
- Short listing for interview to be based on minimum scores in each of the other two tools.
- Scoring of performance in the interview must be aligned to that normally expected at PGY2 level.
- Overall % weighting of tools: CVs 15 – 25%; referees reports 35 - 45%; interview 35 – 45%.

1.4 Principles of Selection — From the 2008 Ottawa Conference

(Agreed 5 March 2008)

1. **Eligibility criteria (long-listing)** for application to specialist surgical training should include generic and specialty specific components.

2. **Responsibility for selection** must involve trained members of the surgical profession and the agencies (including employers) responsible for the delivery of education and training.

3. **Selection** must aim to identify those doctors with the values, attitudes and aptitude required to become a competent surgeon.

4. **Selection methodology** must be predetermined, transparent, include a broad range of approaches to maximise validity and reliability, involve multiple raters, contain clear criteria for marking and allocate weighting for each tool which permits ranking of applicants.

5. **Potential for successful training** in a particular specialty program is the basis for selection and not the extent of prior knowledge, experience and skills in that specialty.

6. **Knowledge** is an essential base for clinical reasoning and judgment. The level of a candidate's knowledge at the extremes of performance is a good predictor of their future overall performance.

7. **Structured referees' reports** can provide credible information from surgeons, colleagues, other healthcare professionals, and employers based on their first hand experience of a doctor's performance in the working and learning environment.

8. **Structured curricula vitae** provide important verifiable biographical information on clinical experience, academic and other accomplishments.

9. **Structured interviews** should use questions which target specific competencies identified through job analysis, and yield important information not available from other selection tools.

10. **Early selection** into a surgical training program must be accompanied by clearly established grounds and methodology to ensure struggling or underperforming trainees do not progress unless competency deficiencies are rectified.

1.5 Summary of outcomes from the RACS Selection Workshop (Agreed April 16, 2009)

The Selection Workshop aimed to provide a paradigm to improve the efficiency and effectiveness of the Royal Australasian College of Surgeons (RACS) selection process. Some of the major points of discussion and agreement are presented in this paper.

1. What is involved in selection?

Selection to surgical training is a high stakes assessment. Refining the selection process involves regular review, updating and implementing improvements.

- Assessment of candidates for selection is different from assessment during training. Selection assessment aims to predict 'trainability'; assessors are judging candidates' *attributes* to determine their potential or aptitude for surgical training.
- Best practice is to identify selection attributes following analysis of what the "final product" (surgeon) should be. This is done through job analysis, such as that conducted by Professor Patterson in the UK. Trainees acquire *competence* during training and competencies are assessed in examinations and during training.
- Reliability of selection is increased when interviewers are trained.

2. CanMEDs and the RACS Competencies

The group was invited to look at CanMEDS afresh and to consider reviewing the 9 RACS Competencies in relation to selection.

Professor Patterson described 11 domains or attributes most, if not all, of which were relevant to surgery. If these were adopted by the College, the specialties could weight each of the attributes differently according to their perception of their relevance and importance to their specialty.

3. Selection tools

Professor Patterson suggested that the College consider the order in which the selection tools are used. She proposed using the most reliable tools early in the selection process: any "short-listing" should not rely on the less reliable tools.

Specialty boards were invited to consider using some selection tools to exclude or 'select out' unsuitable candidates. The group discussed how to discover, for example, behaviours such as repeated dishonesty or harassment or bullying.

4. Eligibility criteria

All eligibility criteria must be achievable at PGY2. The group was invited to review specialty-specific eligibility criteria, particularly recency of clinical requirements including the requirements for ICU and ED (for example, so those who were completing a PhD were not inappropriately disadvantaged).

The group considered the generic and specialty-specific eligibility requirements. There was discussion around compliance with the generic requirements, particularly regarding the identification of unsuitable applicants, e.g. should the College be responsible for conducting police checks, identifying unresolved issues with medical boards, and detecting mental illness that may compromise training. The group also considered requiring applicants to declare that there were no impediments to training, and to accept instant dismissal from SET if these are subsequently discovered.

5. Validity

Seven different types of validity were discussed: Faith Validity; Face Validity; Content Validity; Criterion Validity (Concurrent); Criterion Validity (Predictive); Incremental Validity and Construct Validity.

6. Shortlisting

Many specialties preferred to avoid shortlisting for interview. However, if shortlisting is required, for example due to large numbers of applicants, it should be done using the combined scores of the CV and the Referee Reports. The fairest methods recommended were either to set the cut-off score for selection by adding the CV and RR scores and adding a potentially perfect interview score, or to base it on historical evidence that such an applicant would have no chance of being successful.

7. CV 15% – 25%

- CV scoring must allow for PGY2 applicants to succeed in their application.
- Investigate the concept of scoring applicants' career progression / career trajectory in the CV: inclusion of this concept in the CV in all specialties received strong support.
- Investigate using a generic CV with its component sections weighted as each specialty deems appropriate. This also received strong support.

8. Referee Reports 35% - 45%

- The Referee Report is used to access expert judgements of referees who observe applicants daily over time. The Referee Report provides an opportunity for surgeons' observations to be included in the selection process.
- Consider including a Global Rating and an Open Comment section in the Referee Report, however do not gather information that cannot be scored or that will not be used in ranking applicants.
- Consider refining the Referee Reports to reflect attributes not competencies.
- The more Referee Reports gathered and used, the more reliable is the score.
- Referee Reports may be of less value than we thought – consider reducing the overall weighting of Referee Reports. There was mixed support for this.
- There may be advantages to using a common Referee Report if the specialties have discretion to weight the components differently.
- Consider the timing of the Referee Report in the selection process. Is it appropriate to use Referee Reports to shortlist applicants?
- Consider using Referee Reports to deselect applicants; this may require expanding the Referee Report to gather de-selection information and may be most appropriate to occur after the Interview i.e. at the end of the decision-making process.
- It is tempting to discard extreme Referee Reports but the information at the bottom may be crucial.

9. Interview 35% - 45%

- The group agreed to consider expanding the Interview to a *Selection Centre / Selection Stations* format.
- *Selection Centres* or *Selection Stations* comprise a multi-station format which may combine interviews with other assessment activities. Each station tests a combination of different attributes.
- Applicants should receive comprehensive information about the interview process prior to attending the selection centres/stations
- Where used, scenarios must be designed appropriately to assess the required aptitudes with questions pitched at the appropriate level of knowledge and experience. Scenarios could be non-clinical or even non-medical.
- Precise statements of the positive and negative indicators for scoring must be available to interviewers.
- Consider using CV and Referee Report material at one station (where that information is required) but not at other stations where they are not relevant to the domain(s) being tested, and may introduce bias. Applicants may bring sealed Referee Reports for discussion. Interviewer access to CV and Referee Reports should be on an "as required" basis, and only if required for the assessment of the specific domain.
- Consider using some generic inter-specialty stations with other specialty-specific stations. This may be more cost-effective for specialties.
- There are several logistical aspects to the interviews, the numbers of applicants being one. There is a danger of fatigue and consequent decrease in reliability when scheduling many interviews per day.

- A total minimum of half an hour of “contact time” per candidate is required for reliability – longer times are more reliable — over 90 minutes is preferable. This may be conducted over several stations.
- Interview validity increases with more stations, even when this means that there are fewer assessors per station (e.g. two stations with two assessors per station gives better exposure to the candidates than one station of four assessors).
- Consider the inclusion of non-surgeons (e.g. senior trainees, administrators) on some interview panels, depending on the attribute or domain being tested.
- Interviewers need training to avoid pitfalls such as bias or assessing ‘medical skills’ and previous achievements instead of assessing attributes.
- Interview notes should be factual statements, not judgements. Judgements are made on the basis of the notes.
- Each interviewer should determine a score independently.