ROYAL AUSTRALASIAN COLLEGE of SURGEONS

AMC ACCREDITATION
SURGICAL EDUCATION AND TRAINING
(SET) — 2007

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Executive Summary

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

Values

- Service and Professionalism
    - performing to and upholding the highest standards
- Integrity
    - upholding professional values
- Respect and Compassion
    - being sympathetic and empathetic
- Commitment and Diligence
    - being dedicated, doing one's best to deliver
- Collaboration and Teamwork
    - working together to achieve the best outcome

Surgical Education and Training (SET) is designed to improve the education and training experience for trainees, supervisors, and hospitals, whilst at the same time retaining the best of the existing surgical training programs.

Because the College aims to train surgeons to the level of a competent independently practising specialist — not a "basically" trained or "partly" trained practitioner — the focus of SET is to ensure that once trainees are selected into the program they are able to be trained to that level of competence wholly within their chosen surgical specialty.

Surgical specialties will be able to select the number of trainees required for the available accredited posts and these posts will ensure the delivery of the competencies required.

Those selected into any one of the nine programs will be able to complete the training program and progress into Fellowship following a clearly defined pathway in their discipline, provided they meet the educational requirements. It will also ensure that their entire training program will be under the guidance and direction of the surgical specialty into which they have been selected.

For supervisors and for hospitals it will mean that trainees' clinical placements or rotations, and assessments, will be directly aligned with their career goals, leading to improved efficiency and effectiveness of training. Supervisors will be provided with clear guidelines and training in order to carry out rigorous, early and comprehensive work-place assessment of competence. As a result, any trainee who is identified as unlikely to be able to successfully complete their training will be given career counselling on their professional options.

Community needs and workforce requirements

The College is cognisant of community needs and workforce requirements however our prime responsibility is to ensure quality and standards. To maintain the balance between these multiple expectations the College is very mindful of the resources, including appropriately accredited training positions and the support of supervisors, which are essential in the training of competent surgeons.

Support for the new program

SET has been approved by the College and all nine specialty disciplines. Trainees and jurisdictional stakeholders have been part of the consultative process.

The design of the program, the selection principles, the essential curricula, the in-training supervision and assessments and the preservation of the final Fellowship Examination have all been agreed.

Aims for introducing SET

- To improve the quality and efficiency of surgical education and training, through early selection into specialty training and reduction of the total time for completion of surgical training
- To focus on the development and achievement of surgical competencies rather than the time spent in training, or the number of patients managed
- To enhance surgical training through a greater emphasis on early skills training and assessment
- To use “simulation environments” to optimise training experiences
- To use clinical and learning resources more efficiently, through a flexible and relevant allocation of clinical opportunities
- To have a single selection process into SET for each of the nine specialties
- To achieve greater relevance of the early stages of training, particularly in the basic sciences
- To preserve those proven elements of current basic and specialist surgical training that are essential to the development of a competent surgeon
- To achieve an integrated holistic surgical education and training program for each specialty
- To implement adult learning principles
- To foster better coordination and interfacing into medical schools and prevocational training across the continuum of learning.

The SET program

SET incorporates the most advanced approaches to medical training and assessment selected from around the world and already validated.

The new SET program is based on principles of adult learning in a life-long continuum. It is focussed on the achievement of core competencies that correspond to the essential roles of a specialist surgeon. To this end the emphasis in SET will be on competency-based training and assessment.

Each of the nine surgical specialties have analysed their existing Specialist Surgical Training (SST) programs and identified new training experiences, as well as existing courses and examinations from within Basic Surgical Training (BST) which can be brought together in SET.

At this point there are no planned changes to their required competencies or the curriculum which they have defined for SST — which now become the latter years of their specialty training programs.

Future developments

The development of the SET program is very dynamic, which means that the information provided in this document is current at this time.

Some aspects of implementation (tools of in-training assessment, and the program for training and accreditation of supervisors) are under development and are on track for completion before SET commences in January 2008. Changes to the current BST examinations are also under development and will be implemented during 2008.

Whilst there are minimal changes to the selection processes which are being implemented in 2007, discussions have already begun as to how selection can become more standardised across the specialties in future years.

1. BACKGROUND

Aims of the College

The Royal Australasian College of Surgeons (the College; RACS) has been established for 8y years as the authoritative body for standards, training and continuing professional development as it relates to surgical practice in Australia and New Zealand.

A history of the College is attached to provide a context to its development. Further details are provided in the Mantle of Surgery available on the website.

Documentation:
A Brief History of the Royal Australasian College of Surgeons
Mantle of Surgery (Weblink)

The College is currently structured as a corporation registered with the Australian Securities and Investment Commission (Compliance Certificate). It produces Annual Reports that are distributed to all Fellows and Trainees, the last three years are attached. The activities of the College are reported broadly through the Activities Report.

Documentation:
ASIC Compliance Certificate. (available for reference at the College)
Annual Report 2005
Annual Report 2004Annual Report 2003Annual Activities Report, as at 31 December 2005

Interim Activities Report, as at 30 April 2006Interim Activities Report, as at 31 August 2006

The College is structured in line with its Articles of Association. Its activities are achieved through delegated authority and it's appointed Committee structure. The activities of the College are defined through policy and procedures approved by subcommittees and Council. The list and composition of all Committees are in the respective sections of the AMC submission.

Documentation:
Memorandum and Articles of Association
Royal Australasian College of Surgeons Delegations Manual (available for reference at the College)
List of policies currently approved (available for reference at the College)

The direction of the College is reviewed by the College Council three times a year through the College Council meeting cycle. Briefly the February Council reviews the activities of the previous year combined with acceptance of the Annual Accounts. The June Council establishes the direction of the College for the next 24 months by approving the senior operational document which is distributed to all Fellows and Trainees as the Strategic Plan.

Documentation:
Royal Australasian College of Surgeons Strategic Plan 2006-2008

The resources available to achieve this plan with its priorities and the funding sources are determined by October Council where the budget for the following financial year is approved (the College operates on a calendar financial year). Between these meetings the Executive Committee of Council meets monthly to ensure issues are being properly progressed.

Key Portfolios

There are four key portfolios of the College:

- Resources

- Relationships
- Education
- Fellowship

The core activities are described in the Strategic Plan.

Relationships with Specialist Societies

The Educational Portfolio is principally charged with the training of surgeons. The details of this follow under the broad headings of Competencies, Curricula, Assessment and Delivery. The College has a highly interactive relationship with thirteen Specialist Societies and Associations to deliver surgical training particularly for the nine specialties. The Specialist Societies may have a single nation or bi-national membership.

This relationship is legally defined within the attached Memorandum of Understanding and Service Agreement. The interaction between the College and specialty groups is robust and is substantially progressed in a number of forums including the Board of Specialist Surgical Training but also Meetings of the Presidents that now occur approximately three times a year. Through these meetings a common direction is determined and agreed.

Documentation:
Generic Memorandum of Understanding between the College and Specialist Societies.
Generic Service Agreement between the College and Specialist Societies

The dominant educational activities over the past two years have been the integration of the RACS competencies into the curriculum and the development, documentation and implementation of the new Surgical Education and Training (SET) program. Further details follow below.

Regulatory Environment

Audit – Internal / External

The regulatory environment for the College is complex. Corporate activities are monitored and reported under the Corporations Act 2001. All of this material is appropriately audited by a combination of Internal and External audit. This is available if requested.

AMC

The educational validity of the program is determined by AMC accreditation. The past report by the AMC is attached as are the last two years annual reports. The College benchmarks its activities internationally on a regular basis usually by visits of key Councillors and staff. Reports from these reviews are available.

Documentation:
AMC Report. (available for reference at the College)
Annual Report to the AMC 2005

Annual Report to the AMC 2004

ACCC

The College has also been authorised by the ACCC over the past five years. This is a complex process but effectively provides immunity to prosecution under the Trade Practices Act. The College has never behaved inappropriately under the Trade Practices Act. However a review by the ACCC established the transparency of our systems and made recommendations to further open our processes and actively involve members of the community and jurisdictional representatives. The ACCC Report, the ACCC Review Panels reports on Hospitals and Hospital Post Accreditations and Assessment of Overseas Trained Doctors are attached. The progress reports of the implementation of these recommendations are also attached.

Documentation:
ACCC Report. (Weblink)

ACCC Review of the Criteria for Accrediting Hospital Training Posts for Advanced Surgical Training and Hospitals for Basic Surgical Training (April 2005). (available for reference at the College)

ACCC Review of the Assessment of Overseas-Trained Surgeons (April 2005). (available for reference at the College)

Progress Report Review of the Criteria for Accrediting Hospital Training Posts for Advanced Surgical Training and Hospitals for Basic Surgical Training (November 2005). (available for reference at the College)

Progress Report - Review of the Assessment of Overseas-Trained Surgeons (November 2005). (available for reference at the College)

The College believes there has been much benefit to our training methodologies and significant reassurance to the community through this Authorisation. However due to the expense and the significant opportunity cost, the College has now withdrawn from the Authorisation. The final sections cease to have an impact from June 2007.

The publication of the activities report will be maintained, continuing to reflect the transparency of the College. This report details statistics on the College's activities in education, assessment and the surgical workforce. Education figures provided include details on Basic Surgical Trainees; Transitional Surgical Trainees (TST); and Specialist Surgical Trainees, with associated accredited Basic Surgical Training (BST hospitals and Specialist Surgical Training (SST) accredited hospital post listings (SET1+ as of 2008). New and Active Fellows and International Medical Graduates are also described.

Documentation:

ACCC News Release 14 December 2006. "ACCC Confirms changes to Surgeons Immunity". (Weblink)

Surgical Workforce and MTRP Report

The Surgical Workforce is a critical issue to the College and has resourced the Workforce Assessment Unit to measure, evaluate, plan and advocate for a sustainable surgical workforce. Over the last 18 months work has been completed on a range of projects including the *Census of the surgical workforce*. The purpose of the census was to detail the scope of work of Fellows of the College, track changes in working hours and work patterns (including reduced hours / retirement intentions), and gain a more accurate picture of the present and future requirements in regional, rural and remote locations. Other work that has been carried out includes external reporting including material for the Medical Training Review Panel annual report; data collection and analysis, a pilot S*urgical Job Advertisements* tracking study; *Mapping Access to Surgical Services in Australia,* consultations with Specialty Groups, a range of reports and presentations that examine the rural surgical workforce, *the NZ Surgical Needs Analysis Project* and projection modelling of surgical workforce and training requirements to 2016. The projection model will enable the College to be better equipped when interpreting recommendations proposed by external bodies including the National Health Workforce Secretariat, regional jurisdictions and the Australian Health Ministers' Advisory Council (AHMAC) health workforce advisory committees.

Documentation:

The Surgical Workforce 2005 (Published March 2005)MTRP report (Weblink)

2. COMPETENCIES

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

Based on the original CanMEDS material developed by the Royal College of Physicians and Surgeons of Canada (RCPSC) the College has defined 9 competencies which encompass the spectrum of the profession. Trainees and Fellows are required to demonstrate competence across all nine areas.

It is recognised that whilst the competencies are defined separately they are, in practice integrated into a holistic approach to the profession.

RACS Competencies

Surgical training encompasses nine competencies:

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

These attributes will be demonstrated through clinical skills, patient care, and professional judgement across five domains:

cognitive (acquisition and use of knowledge to recognise and solve real-life problems),

integrative (appraisal of investigative data against patient needs in clinical reasoning, manage complexity and uncertainty, application of scientific knowledge in practice),

psychomotor (procedural knowledge, technical skill, manual dexterity, and adaptability),

relational (the ability to communicate effectively, accountability, work with others, consultative, resolving), and

affective/moral (self-awareness, ethical, critically reflective, responsible, healthy, safe).

Documentation:
Definition of surgical competence (Weblink)

The nine RACS competencies have been accepted by all specialties as the framework for the development of their selection processes, curricula and assessments.

Relevance of RACS Competencies

Increasingly medical specialists, including surgeons, are expected by the communities they serve to be competent in all areas of their profession. The competency-based framework, with clear statements of required outcomes has become an important element in ensuring that trainees and Fellows of the College meet those expectations.

Drawing on the original, extensive social research which contributed to the development of the 7 CanMEDS (1996) roles and statements of competence, the College decided to add two more competencies which are very significant in surgery. Those two competencies are Technical Expertise and Judgement – Clinical Decision Making.

Detailed definition of the nine RACS Competencies

The College definition of competence is deliberately very broad — encompassing knowledge, skills and attitudes. For each competence there are a number of levels of expansion which together constitute the requisite demonstration of competence. For example, Technical Expertise has ‘outcomes' that a Trainee and/or surgeon can: safely and effectively perform appropriate surgical procedures, and demonstrate proficient and appropriate use of procedural skills both diagnostic and therapeutic.

Because these are still very broad statements, the next level of definition is of 'competency standards', which explain more clearly how the competence can be identified as well as the standard required. Again using Technical Expertise as an example, the 'competency standards' are:

- consistently demonstrate sound surgical skills
- demonstrate procedural knowledge and technical skill appropriate to the specialty and their level of experience
- demonstrate the manual dexterity required to carry out procedures
- adapt their skills in the context of each patient—each procedure
- maintain skills and learn new skills
- approach and carry out procedures with due attention to safety of patient, self, and others
- analyse their own clinical performance for continuous improvement

Using the same kind of framework, the non-technical competencies (e.g. communication; teamwork, professionalism, etc.) imply within them meanings of 'outcomes', which are demonstrated through 'competency standards'.

The responsibility for the detailed definition of the competencies has been shared between the College and the surgical specialties.

The modules for the six non-technical competencies have been developed by the College and are common to BST and all specialties.

- Collaboration
- Communication
- Heath Advocacy
- Management and Leadership
- Professionalism and Ethics
- Scholar and Teacher

The modules for the other three competencies have been developed mainly by the surgical specialties to specifically reflect the requirements of their specialty.

- Judgement – Clinical Decision Making
- Medical Expertise
- Technical Expertise

These modules are outlined in material from each of the specialties.

There is a separate module which covers the area of Medical Expertise and Judgement – Clinical Decision Making which is addressed in BST.

More detailed information about each of the competencies is available on-line and in the material from each of the specialties.

Cultural Competence

Cultural competence has not been identified as a separate competence. Rather it has been deliberately incorporated within the non-technical competencies such as Communication, Health Advocacy, and Professionalism and Ethics.

Assessment of competence in Surgical Training

The emphasis in surgical training is moving rapidly towards competency-based training and assessment rather than a traditional time-based program. The competencies now provide an integrating framework for planning and assessing surgical training.

There are three inter-related, and significant impacts of this change of emphasis. One is on the potential to reduce the duration of training. The second is that every Trainee within a specialty, regardless of their geographic location, is being training to the same defined outcomes. The third is to potentially reduce the time required by trainees to develop skills because their training program is more clearly defined.

It is acknowledged that many of the competency standards outlined for Technical Expertise are not different from those which every supervisor has previously expected of their trainees. The difference is that, as competency-based workplace assessment processes are implemented in the program that they will be more carefully monitored and assessed throughout training. A range of assessment tools, based on those which have already been validated by other Colleges and Educational Boards overseas, are being introduced (see Formative Assessment). During 2007 a training program for supervisors will be initiated to provide guidance on competency assessment (see Professional Development).

Competencies in the Cardiothoracic Surgery Program

Elaborating on the RACS competencies Cardiothoracic Surgery has defined the outcomes and competency standards required of a graduating Trainee. There are no plans to change the defined outcomes and competency standards for SET. However the Board does plan to introduce more workplace assessment of competency (see below).

Documentation:
Cardiothoracic Surgery statement of required competence (available for reference at the College)

Integrating competencies with curriculum content and assessment processes

i. Cardiothoracic Surgery have an assessment plan that ensures that each requirement and competency standards are assessed a number of times and with a range of tools. This plan reflects both the assessment processes that are currently being used, and forms a blue-print for the introduction of new, formative assessment tools.

Documentation:
Cardiothoracic Surgery assessment plan (available for reference at the College)

ii. The Cardiothoracic Surgery statement of competence is the frame for all assessment.

iii. In the revision of their in-training assessment forms, Cardiothoracic Surgery used each of the 'competency standards' as the definition of satisfactory performance. For example see the mid-term in-training assessment form.

Documentation:
Cardiothoracic Surgery assessment form

iv. The 12 core modules in Cardiothoracic Surgery are designed to integrate Medical Expertise; Judgement – Clinical Decision Making and Technical Expertise. These are available on the web with password access.

v. The College has developed modules for the non-technical competencies which are recognised as defining the standards in those areas for Cardiothoracic Surgery. These are available on the web with password access.

Documentation:
Cardiothoracic Surgery modules (Weblink)

vi. Medical expertise and Judgement - clinical decision making are the essential competencies which are assessed in the Fellowship Examination. Across the seven different exams that make up the Fellowship Examination some competency standards of Communication, Professionalism, Management and Leadership, and Scholarship are also assessed.

As set out in the Cardiothoracic Surgery assessment plan (see above) the non-technical competencies including cultural competence and attitude are assessed through the in-training assessment forms which are required mid-term and at the end of each rotation. This will be further enhanced with the introduction of additional workplace assessment tools.

During SET1 Trainees will be closely monitored to ensure that they are progressing in developing all areas of competence.

The planned introduction of a range of workplace assessment tools will enhance this process (see Cardiothoracic Surgery assessment plan and formative assessment).

Competencies in the General Surgery Program

General Surgery supports the holist development of a competent surgeon across the nine RACS competencies, as such they include both technical and non-technical competencies. However the detail of the 'competency standards' has been slightly modified to focus on General Surgery. Within the detail of the competency standards, cultural competence is a requirement in a number of competencies including Judgement, Communication, and Professionalism.

There are no plans to change the defined outcomes and competency standards for SET. However the Board does plan to introduce more workplace assessment of competency (see below)

Documentation:
General Surgery statement of competence (Weblink)

Integrating competencies with curriculum content and assessment

i. The General Surgery statement of competence is the frame for all assessment.

ii. General Surgery have an assessment plan that ensures that each requirement and competency standards are assessed a number of times and with a range of tools. This plan reflects both the assessment processes that are currently being used, and forms a blue-print for the introduction of new, formative assessment tools.

Documentation:
General Surgery assessment plan (see Attachment 2 in this document)

iii. In the revision of their in-training assessment forms, General Surgery used each of the 'competency standards' as the definition of satisfactory performance. For example see the mid-term in-training assessment form:

iv. The 12 core modules in General Surgery are designed to integrate Medical Expertise; Judgement – Clinical Decision Making and Technical Expertise. These are available on the web with password access.

v. The College has developed modules for the non-technical competencies which are recognised as defining the standards in those areas for General Surgery. These are available on the web with password access.

Documentation:
General Surgery Mid-term In-training Assessment formGeneral Surgery Modules (Weblink)

vi. Medical expertise and Judgement - clinical decision making are the essential competencies which are assessed in the Fellowship Examination. Across the seven different exams that make up the Fellowship Examination some competency standards of Communication, Professionalism, Management and Leadership, and Scholarship are also assessed.

Assessing competence

As set out in the General Surgery assessment plan (see above) the non-technical competencies including cultural competence and attitude are assessed through the in-training assessment forms which are required mid-term and at the end of each rotation. This will be further enhanced with the introduction of additional workplace assessment tools.

During SET1 Trainees will be closely monitored to ensure that they are progressing in developing all areas of competence.

The planned introduction of a range of workplace assessment tools will enhance this process (see General Surgery assessment plan and formative assessment below).

Competencies in the Neurosurgery Program

The overall objective of the Neurosurgery training program is to produce competent independent specialist neurosurgeons with the experience, knowledge, skills and attributes necessary to provide the communities, health systems and profession they serve with the highest standard of safe, ethical and comprehensive neurosurgical care and leadership.

The Board of Neurosurgery has a statement of competence for graduating trainees which covers each of the nine College competencies. The competencies have been further refined into specific learning outcomes at differing levels which are aligned with the syllabus modules and curriculum components.

Documentation:
Neurosurgery statement of competence (Weblink)

Integrating competencies with curriculum content and assessment

The learning outcomes, aligned with the overall objective and competencies, are delivered by a number of learning methods and opportunities as outlined in the curriculum including structured educational programs, skills courses, self directed learning and workplace hands on service learning and exploration. These areas are expanded upon in the appropriate sections of this submission.

Assessing competence

To assess the accomplishment of the learning outcomes multiple assessment tools and performance based standards are applied to determine the degree of progression towards the competencies and suitability to continue training. The Board has progression regulations, based on the performance standards, which outlines when trainees are eligible to progress, progress on probation, repeat a year of training or when dismissal will occur. This has been clearly articulated for transparency and consistency. These areas are expanded upon in the appropriate sections of this submission.

Proposed changes to the integration and assessment of competencies in the SET

The learning outcomes, learning methods and opportunities and assessment processes have been revised to identify those relevant to each year of the training program, including SET1.

Competencies in the Orthopaedic Surgery Program

It is envisaged that competencies for SET1 Trainees will be either (i) incorporated into; or (ii) devolved from the existent competency framework. It is anticipated that the assessment practices currently employed in SST will be retained in the new training years SET2 through SET5.

The Australian Orthopaedic Association (AOA) strongly supports the College's modification of the CanMEDS competencies. A statement of competence for graduating orthopaedic surgeons can be found in the AOA *Guide to Advanced Training in Orthopaedic Surgery* (Section 3, pp21-25).

To this end, the AOA has designed and implemented a process of quarterly assessment that evaluates the progress of each Trainee across the nine key areas of competence.

In order to accommodate the independent evolution of five Regional Training Programs and their corresponding “Bone Schools”, the statement of competence for graduating orthopaedic surgeons has been augmented by the development of 16 detailed curriculum modules. The curriculum modules set out the clinical, surgical and non-technical competencies that Orthopaedic Trainees are expected to have acquired before presenting for the Fellowship Examination. Each module is sub-divided into a sequence of related Topic Areas.

Each Regional Training Program rotates trainees through a variety of metropolitan and non-metropolitan Orthopaedic Units, with the intention of providing the Trainee with exposure to all major areas within the specialty. Every Trainee is assigned a nominated supervisor at the commencement of a rotation. Each hospital then selects one Trainee Supervisor to represent their accredited SST post(s) on the state RTC. This supervisor is known as the Training Co-ordinator and he or she takes overall responsibility for the management and administration of specialist orthopaedic training at their hospital.

Trainees are provided with formative feedback at three-monthly intervals. In consultation with other members of the Unit, the Nursing Unit Manager and the Operating Theatre Manager, the Training Co-ordinator prepares a Quarterly Assessment Report for each Orthopaedic Trainee at the hospital. The Quarterly Assessment Report (QAR) measures the Trainee’s achievement in the nine CanMEDS competency areas against a seven-point scale (where 1 = an unsatisfactory performance and 7 = an exceptional performance that exceeds expectations). It is a requirement of the assessment process that (i) the QAR is discussed fully with the Trainee prior to submission; and (ii) that the QAR is countersigned by the Trainee to indicate that the assessment outcome has been discussed with him/her.

In addition, trainees are required to complete an Orthopaedic Procedure Assessment Report every 6-months. This assessment focuses specifically on the development of surgical competence and assesses:

- pre-operative management;
- surgical technique, including skills related to (i) checking and care and (ii) technical aspects of the procedure; and
- post-operative care.

Documentation:

Competencies for Graduating Orthopaedic Surgeons (available for reference at the College)

AOA Quarterly Assessment Report (available for reference at the College)

AOA Orthopaedic Procedure Assessment Report (available for reference at the College)

AOA Guide to Advanced Training in Orthopaedic Surgery Section 3, pp21-25) (available for reference at the College)

Competencies in the Otolaryngology Head and Neck Surgery Program

Elaborating on the RACS competencies, Otolaryngology Head and Neck Surgery has defined the outcomes and competency standards required of a graduating Trainee. There are no plans to change the defined outcomes and competency standards for SET. However the Board does plan to introduce more workplace assessment of competency (see below).

Documentation: Otolaryngology Head and Neck Surgery statement of competence (Weblink)

Integrating competencies with curriculum content and assessment

i Otolaryngology Head and Neck Surgery have an assessment plan that ensures that each requirement and competency standards are assessed a number of times and with a range of tools. This plan reflects both the assessment processes that are currently being used, and forms a blue-print for the introduction of new, workplace assessment tools.

ii. The Otolaryngology Head and Neck Surgery statement of competence is the frame for all assessment.

iii. In the revision of their in-training assessment forms, Otolaryngology Head and Neck Surgery used each of the 'competency standards' as the definition of satisfactory performance.

iv. The 13 core modules in Otolaryngology Head and Neck Surgery are designed to integrate Medical Expertise; Judgement – Clinical Decision Making and Technical Expertise.

v. The College has developed modules for the non-technical competencies which are recognised as defining the standards in those areas for Otolaryngology Head and Neck Surgery.

vi. Medical expertise and Judgement - clinical decision making are the essential competencies which are assessed in the Fellowship Examination. Across the seven different exams that make up the Fellowship Examination some competency standards of Communication, Professionalism, Management and Leadership, and Scholarship are also assessed.

Assessing competence

As set out in the assessment plan (see above) the non-technical competencies including cultural competence and attitude are assessed through the in-training assessment forms which are required mid-term and at the end of each rotation. This will be further enhanced with the introduction of additional formative assessment tools.

During SET1 Trainees will be closely monitored to ensure that they are progressing in developing all areas of competence.

The planned introduction of a range of workplace assessment tools will enhance this process.

Competencies in the Paediatric Surgery Program

The Board of Paediatric Surgery supports the holistic development of a competent surgeon across the nine RACS competencies, as such they include both technical and non-technical competencies.

Assessing competence

Non-technical competencies including cultural competence and attitude are assessed through the in-training assessment forms which are required at the end of each rotation. The efforts displayed in performance in Critical Appraisal Tasks (CATs); Directed Online Group Studies (DOGS); and Registrar Annual Training Seminar (RATS) as well as the initiating of Procedure Based Assessments (PBAs) also reflects the attitude of the Trainee.

Planned changes in assessment of competence in SET

An overall assessment plan incorporating the nine competencies is in development.

During SET1 Trainees will be closely monitored to ensure that they are progressing in developing all areas of competence.

The planned introduction of a range of workplace assessment tools will enhance this process. SET1 Trainees will complete assessments every three months and must be assessed as satisfactory in each. The assessments will take the form of the Direct Observation of Procedures (DOPS), Procedure Based Assessments (PBAs), Mini-CEX and 360 Degree Forms.

The Generic Basic Sciences Examination will be conducted by the College in April and October each year, allowing trainees, once selected in July, three opportunities to sit the examination. Should a SET1 Trainee not pass the Basic Sciences Examination after three attempts, they will be placed on probation but allowed to progress into SET2, with training not accredited until the Trainee passes the examination. Should the Trainee fail the examination at the extra attempt, they will be automatically dismissed from the training program.

Paediatric Surgery specific questions from the current Basic Sciences Examination will be included in the Paediatric Anatomy and Paediatric Pathology Examinations.

Documentation:
Draft Paediatric Surgery Assessment Plan (available for reference at the College)

Paediatric Surgery as practised in posts approved for Specialist Surgical Training is defined on the College website as:

1. A detailed knowledge of those conditions recognised as belonging to General Paediatric Surgery including Paediatric Urology.
2. Less detailed knowledge of those conditions recognised as belonging to specialist areas within Paediatric Surgery.
3. General knowledge in adjunct areas of surgery, paediatric neonatology and anaesthesia.
4. Principles of surgical practice such as infection control, electrical and radiation safety, safety in the operating theatre, communication with families, rehabilitation and ethics.

Documentation:
Paediatric Surgery statement of competence (Weblink)
Paediatric Surgery statement of educational objectives (Weblink)

Integrating competencies with curriculum content and assessment

The nine core modules in Paediatric Surgery are designed to integrate Medical Expertise; Judgement – Clinical Decision Making and Technical Expertise.

In addition, the Board has adopted the generic College modules of Communication, Health Advocacy and Professionalism and Ethics as part of the Paediatric Surgery curriculum. All modules are currently undergoing a biennial review and will be available on the website (accessed via log-in and password) in the near future.

Competencies in the Plastic and Reconstructive Surgery Program

Based on the nine RACS competencies the Board of Plastic and Reconstructive Surgery has a statement of competence for graduating trainees that incorporate the nine RACS competencies. There are no plans to change the defined outcomes, competency standards, or assessment for SET.

Documentation:
Plastic and Reconstructive Surgery statement of required competence (Weblink)

Integrating competencies with curriculum content and assessment

Non-technical aspects of surgical practice are part of the Plastic and Reconstructive Surgery curriculum, area continually assessed, and formally assessed at the conclusion of each rotation.

Surgical Competencies are assessed continually, a formal assessment is conducted mid-rotation and at the conclusion of the rotation on the Board of Plastic and Reconstructive Surgery Professional Performance Assessment form. This assessment form assesses both surgical skill and knowledge, as well as decision making ability, patient management, patient communication, interaction with medical staff, interaction with nursing and other staff, teaching skills, patient assessment and communication to senior staff, and general attitude.

Documentation:
Plastic and Reconstructive Surgery assessment (.xls file)
Plastic and Reconstructive Surgery Professional Performance Assessment

Competencies in the Urology program

The Board of Urology has a set of specialty specific competencies based on the nine RACS competencies.

Documentation:
Matrix of Surgical Competencies in Urology (Weblink)

Integrating competencies with curriculum content and assessment

Responses to this question are outlined in sections on curriculum development and assessment.

Assessment in the non-technical competencies (including cultural competency and attitude)

Responses to this question are outlined in section on assessment.

Changes in assessment of competence in SET

Urology intends to introduce semi-structured in-training assessments (potentially mini CEX, CBD, DOPS) to assist in the progressive assessment and monitoring of competencies.

In co-operation with the College, Urology intends to review and redraft the standard in-training Trainee assessment form to reflect more closely the RACS competencies. These will be administered three monthly for all trainees, rather than the current six-monthly for senior trainees.

Competencies in the Vascular Surgery Program

Based on the nine RACS competencies the Board in Vascular Surgery has a 'Statement of required Competencies' for graduating trainees covering nine competencies.

This statement of required Competencies is in addition to the detailed curriculum modules which provide more detailed competency statements for each identified area.

There are no plans to change the defined outcomes and competency standards for SET. However the Board does plan to introduce more workplace assessment of competency (see below)

Documentation:
Vascular Surgery statement of required competence (Weblink)

Integrating competencies with curriculum content and assessment

i. The Board in Vascular Surgery has an assessment plan that ensures that each requirement and competency standards are assessed a number of times and with a range of tools. This plan reflects both the assessment processes that are currently being used, and forms a blue-print for the introduction of new, formative assessment tools.
ii. The Vascular Surgery statement of competence is the frame for all assessment.
iii. In the revision of their in-training assessment forms, Vascular Surgery used each of the 'competency standards' as the definition of satisfactory performance. For example see the mid-term evaluation form:

Documentation:
Vascular Surgery assessment plan (available for reference at the College)
Vascular Surgery Mid-term evaluation form

iv. The nine core modules in Vascular Surgery are available on the web. With password access.
v. The College has developed modules for the non-technical competencies which are recognised as defining the standards in those areas for Vascular Surgery. These are available on the web with password access.
vi. Medical expertise and Judgement - clinical decision making are the essential competencies which are assessed in the Fellowship Examination. Across the seven different exams that make up the Fellowship Examination some competency standards of Communication, Professionalism, Management and Leadership, and Scholarship are also assessed.

Documentation:
Vascular Surgery modules (Weblink)

Assessing competence

The non-technical competencies including cultural competence and attitude are assessed through the in-training assessment forms which are required mid-term and at the end of each rotation. This will be further enhanced with the introduction of additional formative assessment tools.

During SET1 Trainees will be closely monitored to ensure that they are progressing in developing all areas of competence.

The planned introduction of a range of workplace assessment tools will enhance this process.

3. CURRICULUM

The goal of Surgical Education and Training (SET) is to train surgeons to the point where they are competent to practice independently and safely and provide the highest standards of specialist care to their patients. The College continues to work with a number of Federal, State and Territory Government departments and working groups to review the goals of surgical education and training within the broad spectrum of delivery of services within the Australian health system. As trainees are located in various regions in a bi-national training program, the College utilises a combination of face to face, computer assisted and distance learning educational resources in a range of settings including hospitals, skills centres and universities.

The College has well-developed content and assessment for training. However, the aim of more recent curriculum development has been to develop clearly articulated learning objectives regarding what the Trainee should be able to do, and competencies necessary to practise as an independent surgical specialist in the Australian and New Zealand health systems. Therefore the focus has been on linking content with objectives and desired competencies and to appropriate assessment procedures.

Principles of Surgical Education

The College has incorporated the CanMEDS principles into its curricula and is collaborating with a number of organisations, including the AMC, and the Committee of Presidents of Medical Colleges to ensure that curricula meet required standards for quality assurance.

As well as competence, the curriculum for surgical training is based on the following interlinking beliefs about knowledge and learning (see concept map, Attachment 3).

- Curriculum is a process through which the elements of the teaching and learning are translated into practices
- Andragogy as a theory of adult learning, plus commitment to lifelong learning
- The traditional approach to training in surgery where an apprentice learning their skills from a master
- A view of learning, knowledge, and ways of knowing that encourages flexibility, critical reflection and independent research and enhances self-direction, discovery and problem-solving.

Documentation:
Curriculum in SET (see Attachment 3 in this document)
Principles of surgical education (Weblink)

Program Overview

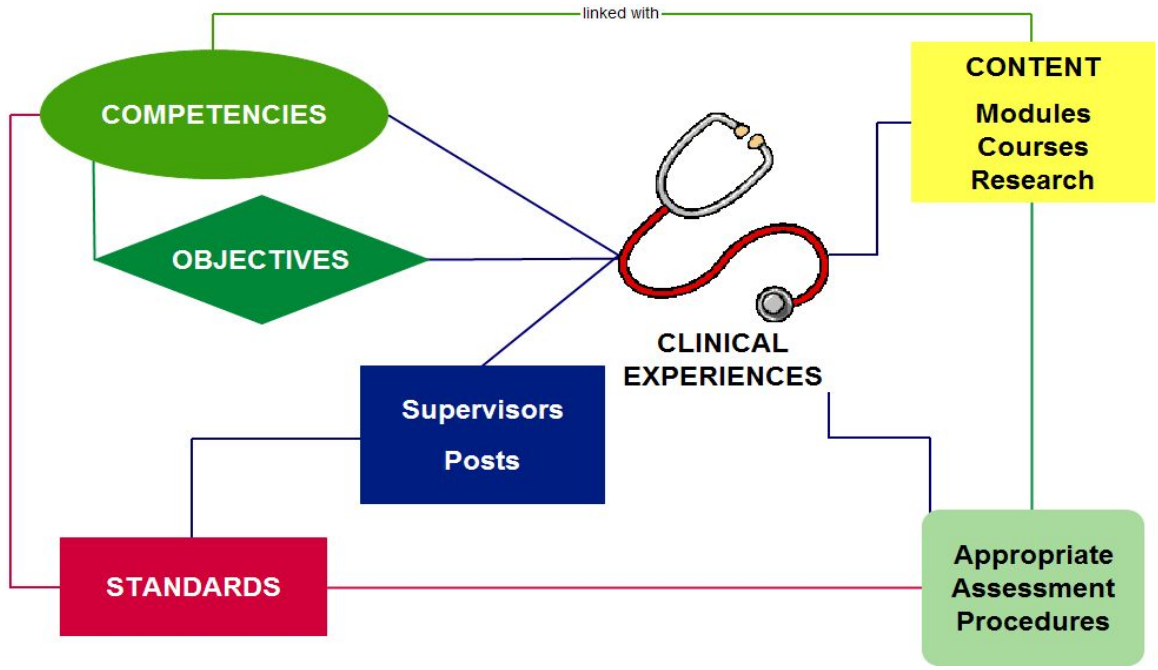
Specialist surgical training programs for SET are developed and supervised by the College, through the agency of the surgical boards and the regional surgical training committees.

All of the specialist surgical training programs in SET are for a minimum of five years with trainees being required to successfully complete every rotation, to fulfil the research requirement, and pass the Fellowship Examination.

SET is a combination of interconnecting and complimentary elements:

- Competencies (as outlined above)
- Clinical experiences
- Modules
- Courses
- Research
- On-line training resources
- Assessment – both formative and summative
- Surgical supervisors
- Accredited training posts

Below is a diagrammatical representation of the interconnectedness of the various components of surgical training.



Clinical Experiences

It is recognised that, for any Trainee, a single training post will not offer complete training. Several posts are usually required to obtain sufficiently wide experience. Such a combination of training posts constitutes a training program.

For each rotation specialty trainees are allocated to train in an accredited training position or post. It is the responsibility of the specialty boards to manage the allocation of trainees across the available posts to ensure that each Trainee gains the widest possible experience and achieve the required case-mix in line with the modules.

Modules

The modules have been developed by the College and Specialties to encompass and define all of the competencies — all of the knowledge, skills and attitudes which are required to be achieved by every Trainee. Within the modules the competencies are stated as specific outcomes or objectives, plus the standard at which those competencies are expected to be performed.

Because of the complexity and variety of the required training, in most specialties there is no pre-defined order or sequence for the completion of the modules. The area or areas that they focus on in a given rotation are defined by the work in the unit to which they are allocated.

Courses

The College offers five courses which have been developed over many years:

- Trainees in Basic Surgical Training (BST) were required to complete ASSET, CCrISP and EMST
- CLEAR and STATS were taken in either BST or Specialist Surgical Training (SST)

The courses are recommended to be taken in that sequence to correlate with trainees' increasing knowledge and clinical experience. In SET most of the specialties state that they will require their trainees to complete ASSET and CCrISP in SET1, with several also nominating EMST to be taken in either SET1 or SET2 (see Attachment 4).

Each course contributes to trainees' overall clinical knowledge and understanding in different ways. Participants are provided with mentoring and assessment of performance beyond the courses through feedback to their surgical supervisors identifying candidates with exceptional

abilities; those who failed the course, and those in between who require further development and guidance.

Documentation:
Basic Surgical Training Skills Courses (Weblink)

ASSET (Australian and New Zealand Surgical Skills Education and Training)

Currently the ASSET course is done in BST1. Four modules are undertaken over the three days of the Course:

- Skills in Open Surgery 1
- Skills in Open Surgery 2
- Musculoskeletal Injury, and
- Minimal Access Surgery

Currently this course is not assessed. Participation only is required.

There is a proposal to develop a Basic ASSET course which could be more readily available in future and could be completed in PreSET.

Documentation:
Course Book, DVD and training material (available for reference at the College)

CCrISP (Care of the Critically Ill Surgical Patient)

CCrISP focuses on the prevention of organ failure through clinical expertise and attention to clinical detail, offering a systematic approach to the assessment and management of these patients and their problems. The course stresses the importance of the individual doctor accepting responsibility for the coordination and management of the patient's care. The course features:

- simulated patient assessment
- clinical decision making
- communication issues (the ethics/medico-legal component has been largely replaced by the surgical ward round)
- analysis of data in critical care
- systems and protocol based learning

This course is assessed by contribution to the various sections and in a 45 minute simulated patient scenario.

Documentation:
Course Book and training material (available for reference at the College)

EMST (Early Management of Severe Trauma)

EMST is an intensive course in the management of injury victims in the first 1–2 hours following injury, with emphasis on life saving skills and systematic clinical approach. After completing the EMST course, a Trainee will be able to:

- demonstrate concepts and principles of primary and secondary patient assessment
- establish management priorities in a trauma situation
- initiate primary and secondary management of unstable patients
- demonstrate skills used in initial assessment and management

This course is assessed by participation in all sections of the course, demonstration of identified skills, a 40 question MCQ questionnaire, and a 15 minute simulated patient scenario.

Some specialties have nominated this course to be completed in SET1, and others in SET2.

Documentation:
Course Book and training material (available for reference at the College)

Critical Literature Evaluation and Research (CLEAR)

CLEAR is designed to provide tools to undertake critical appraisal of surgical literature and to assist surgeons in the conduct of clinical trials. Topics covered include:

- Guide to clinical epidemiology
- Framing clinical questions
- Randomised controlled trial
- Non randomised and uncontrolled studies
- Evidence based surgery
- Diagnostic and screening tests
- Statistical significance
- Searching the medical literature
- Decision analysis and cost effectiveness studies

Documentation:
Course Book and training material (available for reference at the College)

Statistics for Surgeons (STATS)

The aim of this workshop is to increase the conceptual understanding and practical skills in medical statistics as it is commonly applied to surgical clinical research, topics include: elementary and descriptive statistics such as the comparison of groups and small contingency tables, and specific intermediary topics such as logistic regression, survival analysis, meta-analysis, and the design of relational databases.

At the end of the Statistics workshop participants should be able to identify and manipulate common types of data, express and graph summaries of data, and they will have performed a selection of statistical tests and been exposed to the interpretation and expression of the results. STATS is typically attended by trainees who have previously completed CLEAR.

Documentation:
Course Book and training material (available for reference at the College)

Besides the College courses each specialty arranges their own training courses to compliment trainees' clinical experiences and module requirements. In some specialty courses are organised regionally with weekly meetings, others are organised as annual national or bi-national programs.

Skills Training in the Synthetic Environment

With the introduction of SET, the utilization of simulated training environments will have increasing relevance as simulation modalities and skills training is developed to augment the training program.

The Clinical Skills Advisory Group (CSAG) was inaugurated in April 2006 with the objective to work with speciality boards, skills laboratories and individual Fellows to define and develop clinical skills training as a component of the curriculum of surgical training and as part of the ongoing professional development of Fellows.
Since inception CSAG has:

- Defined the current use of skills courses in the surgical curriculum
- Assisted with the introduction of the Fundamentals of Laparoscopic Surgery (FLS) course to Australia
- Through a pilot program, FLS is being evaluated as a mandatory component of the General Surgery training program and it relevance to training in Urology defined.

Documentation:
Skills Training Matrix (available for reference at the College)
CSAG Terms of Reference

Research

An investigative project is mandatory for all surgical trainees prior to presenting for the Fellowship Examination. One or more of the following is required:

- presentation of a paper or poster display to a meeting for which abstracts are subject to review and selection
- a publication in a journal which referees all manuscripts
- a dissertation with a written review of a clinical problem, together with a critical literature review
- a period of full-time research
- a higher degree

The project should be certified as completed by the regional committee of the appropriate surgical board, and this certification forwarded to the board prior to the Trainee being accepted for presentation for the Fellowship Examination.

Trainees can apply for research leave, and/or to undertake a higher degree as part of their training program. A case for the crediting of a research program as a component of a specialist surgical training program must be lodged and approved, normally in advance, by the specialty board.

The College offers a number of opportunities for trainees who are wishing to do research contributing to a higher degree, or to travel to further their training or research. The Board of Surgical Research of the College Council is responsible for assessing applications for Fellowships and scholarships.

Documentation:
Scholarship programs (Weblink)

On-Line Training Resources

The College website and/or specialty websites function as timely sources of information and communication, providing clear indications of what is expected of trainees during and on completion of the program. This includes information on program content (modules), assessment requirements and proforma, plus significant dates. Several of the specialties are developing the resources to support on-line logbooks.

Besides the on-line resources that each of the specialties have developed for their trainees, there are substantial resources that have been developed for BST. These were designed for trainees to learn and apply the basic sciences of surgery. Case studies, examples of practice multiple choice questions and discussion forums are presented on the College website, complementing trainees' in-depth reading and study of basic sciences. Trainees are encouraged to use this material as a flexible, self-directed learning resource to be accessed in any order at convenient times.

At this point there has been no discussion about how these might be best utilised by SET Trainees.

Online Training comprises a number of interactive components:

- MCQs - Practice bank
- Case studies
- Resource units
- Discussion forum
- Image bank

Access to online training is restricted by password to trainees and Fellows of the College.

The Case studies also provide opportunities for trainees to practise applying different kinds of knowledge to clinical situations – to use basic sciences, patient history and the results of

physical examination and investigation to build judgement, make diagnoses, make clinical decisions and recommend treatment. Clinical scenarios are presented in a format that encourages trainees to apply their knowledge as they progress sequentially through a number of stages of unfolding information. Trainees are challenged at each stage with questions and discussion points.

In the *Practice Examination Bank* trainees can practise answering multiple choice questions online to prepare for the Basic Science Examination. There are some 2000 questions in the Bank which is used extensively by trainees. The Practice Bank provides trainees with feedback including: information on their performance, answers and explanations. This allows trainees to self-correct their responses.

The Discussion Forum

BST Trainees have access to an on-line discussion forum in which they can ask questions about their training program and talk to each other about their training issues. This Forum is monitor by College staff.

Documentation:

BST on-line resources (Weblink)

Assessment

Both the formal formative and summative assessment requirements are linked to the module content and the competencies. Trainees are required to demonstrate satisfactory performance in all formal assessments throughout their training.

Surgical Supervisors

The support of the surgical supervisors is central to the clinical program. All hospitals with accredited specialist surgical training programs have hospital supervisors of surgical training and specialty supervisors of training approved by the College, and these Fellows of the College oversee the Trainee's clinical development.

Accredited Training Posts

The specialty training boards monitor the quality and outcomes of training in each post for SST. They do this through their regular hospital accreditation processes and also through information drawn from trainees' logbooks and in some specialties the Trainee Evaluation processes.

Posts are only accredited when they are recognised as being able to offer appropriate training opportunities including case load, case mix and supervision. This process will continue for training posts for SET2^{+}.

SET1 Trainees will complete clinical placements in hospitals accredited for training. Specialty Boards will allocate trainees to accredited hospitals in the same way as they now do in allocating SST Trainees to accredited posts. Within the hospital the Trainee will nominate their preferred rotations, and the hospitals will arrange the rotations in consultation with the College when necessary (as is done for BSTs) (see Accreditation of positions for SET1 in Section 4).

Documentation:

Curriculum in Specialist surgical Training (Weblink)

Clinical placements, Supervisors and Accredited Training Posts (Weblink)

Research opportunities in Specialist Surgical Training (Weblink)

Cardiothoracic Surgery Curriculum

The SET program in Cardiothoracic Surgery is six years in duration with 1 of these years being devoted to experience in General Surgery. The existing training program will increasingly be focused on areas that complement basic and specialist cardiothoracic training in the new SET program.

- The first year will be a basic cardiothoracic surgical year known as SET1, and will include cardiology, trauma medicine, and intensive care (see Attachment 4)
- SET2 will be in General Surgery (2X26 week terms of either: Trauma [rural or specialised city trauma hospital]; Vascular Surgery; Upper GI surgery)
- Four years Cardiothoracic training

The Board of Cardiothoracic Surgery will liaise with the Board of General Surgery to ensure that specialist trainees in Cardiothoracic Surgery receive a suitable experience in General Surgery.

Specialist Trainees in General Surgery may apply for selection into specialist training in Cardiothoracic Surgery during the first three years of their General Surgery training or upon completion of their FRACS in General Surgery. Time already spent in specialist General Surgery training will be taken into consideration when planning the General Surgical component of the Trainees Cardiothoracic Surgery training program.

Trainees having completed the FRACS in General Surgery will be required to do four years of specialist training in Cardiothoracic Surgery.

Documentation:
The Cardiothoracic Surgery Program (Weblink)

Training in Paediatric Cardiac Surgery

The Board of Cardiothoracic Surgery considers that credentialing in Paediatric Cardiac Surgery can only be achieved after post-fellowship training.

The Board would encourage trainees to rotate through one of the hospitals offering Paediatric Cardiac Surgery (Royal Children's Hospital in Melbourne, Westmead Children's Hospital, Royal Perth Hospital - on rotation to Princess Margaret Hospital and Prince Charles Hospital) for 6 months. This would preferably be in the second or third year of Cardiothoracic Surgery training.

Should a Trainee spend 6 months in a Paediatric Cardiac Surgery post, then the criteria for minimal operative experience would be reduced by half for year two or three as appropriate.

Ensuring Trainees attain the widest possible experience in Cardiothoracic Surgery

Trainees cannot spend more than two years in any one unit. All training units have a varied mix of experience and by ensuring six-monthly review of logbook data and assessment forms trainees are provided with feedback identifying areas of deficiency. Consequently recommendations to spend time in different training units that may allow those deficiencies to be corrected.

Documentation:
Case mix and minimum operative experience (Weblink)
Training placements (Weblink)

Integrating curriculum components

Clinical experience is the core of the training program and it is during this experience that the knowledge, skills and attitudes that are articulated in the nine RACS competencies are developed and assessed. The modules, courses and examinations compliment this process by explicitly defining what is required, providing a planned learning context, and establishing the required standards.

During the six years of training in Cardiothoracic Surgery Trainees are employed in accredited hospitals where they are required to participate fully in the professional life of a surgeon. During all of this time they are under the supervision of and accredited supervisor. This apprenticeship training creates an environment where the trainees are constantly required to use and hone all

of their knowledge, skills and attitudes as they work with patients, colleagues and other professionals. It is in the Trainee's performance in the clinical environment that requires the integration of all of the curriculum elements.

Clinical experience

Clinical Experience for SET1

Trainees will need to achieve the clinical and operative competencies as defined in the SET1 curriculum. To ensure that SET1 Trainees are able to meet the required standards, it is planned that Cardiothoracic Surgery will introduce workplace assessment requirements for SET1 Trainees. Further workplace assessment will be introduced in subsequent years (see Assessment plan above, and Formative assessment below).

Clinical Experience for SET3+

Each of the 12 core modules define the clinical experiences required in that sub-disciplines including the operative management skills in that area which are essential for all trainees, and those that are desirable.

Because of the diversity of the program, primary operator experience will vary depending upon the year of training, the nature of the six-month rotation, and in particular the nature and complexity of the surgery undertaken in that training unit. It will also vary depending upon the inherent skills and ability of the individual Trainee.

It is the responsibility of the Board of Cardiothoracic Surgery, through the supervisors of surgical training and the individual surgeon trainers, to maximise the training experience for each Trainee. It is therefore considered imperative that the surgical trainer in the first instance duly instructs the Trainee in surgical technique and the specific requirements of individual operations, initially with the Trainee as assistant, but rapidly progressing the Trainee to a supervised primary operator role for part and then ultimately all of the operation.

The minimum operative experience to be gained in the six years is 800 major cases, with minimum primary operator experience published on the web. Unsatisfactory performance as a primary operator should be identified by the supervisor of surgical training, appropriate enquiry undertaken, and a report forwarded to the board for further discussion.

Documentation:
Case mix and minimum operative experience (Weblink)
Training placements (Weblink)
Placement of specialist Trainees (Weblink)

Modules

The 12 core modules in Cardiothoracic Surgery are designed to integrate Medical Expertise; Judgement – Clinical Decision Making and Technical Expertise. In each module the essential and desirable operative management competencies have been stated. There are no plans to change the modules for SET.

- Coronary Artery Disease
- Trachea and Bronchi
- Oesophagus
- Lungs and Pleura
- Paediatric Cardiac Surgery
- Heart/Failure Transplantation
- Mediastinum and Pericardium
- Electrophysiology
- Lung Transplantation
- Chest Wall
- Thoracic Trauma
- Valvular Disease

The generic modules for the non-technical competencies are recognised as defining the standards in those areas for Cardiothoracic Surgery. They each include a self-assessment component.

- Collaboration
- Communication
- Health Advocacy
- Management and Leadership
- Medical Expertise
- Professionalism and Ethics

These are all available on the web with password access.

Documentation:
Cardiothoracic Surgery modules (Weblink)

Courses

Trainees must satisfactorily complete the ASSET and CCrISP courses during SET1. Trainees must satisfactorily complete the EMST course during SET2.

In 2007, a Cardiothoracic Surgery inaugural training course will be available for all Cardiothoracic Trainees in Australia and New Zealand. This annual course will be compulsory for trainees who are in the second and third years of their Cardiothoracic training component and optional for those who are in their first or 4th years.

Trainees in their second and third years will be expected to give one to two presentations on topics that the Board have designated as core curriculum. Over a four year period, the Board will rotate through various topics that are believed to be core curriculum.

In addition to this, Cardiothoracic surgeons are encouraged to attend the College Annual Scientific Congress.

Also the ASCTS holds a scientific meeting annually with invited international experts. The meeting convened by the science and education committee also conducts a satellite program for trainees. This usually includes a workshop and tutorials which involve the overseas experts. The meeting also has a dedicated section for trainees to present scientific work or research for which there is a coveted award.

Research

All trainees in Cardiothoracic Surgery must have completed the mandatory research requirement prior to applying to present for the Fellowship Examination. If the Supervisor of training is certifying the completion of the Research Requirement on the Logbook, documentation proving this completion must be attached and sent to the Executive Officer.

A period of full time research during the Specialist Cardiothoracic Surgical Training Program is strongly supported. The Board in Cardiothoracic Surgery, in its own right, may prospectively grant exemption from 1 year of clinical training in lieu of satisfactory completion of full time research leading to the acquisition of an MD or PhD. Such exemption does not reduce the minimum clinical requirement. The minimal clinical requirements must be completed before permission is granted for sitting the Fellowship Examination. Trainees on research leave are required to provide both a satisfactory assessment report from their research supervisor, and a research progress report for each six month of the research period.

Documentation:
Research in Cardiothoracic Surgery (Weblink)

General Surgery Curriculum

The General Surgery SET program is five years. Trainees must accept the varying rotations assigned to them by the Regional Subcommittee.

In SET1 Trainees will do terms that are in general surgery and surgery in general. There is a mandatory requirement of at least 26 weeks in general surgical training, where possible this term will be in a general surgical term or acute surgical unit. There will be a wide variation in the type of clinical work done in these terms, but all address the core competencies required (see Attachment 4).

In SET2^{+} Trainees are required to demonstrate satisfactory performance in eight X six month rotations in approved Specialist General Surgery Training Posts.

Because of the diversity of the General Surgery program it has not been developed on a model of yearly progress. Instead the curriculum has been developed around the 12 core sub-disciplines.

Documentation:
General Surgery regulations

Ensuring Trainees attain the widest possible experience in General Surgery

To ensure that trainees gain the widest possible experience across the sub-disciplines the Board of General Surgery allocate trainees for each rotation to specific surgical units. The areas of surgery performed in General Surgery posts have a wide variation in case mix. Some posts have a broad mix of general surgery and these tend to be in the provincial towns and Metropolitan hospitals. Others have very specific areas of sub-speciality to which the Trainee is exposed. These posts tend to be in the larger teaching hospitals. The specific areas may include; colorectal, upper gastro-intestinal, breast endocrine, trauma or vascular.

The allocation of trainees to posts is organised in the Regions by either the Regional Board (South Australia and Western Australia) or within the specific rotation (NSW, Victoria, Queensland and New Zealand). The rotations are organised to provide broad, balanced experience. In order to monitor this more effectively the Board in General Surgery is developing a scoring system for each post. Points are allocated according to the case mix of the post with a total of 10 points being the maximum allocated. A post with a broad General surgery experience will be awarded 10 points for General Surgery, while, for example, a post with a predominance of colorectal experience may be awarded eight points for colorectal and two points for General Surgery. Each Trainee will need to have accrued the minimum number of points in each area by the completion of their 8th SST rotation in General Surgery. The points system is a guide for Supervisors to ensure there is a balanced program for each Trainee.

Currently the system is being piloted in South Australia with a view to commencing a pilot in some other rotations during 2006. There shall be regular reviews and updates. Once the system is proven to be functional it shall be introduced across the whole General Surgery program. There are 2components:

1. The points system as mentioned above that is still being piloted.
2. The current process of quinquennial inspections.

Documentation:

- General Surgery regulations
- Outline of the scoring system for each post being piloted in SA (available for reference at the College)
- Recent reports from hospital inspections in Vic/Tas, SA, WA and Hong Kong, submitted to demonstrate the process for the assessment and inspections (available for reference at the College)

Integrating the curriculum components

Clinical experience is the core of the training program and it is during this experience that the knowledge, skills and attitudes that are articulated in the nine RACS competencies are developed and assessed. The modules, courses and examinations compliment this process by explicitly defining what is required, providing a planned learning context, and establishing the required standards.

During the five years of training in General Surgery Trainees are employed in accredited hospitals where they are required to participate fully in the professional life of a surgeon. During all of this time they are under the supervision of and accredited supervisor. This apprenticeship training creates an environment where the trainees are constantly required to use and hone all of their knowledge, skills and attitudes as they work with patients, colleagues and other professionals. It is in the Trainee's performance in the clinical environment that requires the integration of all of the curriculum elements.

Clinical experience

Each of the 12 core modules define the clinical experiences required in that sub-disciplines including the operative management skills in that area which are essential for all trainees, and those that are desirable.

SET1 Trainees will need to achieve the clinical and operative competencies as defined in the SET1 curriculum. To ensure that SET1 Trainees are able to meet the required standards, it is planned that General Surgery will introduce workplace assessment requirements for SET1 Trainees. Further workplace assessment will be introduced in subsequent years (see Assessment plan above, and Formative assessment below).

Because of the diversity of the program, primary operator experience will vary depending upon the year of training, the nature of the six-month rotation, and in particular the nature and complexity of the surgery undertaken in that training unit. It will also vary depending upon the inherent skills and ability of the individual Trainee.

It is the responsibility of the Board of General Surgery, through the regional board, supervisors of surgical training and the individual surgeon trainers, to maximise the training experience for each Trainee. It is therefore considered imperative that the surgical trainer in the first instance duly instructs the Trainee in surgical technique and the specific requirements of individual operations, initially with the Trainee as assistant, but rapidly progressing the Trainee to a supervised primary operator role for part and then ultimately all of the operation.

Currently the minimum operative experience to be gained in the 4 years of the SST program is 800 major cases, with minimum primary operator experience as follows:

First 6 months:	20%
Second 6 months:	25%
Third 6 months:	30%
4th 6 months:	40%
Fifth 6 months:	50%
6th 6 months:	50%
7th 6 months	60%
8h 6 months	60%

This is yet to be reviewed for SET.

Within the operative experience requirements there is specific gastrointestinal endoscopy requirement for General Surgery which are as stipulated by the Conjoint Committee for Endoscopy Training. Currently that is 200 supervised unassisted upper gastrointestinal endoscopies and 100 supervised unassisted total colonoscopies in intact colons, with 25 supervised polypectomies. SET1 General Surgery Trainees will be registered with the conjoint committee in endoscopy training. Although they may not get exposure in endoscopy during SET1, any experience shall be accredited for the conjoint committee.

Unsatisfactory performance as a primary operator should be identified by the supervisor of surgical training, appropriate enquiry undertaken, and a report forwarded to the regional subcommittee of the board for further discussion.

Documentation:
General Surgery regulations

Modules

The 12 core modules in General Surgery are designed to integrate Medical Expertise; Judgement – Clinical Decision Making and Technical Expertise. In each module the essential and desirable operative management competencies have been stated. There are no plans to change the modules for SET.

- Abdominal Wall and Retroperit1um
- Breast
- Colorectal
- Emergency
- Endocrine
- Head and Neck
- Peripheral Arterial and Venous
- Sepsis and the Critically Ill Patient
- Skin and Soft Tissue
- Small Bowel
- Trauma
- Upper GI-HPB

The generic modules for the non-technical competencies are recognised as defining the standards in those areas for General Surgery. They each include a self-assessment component.

- Collaboration
- Communication
- Health Advocacy
- Management and Leadership
- Medical Expertise
- Professionalism and Ethics

These are all available on the web with password access.

Documentation: General Surgery modules (Weblink)

Courses

SET Trainees in General Surgery will be required to complete ASSET (during SET1), and CCrISP, CLEAR, and EMST by the end of SET2. Once it is able to be delivered to all trainees a satisfactory rating in the SAGES course will also be required prior to advancement to SET3. (See Attachment 4).

The program of weekly workshops organised by the Regional Boards for SST Trainees will continue in SET. The program of the workshops is organised so that over period of 3 years all of the material in the modules is covered. Attendance at these workshops is considered essential, however, due to work commitments and rotations out side of the major cities mandatory ascendance is impossible to organise. To that end NSW regional board has developed a system of recording the meetings. A DVD is made that contains the video of the presentations and discussion, the PowerPoint presentation given by the presented and other documentation, literature and references relevant to the topic. These DVDs are then distributed to all trainees in NSW. Currently Boards in some other regions are looking into a similar program. It is hoped that in the next two years, three to four sets of DVDs shall be produced and these shall be distributed to all trainees or made available on the web. Each workshop focuses on a specific topic. Trainees are allocated a topic to research and present to their peers.

In some regions the Trainee presentations are recorded and work is currently being done to publish these presentations on the web so that all trainees, in all regions, will have access to that material.

The Regional Boards also arrange examination preparation workshops which provide trainees who are preparing for the Fellowship Examination the opportunity to practice answering the different kinds of questions. Attendance at these workshops is voluntary. These workshops, programs vary from each region. They are organised by the regional board and are specific for that region. What each region does can be obtained from the relevant regional boards. In NSW there is a three week pre-examination course that is organised across all the Sydney teaching

hospitals. Although it is not mandatory, all trainees coming to the exams enrol and attend the course.

Documentation:
General Surgery regional courses — NSW
General Surgery regional courses — SA
General Surgery regional courses – Victoria/Tasmania
General Surgery Trainee presentations — Queensland

Research

All trainees in General Surgery must have completed the mandatory research requirement prior to applying to present for the Fellowship Examination. If the Supervisor of training is certifying the completion of the Research Requirement on the Logbook, documentation proving this completion must be attached and sent to the Regional office.

A period of full time research during the Specialist General Surgical Training Program is strongly supported. The Board in General Surgery, in its own right, or on the advice of the appropriate Regional Training Board may prospectively grant exemption from 1 year of clinical training in lieu of satisfactory completion of full time research leading to the acquisition of an MD or PhD. Such exemption does not reduce the minimum clinical requirement. The minimal clinical requirements must be completed before permission is granted for sitting the Fellowship Examination. Trainees on research leave are required to provide both a satisfactory assessment report from their research supervisor and a research progress report for each 6 month of the research period.

Documentation:
General Surgery research requirements

Neurosurgery Curriculum

The SET program for Neurosurgery has been structured on a standard six year sequential curriculum to facilitate the cumulative acquisition of the experience, knowledge, skills and attributes aligned with the overall program objective. The minimum duration of the program may be decreased in accordance with the Board regulations for recognition of prior learning or increased for any reason in accordance with the regulations.

Five years of the SET program will be accredited clinical training years including SET1 which is a basic neurosurgical training year designed as a foundation year and SET2, SET3, SET5 and SET6 inclusive which are focused on specialist neurosurgical training increasing in complexity as the trainee assumes more responsibility and builds on the foundational experience, knowledge skills and attributes towards the required level of competence. One year of the SET program, SET4, will remain as a compulsory research year designed to provide trainees with the necessary skills and experience to critically appraise new trends in surgery and contribute to the development, dissemination, application and translation of new medical knowledge and practices relevant to neurosurgery.

The detailed syllabus modules of the curriculum, which provide specific learning outcomes for each identified area of neurosurgical practice, are structured in levels designed to correspond with the trainees continued development of the relevant skills and knowledge commencing from a basic level and increasing in difficulty to the level of competence required in an independent neurosurgical consultant.

The learning outcomes are delivered by a number of learning methods and opportunities as outlined in the curriculum. To assess the accomplishment of the learning outcomes multiple assessment tools and performance based standards are applied to determine the degree of progression towards the competencies and suitability to continue training.

The curriculum components and performance standards for SET2 are:

i. Satisfactorily complete two (2) six month clinical training rotations in accredited neurosurgical training positions as allocated by the Board; and
ii. Satisfactorily participate in a minimum 100 major neurosurgical procedures during each six month clinical training rotation; and
iii. Satisfactorily complete the EMST Course; and
iv. Satisfactorily complete the Neurosurgical Anatomy Examination; and
v. Satisfactorily complete two compulsory Trainee Seminars; and
vi. Satisfactorily complete three core workplace competency assessments.

These are aligned with the first clinical year of the current training program. The only significant change is the addition of the EMST course. It is proposed that the Neurosurgical Anatomy Examination will be undertaken by current first year trainees during 2008, instead of 2007 as this will be the first time the Examination will be delivered.

The curriculum components and performance standards for SET3 are:

i. Satisfactorily complete two (2) six month rotations in accredited neurosurgical clinical rotations as allocated by the Board; and
ii. Satisfactorily participate in a minimum 100 major neurosurgical procedures during each six month rotation; and
iii. Satisfactorily complete two Neurosurgical Trainee Seminars; and
iv. Satisfactorily complete four core workplace competency assessments.

These are aligned with the second clinical year of the current training program with no significant changes.

The curriculum components and performance standards for SET4 (the research year) are:

i. Satisfactorily complete two (2) six month rotations in approved research activities; and
ii. Satisfactorily complete two Neurosurgical Trainee Seminars.

These are aligned with the current research / elective year with the exception that the timing of the research year was not previously aligned with a particular year and with an increased focus on research by removing the elective activities. Undertaking an elective is still an option at the discretion of the Board. Prospective approval of the planned activities is required.

The curriculum components and performance standards for SET5 are:

i. Satisfactorily complete two (2) six month rotations in accredited neurosurgical clinical rotations as allocated by the Board; and
ii. Satisfactorily participate in a minimum 100 major neurosurgical procedures during each six month rotation; and
iii. Satisfactorily complete two Neurosurgical Trainee Seminars; and
iv. Satisfactorily complete four core workplace competency assessments; and
v. Satisfactorily complete the research requirement.

These are aligned with the third clinical year of the current training program with no significant changes.

The curriculum components and performance standards for SET 6 are:

i. Satisfactorily complete two (2) six month rotations in accredited neurosurgical clinical rotations as allocated; and
ii. Satisfactorily participate in a minimum 100 major neurosurgical procedures during each six month rotation; and
iii. Satisfactorily complete one Neurosurgical Trainee Seminar; and
iv. Satisfactorily complete two elective workplace competency assessments; and
v. Satisfactorily participate in a minimum of 50 major paediatric neurosurgical procedures during accredited clinical rotations approved for paediatric experience; and
vi. Satisfactorily complete the College Fellowship Examination in Neurosurgery.

These are aligned with the fourth and final clinical year of the current training program. The paediatric operative experience does not necessarily have to be completed during SET6 but must be completed at some point in training prior to the end of SET6. It was previously a requirement that trainees had to attend two Neurosurgical Trainee Seminars. This has now been reduced to one to allow trainees preparing for the Fellowship Examination to concentrate on their studies.

The Board has progression regulations, based on the assessed outcome of the performance standards, which outlines when trainees are eligible to progress, progress on probation, repeat a year of training or when dismissal will occur. This has been clearly articulated for transparency and consistency. These areas are as outlined in the assessment section of this submission.

Ensuring that Trainees attain the widest possible experience in Neurosurgery

During the SET program trainees in SET2^{+} rotate between hospital units with no more than two years of training accredited in one training unit. This requirement is in recognition that each surgical unit has its own profile for patient case mixes, supervision, staffing levels, working requirements for trainees and equipment. Exposure to varied working environments is considered essential to provide trainees with the widest possible experience in the practice of neurosurgery. In allocating trainees to training positions consideration is given to competencies where the trainee may require further development or exposure and identifying training positions which best meet those needs.

The Board of Neurosurgery has comprehensive regulations for the accreditation of training positions. The criteria are focused on ensuring that the training positions provide workplace hands on service learning and exploration in a range of training environments providing the opportunity for the trainee to develop, with supervision, the requisite experience, knowledge, skills and attributes necessary to become a competent independent specialist neurosurgeon. In addition, the regulations include accreditation of training positions in public hospitals, combined positions with public and private hospitals, paediatric hospitals and regional hospitals allowing exposure to a full breadth of case mixes and training environments.

The trainee seminar topics are also delivered twice yearly on a four year rotational basis to ensure that, during training, each trainee is exposed to all topics delivered. The trainee seminars are designed to cover basic to advanced knowledge with trainees presenting topics consistent with their level of progression in the SET program.

Integrating the elements of SET1 into the specialty training program

The existing SET program will increase by one year to incorporate basic and specialist neurosurgical training in the new SET program. The first year will be a basic neurosurgical year known as SET1. The curriculum components and performance standards for SET1 are:

i. Satisfactorily complete four three month rotations in accredited neurosurgical clinical rotations as approved by the Board. This may be adjusted to include a maximum of two three month rotations in another surgical specialty or intensive care unit as approved by the Board; and
ii. Satisfactorily participate in a minimum of 75 major neurosurgical procedures for each six months in neurosurgical rotations or equivalent; and
iii. Satisfactorily complete one core workplace competency assessment as designated by the Board; and
iv. Satisfactorily complete the Basic Science Examination in Neurosurgery; and
v. Satisfactorily complete the Clinical Examination; and
vi. Satisfactorily complete the ASSET and the CCrISP Course.

Clinical Experience

First year trainees (SET1) will be required to satisfactorily complete four three month rotations in accredited neurosurgical clinical rotations. This may be adjusted to include a maximum of two three month rotations in another surgical specialty or intensive care unit if the trainee has a minimum 26 weeks neurosurgical experience prior to selection. Trainees must satisfactorily participate in a minimum of 75 major neurosurgical procedures for each six months in neurosurgical rotations or equivalent during SET1.

During the subsequent clinical years (SET2, SET3, SET5 and SET6) trainees must satisfactorily complete two six month rotations in accredited neurosurgical clinical positions and participate in a minimum of 100 major neurosurgical procedures, which must, at some point during clinical training, include a minimum of three and a maximum of six months in clinical rotations accredited by the Board for paediatric neurosurgical training.

Appropriately supervised operative experience obtained during clinical training, including good case mixes and case loads, are also considered essential learning opportunities for trainees to acquire the necessary technical skills and expertise to practice as an independent neurosurgical consultant.

Modules

In addition to the generic College training modules, the curriculum for the SET program includes twenty two syllabus modules. The SET program competencies have been refined into specific learning outcomes for year clinical year which are detailed in each of the syllabus modules and curriculum components. The syllabus modules are currently undergoing a complete review through the Education Development Committee.

The syllabus modules are delivered by a number of learning methods and opportunities as outlined in the curriculum including structured educational programs, skills courses, self directed learning and workplace hands on service learning and exploration.

The learning outcomes detailed in the syllabus are assessed using multiple formative and summative assessment tools and performance based standards to determine the degree of progression towards the competencies and suitability to continue training. The syllabus modules are:

- Clinical Neurology
- Infection
- Neuroanaesthesia
- Neuroanatomy
- Neuro-oncology
- Neuro-opthalmology
- Neuro-otology
- Neuropathology
- Neuropharmacology and Neurochemistry
- Neurophysiology
- Neuroradiology

- Nuclear Medicine
- Operative Neurosurgery
- Paediatric Neurosurgery and Developmental Neurology
- Pain
- Perioperative Care
- Peripheral Nerve Disorders
- Psychiatry and Neuropsychology
- Spinal Surgery
- Statistics
- Trauma
- Vascular Disease

Documentation:
Neurosurgery Training Website (www.neurosurgerytraining.orgCurriculum Modules – username & password AMC)
Neurosurgery Syllabus Modules (online and paper based)

Courses

Trainees must satisfactorily complete the ASSET and CCrISP courses during SET1 and the EMST course during SET2. Recognition of prior learning is available for these components.

In SET2 to SET5 inclusive trainees are required to attend and satisfactorily participate in the two compulsory trainee seminars per year and one during SET6.. The seminars are held in venues throughout Australasia and trainees are allocated presentation topics, based on the relevant syllabus modules and their experience level, and sit a short examination on the seminar content. Expenses incurred in attending the seminars are the responsibility of the trainee however no seminar fees are charged as they are funded through the Neurosurgical Society of Australasia.

The trainee seminars are focused on the following topics, on a rotational basis. Trainees may attend more than one seminar on the same topic during training however the content at each is new and up to date. The seminar topics, which place emphasis on the competencies of medical expertise, technical expertise and judgement, and clinical decision making, are:

Cerebrovascular and Radiosurgery
Neurotrauma and Rehabilitation
Paediatric Neurosurgery
Peripheral Nerve, Pain and Epilepsy
Neurosurgical Tumours
Spinal Surgery
Neuropathology and Neuro-imaging

Documentation:
Neurosurgery Training Website (www.neurosurgerytraining.orgTrainee seminar – username & password AMC)
Neurosurgery SET Program Regulations (online and paper based)

Research

The SET program has a standard research requirement that trainees must prepare a paper and present at the Neurosurgical Society of Australasia Annual Scientific Meeting prior to the end of SET5. This involves the research and preparation of a paper which is subject to peer review selection.

The SET program also includes a compulsory research year. The research year is designed to be an educationally enriching year with flexibility allowing trainees who have undertaken previous periods of research to pursue other elective activities. Trainees are allocated a year in which this must be undertaken which will be SET4 for new trainees. It is the responsibility of the trainee to make arrangements for the research year and to submit a proposal in the year prior for approval by the Board of Neurosurgery.

During the research year six monthly assessment reports are sought from the supervisor and a final report is considered at the conclusion of the year to ensure that the objectives were achieved and the period can be accredited.

The Neurosurgical Society of Australasia offers a number of research scholarships each year for Neurosurgical Trainees undertaking research as part of the SET program.

Documentation:
Neurosurgery Training Website (www.neurosurgerytraining.orgResearch / elective – username & password AMC)
Neurosurgery SET Program Regulations (online and paper based (Weblink)
Research Elective Assessment Form (online and paper based)

Orthopaedic Surgery Curriculum

Presently, the SST program in orthopaedics builds a Trainee's skill and experience over a four year period. Trainees are re-appointed to the training program on a yearly basis, dependent on performance. As a Trainee progresses through SST Years one-four, s/he will have the opportunity to undertake increasingly complex surgery and assume greater responsibility both for decision-making and operative technique. Exposure to sub-specialty areas may occur at different intervals during the four year program. In particular, exposure to Paediatric Orthopaedic Surgery can be offered at any point during the training program.

SET will extend training in Orthopaedic Surgery to five years with SET1 as a clinical hospital position, identified as being of high clinical value, based in a Unit that currently supports a BST position.

Documentation:
Curriculum Outline (available for reference at the College)

How Orthopaedic Trainees attain the widest possible experience

For the purpose of in-training assessment, the current 4-year SST program in Orthopaedics is divided into at least 8 surgical rotations of six-month duration. In most cases, an attachment to a particular Orthopaedic Unit will last for six months, but some rotations will last for a full 12-month period. This system of rotation provides trainees with exposure to both the broadest variety of working environments and the greatest number of sub-specialties.

It is a requirement of the training program that all trainees attend "Bone School", the formal training component offered by each RTP. These sessions are held in each state capital city and in Newcastle on a weekly basis and attendance is compulsory for all trainees. Those Trainees working in non-metropolitan areas in NSW and Queensland now have access to 'Bone School' via videoconferencing. The entire curriculum of the clinical training program is covered in 'Bone School' over the mandatory four year training period. The 'Bone School' program in each RTP is managed by a designated Course Coordinator.

Clinical experience

SET1 will be arranged in a sequence of three month attachments. This may include up to two to three-month attachments to related specialties, i.e. Plastic Surgery, Neurosurgery or Vascular Surgery. Satisfactory completion of each term, including the assessment of all generic competencies and the completion of a logbook, must be achieved in order for the Trainee to progress to SET2. An OPAR must be completed and signed off satisfactorily during each Orthopaedic term.

It is anticipated that the clinical experience and requirements for SET2 through SET5 will remain largely unchanged from those defined in the current SST program.

Prior to application for the SET program, the AOA Federal Training Committee has mandated that potential trainees complete rotations in both an Emergency Department and an Intensive Care Unit as part of Pre-SET.
In the SET2^{+} program, at the end of each 6-month period during the four-year SST program, trainees must:

- satisfactorily complete and submit an Orthopaedic Procedure Assessment Report; and
- submit a logbook of procedures undertaken, either in electronic or hard copy format.

Documentation:
AOA Orthopaedic Procedure Assessment Report (available for reference at the College)
AOA Mini-Log Sheet (available for reference at the College)

Initially, failure to complete an assessment satisfactorily will occasion a process of review by the relevant RTC. Depending on the outcome of this review process, a Trainee may be placed on probation and monthly review. In the case of a serious misdemeanour, a dismissal action may be instituted in accordance with the College Dismissal Policy. However, it should be pointed out that the standard of applicant to SST in Orthopaedics has been extremely high, and the number of trainees underperforming at any time is small.

Modules

In addition to the generic College training modules, the AOA has developed specialty-specific modules in the following areas:

Module 1	Basic Principles of Orthopaedic Science (OPBS)
Module 2	Principles of Surgical Techniques
Module 3	Paediatrics
Module 4	Spine
Module 5	Shoulder and Elbow
Module 6	Hand
Module 7	Hip
Module 8	Knee
Module 9	Arthroplasty
Module 10	Trauma
Module 11	Foot and Ankle
Module 12	Tumour
Module 13	Genetic/Metabolic/Neurological Disorders
Module 14	Radiation Safety
Module 15	Professional Ethics
Module 16	Risk Management

The Training Modules are further divided into 85 separate Topic Areas, each of which provides a template for the comprehensive study and review of a specific orthopaedic condition or particular aspect of professional practice.

The major module for SET1 will be the OPBS. Currently trainees are strongly encouraged to sit the OPBS Examination in SST Year 1 as the curriculum for this module helps to develop the competence of Medical Expertise.

The SET1 Trainee will be required to sit and pass an examination comprising specialty appropriate generic material from both the current primary examination and the OPBS module. Candidates who are unsuccessful at examination may repeat SET1 on 1 occasion, but may not progress to SET2 without completing the basic exam successfully. After 3 unsuccessful attempts, the Trainee would be subject to automatic dismissal from the program.

The Training Modules focus on the following core competencies:

- Medical Expertise
- Technical Expertise
- Judgment – Clinical Decision Making
- Communication.

Documentation:
AOA Training Modules and Topic Areas (available for reference at the College)

Courses

During SET1 Trainees must satisfactorily complete the ASSET and CCrISP courses.
Trainees must satisfactorily complete the EMST course before the end of SET2.
It is hoped that with greater course availability, the majority of candidates applying from PreSET will have completed the ASSET course prior to commencing SET1.

SET1 Trainees will not be required to attend the formal 'Bone School' as the year will already be extremely busy, especially for those with little surgical experience prior to gaining selection into SET.

'Bone School'

Each Regional Training Committee runs a program of formal coursework known colloquially as “Bone School”. Although the exact format of Bone School varies between Regions, the basic principle is that trainees be provided with one half-day (approx. four hours) per week of orthopaedic education. These sessions incorporate didactic lectures, case presentations and clinical material.

In-Training and Trial Exams

As a complement to Bone School, most Regions provide trainees with the opportunity to sit in-training examinations. In-training examinations are designed to measure a Trainee's acquisition of orthopaedic knowledge and clinical skill in order to identify areas of weakness. The assessment of non-technical competencies is undertaken in conjunction with examination of clinical skills. In-training examinations also serve to provide trainees with experience in answering questions under exam conditions.

Pre-exam Course

The AOA convenes an annual Pre-Examination course prior to May sitting of the Fellowship Examination. The course is run over three days in the city in which the Fellowship Examination is to be held, and provides trainees with the opportunity to undergo a trial examination in the clinical assessment and oral parts of the Fellowship Examination.

Radiation Safety Course

It is mandatory for all trainees to attend and successfully complete a Radiation Safety Course leading to the issuing of a radiation user's licence. The AOA offers a Radiation Safety Course for Orthopaedic Surgeons annually at no cost to trainees.

Documentation:
AOA Radiation Course

Research

It is unlikely there will be time for any significant research project during SET1 given the course and exam commitments detailed above. The research requirements as outlined in the *Guide to advanced training in Orthopaedic Surgery* will remain for those progressing from SET2 through SET5.

The AOA requires every Trainee to fulfil a designated research requirement. In order to broaden the range of possibilities by which registrars may satisfy the research requirements set down by the AOA Federal Training Committee, the Committee has introduced a points system for research in which the Trainee must achieve a minimum of four points. These points must be accrued prior to sitting the Fellowship Examination and are allocated in accordance with the following schedule:

- Paper presented by the Trainee at a state or national meeting during BST program (1 point)
- Paper presented by the Trainee at the Annual Registrars' meeting (1 point)
- Paper presented by the Trainee at a State Branch meeting (1 point)
- Paper presented by the Trainee at the AOA/NZOA/ANZORS meeting (2 points)
- Paper presented by the Trainee at a national/international society meeting (2 points)
- Publication by the Trainee as author in a journal which referees all manuscripts (3 points)
- Period of full time research of 12 months or a higher degree from a recognised institution (4 Points)

In addition, a Trainee wishing to pursue a higher degree may have one year of this period of research accredited as part of SST, providing the Regional Training Committee is satisfied that the candidate has received sufficient clinical training prior to this time to allow him/her to present for the Fellowship Examination. Ongoing assessment is required during the research period.

Documentation:
AOA Research Policy and Requirements (available for reference at the College)

Additional requirements

Trainees may not present for the Fellowship Examination unless they have satisfactorily completed the OPBS module.

Trainees are strongly encouraged to undertake the teaching of medical students, nursing staff and more junior colleagues. This is a fundamental requirement of building competence in the "Scholar and Teacher" category, and progress against this criterion is assessed in the QAR.

At present, all Registrars selected into SST must have completed the EMST course. It is envisaged that this will become a requirement for those trainees in the SET1 year prior to advancing to SET2.

Otolaryngology Head and Neck Surgery Curriculum

The Otolaryngology Head and Neck Surgery program in SET is a five year. Trainees must accept the varying rotations assigned to them by the Regional Subcommittee.

In SET1 Trainees will do four terms that in any of the following areas: Otolaryngology Head and Neck; General Surgery; Cardiothoracic Surgery; Neurosurgery; Plastic Surgery; or Paediatrics Surgery. This will depend on available jobs and competition for them. It is expected that trainees will get experience across the nine competencies during these rotations (see Attachment 4).

In SET2^{+} Trainees are required to demonstrate satisfactory performance in eight X six month rotations in approved Specialist Otolaryngology Head and Neck Surgery Training Posts.

Documentation:
Otolaryngology Head and Neck Surgery Training Posts (Weblink)

Because of the diversity of the Otolaryngology Head and Neck Surgery program it has not been developed on a model of yearly progress. Instead the curriculum has been developed around the 13 core sub-disciplines. Notwithstanding this however, there is a yearly progression of skill and knowledge building and a graduated level of responsibility that each Trainee accepts. The Board recognises that different trainees gain exposure to different subspecialty areas depending on the rotation, however the common theme is that the basic competencies are the ones initially acquired.

Ensuring Trainees attain the widest possible experience in OH&NS

During training, trainees rotate between hospitals with no more than twelve months accredited to one training unit. In addition, trainees must spend a minimum of six months at institutions with major a major paediatric component and 6 months at an institution with a major Head and neck component. These institutions are designated by the State training subcommittees. Care is taken to allocate rotations on the educational needs of the trainees.

The Trainee seminar topics are delivered on an 18 month timetable so that each Trainee has had 2 training opportunities by the time they sit the Fellowship Examination.

Documentation:
Otolaryngology Head and Neck Surgery Logbook and Summary of Operative Experience (Weblink)

Integrating curriculum components

Clinical experience is the core of the training program and it is during this experience that the knowledge, skills and attitudes that are articulated in the nine RACS competencies are developed and assessed. The modules, courses and examinations compliment this process by explicitly defining what is required, providing a planned learning context, and establishing the required standards.

The current training program will increase by one year to incorporate a basic clinical SET1 year. Rotations identified as advantageous to a surgical career in the specialty are nominated as being the required ones.

There will be co-operation between the various specialties to ensure that the SET1 year achieves what the training program requires when trainees are rotated through these speciality rotations.

During training in Otolaryngology Head and Neck Surgery Trainees are employed in accredited hospitals where they are required to participate fully in the professional life of a surgeon. During all of this time they are under the supervision of and accredited supervisor. This apprenticeship training creates an environment where the trainees are constantly required to use and hone all of their knowledge, skills and attitudes as they work with patients, colleagues and other professionals. It is in the Trainee's performance in the clinical environment that requires the integration of all of the curriculum elements.

Clinical experience

Trainees will need to achieve the clinical and operative competencies as defined in the SET1 curriculum. To ensure that SET1 Trainees are able to meet the required standards, it is planned that Otolaryngology Head and Neck Surgery will introduce workplace assessment requirements for SET1 Trainees. Further workplace assessment will be introduced in subsequent years (see Assessment plan above, and Formative assessment below).

Each of the core modules define the clinical experiences required in that sub-discipline including the operative management skills in that area which are essential for all trainees, and those that are desirable.

Because of the diversity of the program, primary operator experience will vary depending upon the year of training, the nature of the six-month rotation, and in particular the nature and complexity of the surgery undertaken in that training unit. It will also vary depending upon the inherent skills and ability of the individual Trainee. The Board is currently working to establish what would be a minimum number of procedures expected to be performed by a Trainee, and at the same time recognises that competence rather than raw numbers is important.

Trainees are required to submit to the Board a formal workplace competency assessment form and log book of surgical cases at the end of each 6 month rotation. These must be signed off as satisfactory by the Trainee's current supervisor of training.

The Trainee is tutored in an outpatient environment in the skills of a relevant history and clinical examination. In early training these skills are closely observed by attending consultants, one of whom is usually rostered to accept this responsibility for that particular clinic.

It is the responsibility of the Board of Otolaryngology Head and Neck Surgery, through the regional subcommittees, supervisors of surgical training and the individual surgeon trainers, to maximise the training experience for each Trainee. It is therefore considered imperative that the surgical trainer in the first instance duly instructs the Trainee in surgical technique and the specific requirements of individual operations, initially with the Trainee as assistant, but rapidly progressing the Trainee to a supervised primary operator role for part and then ultimately all of the operation.

Documentation:
Otolaryngology Head and Neck Surgery Logbook and In-training

Modules

There are no plans to change the modules for SET. The 14 core modules in Otolaryngology Head and Neck Surgery are designed to integrate Medical Expertise; Judgement – Clinical Decision Making and Technical Expertise. In each module the essential and desirable operative management competencies have been stated.

- Audiological and Vestibular Medicine
- Paediatric Otorhinolaryngology
- Benign Laryngeal Conditions
- Rhinology
- Facial Plastic Surgery
- Scientific Foundation of Otolaryngology Head and Neck Surgery
- Head and Neck
- Snoring and Sleeping Disordered Breathing
- Otology and Neuro-otology
- Temporal Bone Dissection Curriculum
- Communication
- Health Advocacy
- Professionalism and Ethics
- Broncho-oesophagology

Documentation:
Otolaryngology Head and Neck Surgery Modules (Weblink)

Courses

Trainees are required to complete ASSET and CCrISP before progression to SET2.

EMST is desirable but can be carried into SET2 and be completed before SET3.

CLEAR is to be completed by the end of SET3.

During the five years of training, trainees are required to attend:

Two temporal bone dissection courses

One Endoscopic sinus surgery course

One head and neck course

The above courses have a theme of interactive lectures, video presentations and cadaver dissections. The dissection part of the courses are on a more intimate basis between Trainee and demonstrator. These courses tend to concentrate on the competencies of medical expertise, technical expertise and judgement and clinical decision making.

The courses are organized by local state surgeons. There is a requirement by the Board that at least 1 of the required courses is run at the annual registrars' conference.

Trainees are also required to complete the CLEAR course by end of SET3.

Documentation:
Otolaryngology Head and Neck Surgery Bone Courses (Weblink)

Research

Trainees must have completed an authorised research project prior to sitting for the Fellowship Examination. The project must be approved by the State Subcommittee Chairman and must be completed and presented, or published in a peer reviewed journal prior to the Trainee being signed off to sit for the exam.

The Garnet Passe and Rodney Williams Memorial Foundation make available four generous scholarships per year specifically for new trainees in the specialty. Trainees are accepted onto the program as scholarship holders and undergo the same selection process as do other trainees. If they are selected and have nominated for one of the research scholarships, they complete the scholarship and are guaranteed a clinical position on the training program once the research year/s are completed. The research positions must be for an advanced university degree.

The Board has recently approved the possibility for a trainee to interrupt their training program to take up one of these scholarships, with the proviso that:

i. Adequate notice is given by the trainee such that the vacated clinical training position can be filled.
ii. The Board reserves the right to extend training if it is deemed appropriate. This would be the case for example if the interruption was long enough for the trainee to lose clinical skills.

Documentation:
Research in the Otolaryngology Head and Neck Surgery Training Program (Weblink)
Research Progress Report

Paediatric Surgery Curriculum

The training program is a minimum five year duration with conditions to lengthen or shorten the program (please refer to section two of the Regulations for Specialist Surgical Training in Paediatric Surgery).

Trainees must satisfactorily complete SET1 (incorporating 6 months surgery in general and 6 months paediatrics (see Attachment 4), plus 4 years of Specialist Paediatric Surgical Training in posts accredited by the Royal Australasian College of Surgeons.

Trainees are not required to complete Critical Appraisal Tasks (CATs) or Directed Online Group Studies (DOGS) until completing their Paediatric years of surgical training. There are also separate CATs assessment forms for Years one and two of Paediatric Surgery and Years three and four of Paediatric Surgery to factor in Trainee progression for assessment.

Documentation:
Regulations for Specialist Surgical Training in Paediatric Surgery

Ensuring Trainees attain the widest possible experience in Paediatric Surgery

Diversity of experience is considered of utmost importance by the Board of Paediatric Surgery. Section 4 of the Regulations covers this in great detail, including the process for appointment.

Integrating curriculum components

Clinical experience is the core of the training program and it is during this experience that the knowledge, skills and attitudes that are articulated in the nine RACS competencies are developed and assessed. The modules, courses and examinations compliment this process by explicitly defining what is required, providing a planned learning context, and establishing the required standards.

During the six years of training in the program trainees are employed in accredited posts in hospitals where they are required to participate fully in the professional life of a surgeon. During all of this time they are under the supervision of an accredited supervisor. This apprenticeship training creates an environment where the trainees are constantly required to use and hone all of their knowledge, skills and attitudes as they work with patients, colleagues and other professionals. It is in the Trainee's performance in the clinical environment that requires the integration of all of the curriculum elements.

The Critical Appraisal Tasks, Directed Online Group Studies and Procedure Based Assessments all provide an avenue through which the Trainee can critically review literature, formulate actions, discuss treatments with colleagues and assess their own performance. The Registrar Annual Training Seminar also provides educational opportunities for trainees to present clinical cases to their peers and learn from surgeons in different locations and with different areas of special interest/expertise.

The compulsory completion of the Advanced Paediatric Life Support Course and Early Management of Severe Trauma Course supports the curriculum modules such as Trauma and Burns.

The trainees also have input into the development of curriculum modules and Regulations via the Trainee Representative on the Board of Paediatric Surgery.

Clinical experience

By the end of SET1 Trainees will need to achieve the clinical and operative competencies as defined in the SET1 curriculum. They will have completed a minimum of:

- six months of Surgery – the most useful specialties being General Surgery, Urology, Vascular Surgery, Plastic and Reconstructive Surgery
- six months Paediatrics (preferably non-surgical)

To ensure that SET1 Trainees are able to meet the required standards, it is planned that Paediatric Surgery will introduce workplace assessment requirements for SET1 Trainees taking the form of DOPS, PBAs, Mini-CEX and 360 Degree Forms to be completed and be assessed as satisfactory every 3 months.

Trainees must satisfactorily complete the requirements for SET1, plus eight rotations of Paediatric Surgery. Trainees are expected to undertake training in at least one region outside their home state (see section 4.1.4).

It is the responsibility of the Board of Paediatric Surgery, through the supervisors of surgical training and the individual surgeon trainers, to maximise the training experience for each Trainee. For this reason, Trainee Logbooks and evaluation forms from previous years are provided to the supervisor for the coming training year to assist the supervisor and Trainee to develop a learning action plan to maximise their training experience. This process commenced in 2006 and has received positive feedback.

Unsatisfactory performance is identified by the surgical supervisor and appropriate steps taken in section 5.2 of the College SST Dismissal from Surgical Training policy.

Modules

There are no plans to change the modules for SET. The 9 core modules in Paediatric Surgery are designed to integrate Medical Expertise; Judgement – Clinical Decision Making and Technical Expertise. In each module the essential and desirable operative management competencies have been stated.

- Trauma and Burns
- Tumours
- Genito-Urinary Tract
- Head and Neck
- Neonatal Surgical Abnormalities
- Skin, Subcutaneous and Extremities
- Thoracic (Non-Cardiac) Conditions
- Ventral Abdominal Wall
- Abdomen

The generic modules for the non-technical competencies are recognised as defining the standards in those areas for Paediatric Surgery. They each include a self-assessment component.

- Collaboration
- Communication
- Health Advocacy
- Management and Leadership
- Medical Expertise
- Professionalism and Ethics

All modules are currently undergoing a biennial review and will be available on the website (accessed via log-in and password) in the near future.

Documentation:

Paediatric Surgery Modules (Weblink)

Courses

Compulsory

vii. Trainees must complete EMST, ASSET and CCrISP by mid-SET2

viii. Advanced Paediatric Life Support Course (APLS) (provided by Advanced Paediatric Life Support Australia). This course must be completed by mid-SET2.

Course content includes basic and advanced life support, serious illness, serious injury and practical procedures, including radiology and pain management. The course integrates with all RACS competences.

ix. Early Management of Severe Trauma (EMST) – College Course

x. Registrar Annual Training Seminar (RATS) – Trainees attend this four-day seminar that involves practical educational sessions, lectures from consultants, team-building activities, the opportunity to meet with the Board as individuals and as a group and the compulsory presentation of a case study. The RATS integrates aspects of Technical Expertise, Communication, Collaboration, Management and Leadership, Learner and

Teacher and Professionalism. Details of the RATS are outlined in section six of the Regulations.

Recommended

xi. Critical Literature Evaluation and Research (CLEAR) Course – College Course

xii. Early Management of Severe Burns (EMSB) Course – provided by Australian and New Zealand Burn Association

The course teaches how to recognise, assess, stabilise and transfer the severely burned patient. There is a brief series of lectures highlighting important aspects of the aetiology, pathophysiology, emergency examination and treatment of the patient. Relevant clinical skills are demonstrated and important topics are explained in more detail with group discussions. Life-like case simulations are used to consolidate and integrate the course material. The course concludes with an assessment in the form of a short answer paper. The EMSB integrates aspects of Technical Expertise, Communication, Collaboration, Management and Leadership, Learner and Teacher and Professionalism.

Documentation:
Advanced Paediatric Life Support Course (Weblink)
Early Management of Severe Burns Course (Weblink)

Research

All Trainees in Paediatric Surgery must have completed the mandatory research requirement prior to applying to present for the Fellowship Examination. Research is not considered part of the clinical program for the current Paediatric Surgery SST program. Research is outlined in more detail in section five of the Regulations.

Additional requirements

The Board is trialling the use of Procedure Based Assessment (PBA) forms with trainees and surgical supervisors. There are separate forms for trainees and supervisors and the Trainee is expected to initiate the assessment prior to completing the procedure. The Board is evaluating the process with trainees and supervisors prior to making a decision whether or not to include in the program as an assessment requirement.

Plastic and Reconstructive Surgery Curriculum

Specialist Surgical Training in Plastic and Reconstructive Surgery is a minimum five years of specialist training planned on a yearly progression with trainees building on their knowledge and skills. Trainees must demonstrate competency in both technical and non-technical skills, targeted to their year of training for each rotations to be accredited towards their training time. Trainees who have not demonstrated competence in generic and technical skills are required to undertake further training rotations.

All 5 years of the SET program will be accredited clinical years

- SET1 will focus on basic surgical training incorporating rotations through any of the nine specialities' surgical rotations in posts where the clinical content and workload of these positions is approved by the Board of Plastic and Reconstructive Surgery. Trainees will obtain the clinical exposure and experience to demonstrate the basic surgical competencies required to progress into the more speciality focused SET2
- SET2 to SET5 focus on Specialist Surgical Training in Plastic and Reconstructive Surgery.

SET1 Trainees will be required to successfully complete the basic examinations (formerly taken in BST) to progress to the more specialist Training in SET2 and beyond.

The Plastic and Reconstructive Surgical Sciences and Principles Examination may be taken in SET1, however, it must be taken in SET2 and trainees must pass this examination to progress beyond SET3. This provides trainees with at least three attempts to successfully pass this examination, in line with current SST regulations.

Documentation:
Trainee Handbook for Plastic and Reconstructive Surgery

Ensuring Trainees attain the widest possible experience in P&RS

Trainees are allocated to accredited training posts, with increasing levels of difficulty to reflect their level of skill and experience. Trainees generally rotate through different hospital posts every six months; however some postings are for 12 months which allows exposure to departments with different areas of focus in Plastic and Reconstructive Surgery, varying caseloads, supervision and staff. Within each region, there is a formal teaching program, which is compulsory to attend lead by members of the regional training board; senior and more junior registrars present topics throughout the year in these regular teaching sessions. Trainee topics are delivered on a rotational basis. Each year a compulsory registrar conference is held, rotating through the capital cities of Australia. This provides Trainee's exposure to different speakers, and the curriculum in its entirety is covered every two years.

Integrating curriculum components

This is covered in the following sections.

Clinical experiences

Clinical experience in SET1 rotations will be targeted to reflect the level of skills and competency of the trainees undertaking SET1 rotations. This clinical experience of SET1 posts will be approved by the Board of Plastic and Reconstructive Surgery.

The SET2^{+} program requires rotations through accredited hospital training posts, generally trainees rotate through different hospitals every 6 to twelve months. Trainees are required to demonstrate their clinical exposure and surgical experience on the Board of Plastic and Reconstructive Surgery logbook.

Modules

There are no plans to change the modules for SET. The statement of competencies is in addition to the detailed curriculum modules which are divided into the following areas, each of the eight modules are of equal weightings

- Surgical Sciences and Principles

- Craniomaxillofacial
- Facial soft tissue
- Hand, upper limb, and microsurgery
- Head and Neck
- Lower limb and foot
- Skin and integument
- Trunk, perineum and breast.

These modules have also been reorganised into identified sub-classifications reorganised as follows:

- Aesthetic
- Congenial and paediatric
- Degenerative and others
- Inflammatory and infection
- Neoplastic and tumours
- Procedures and techniques
- Trauma

Documentation:

Plastic and Reconstructive Surgery – Modules (Weblink)

Diagrammatical representation of the Plastic and Reconstructive Surgery course and its constituents (Weblink)

Courses

The three training courses CCrISP, EMST and ASSET will be undertaken in SET1.

There is a compulsory Registrars Conference held in March/April each year. The entire Plastic and Reconstructive Surgery curriculum is covered every two years at the conference.

Research

Trainees must achieve four or more points during their period of Specialist training in Plastic and Reconstructive Surgery, which are allocated in the following fashion:

a) Plastic surgery paper selected and presented at the Annual Registrars Conference (1 point)
b) Plastic surgery paper presentations at the College state/NZ meeting (1point)
c) Plastic surgery paper presentations at the ASC, AHSS, ASAPS or equivalent annual meeting or international meeting (2 points)
d) Plastic surgery publication in refereed Journal (3 points)
e) Completion of a minimum of a 12 month period of full-time research with enrolment in a higher degree from a recognised institution that is assessed and approved prospectively by the Board of Plastic and Reconstructive Surgery (5 points)

Urology Curriculum

SET Urology is a minimum six year training program with three distinct components.

In the first component, SET1, trainees will have clinical exposure with rotations in Anaesthetics/ICU, ED, some Urology, and some General Medicine. SET1 is anticipated to provide knowledge and skill in a structured and predictable manner, without repetition, and with elimination or minimization of non-contributory service rotations.
SET1 positions must have an educational structure, governance, the opportunity for progressively increased level of responsibility, and opportunity for independent clinical and management decision making.

Trainees are expected to pass the BSE exam before the completion of SET1. No additional exams are anticipated in SET1. Three monthly Supervisor reports, and probably some mini-CEX's, CBD's, and DOPS's are expected to be included in SET1.

The second component comprises a year of surgery in general. During this year, trainees are expected to acquire a defined experience in surgical skills and management, as applicable to Urology. This experience is best acquired in general surgery, vascular surgery, and paediatric surgery terms.

The next component is a coordinated rotation through a series of Urology Training Posts, usually in a single Section. Progress assessment is competence based. Most trainees fulfil the requirements of all aspects of this component of training in three years, though some trainees find the need to undertake an extension of training to ensure attainment of all surgical skill sets and learning objectives.

This component of Urology training is referred to as Core Urology Training, and trainees generally sit their Fellowship Examination in the last year of Core Training.

The final component of Urology training is a Fellowship year. This can be undertaken in clinical urology, or urological research. An outline of the proposed Fellowship must be submitted to the Board of Urology, as prospective accreditation of this year is mandatory.

This component of training must extend over a minimum of one year, but if felt appropriate for personal development or future career prospects, the Fellowship can be extended to two years or beyond, and is often undertaken in an area of sub-specialty interest.

Ensuring Trainees attain the widest possible experience in Urology

Trainees are rotated to a different accredited hospital post for each of the three core years of training. Each training post is subtly or substantially different from other posts. This rotation ensures a wide range of experience.

Each year, trainees are assessed in terms of their surgical exposure and clinical knowledge and are allocated to future posts based on areas requiring further development.

Integrating curriculum components

The bases of urological training are clinical experience and an education program. Each Trainee is employed full-time in a clinical post ensuring a wide exposure to planned and unplanned urological pathology. A program of scheduled educational sessions, tutorials and clinical skills workshops is timetabled to complement this clinical activity. During all workplace education and designated teaching sessions, regard is paid to the nine RACS competencies. Careful attention is paid to enabling adequate time for the trainee to optimally benefit from all of these.

A requirement of urology post accreditation is a commitment from the employer to release trainees for all reasonable scheduled educational activities.

A publicised clinical timetable for each post should marry with a publicised education schedule for the relevant region. The jurisdictions must be aware of the educational (including leave) requirements of trainees, and commit to enabling trainee attendance. The educational body (Board of Urology) must respect the service requirements of the jurisdictions.

Clinical experience

Every Urology Trainee is exposed to the challenge of managing individuals with acute and elective conditions of a urological nature. They are supervised in the process of acquisition of the knowledge and skills necessary to evaluate, diagnose and manage these individuals

An expected range of experiences for SET is outlined in the Modular Curriculum Portfolio.

SET1 is a preparatory year, by the end of which the selected Trainee should reach a level of competence appropriate to commence the more challenging and responsible years of SET2^{+}. The majority of the year will be spent in rotations of surgery in general, where trainees are expected to be accorded a degree of responsibility, with access to an education program, and primary surgeon operative exposure. There should be opportunity to undertake the initial assessment, and form a primary management plan, for planned and unplanned surgical cases. The appointment should be as a middle grade hospital doctor. There will be flexibility for trainees to spend some portion of the year in a term of a complementary specialty, where such attachment is to the educational benefit of the Trainee. Such attachments include, but are not limited to, Emergency Department, ICU/Anaesthesia, and Medical firms such as Nephrology, General Medicine, Geriatrics, and Neurology.

Technical experience (including, but not limited to);

- Introductory skills in endoscopy, flexible and/or rigid
- Introductory skills and principles in laparoscopy, including port insertion and placement, and recognition of abdomino-pelvic anatomy
- Education in a variety of suture techniques, and safe knot-tying
- Open surgical access to the abdomen, pelvis, and inguino-scrotal region. Familiarity with anatomical landmarks, surgical planes, and principles of dissection and mobilisation. The principles of sound wound closure
- Introduction to the principles of haemostasis, and safe tissue handling
- Introduction to the principles of appropriate and safe anastomoses of a variety of tissues
- Awareness of the factors, including co-morbidities, that impact on the safety and appropria10ess of surgical interventions.
-

Surgical experience (including, but not limited to);

- Experience in the clinical assessment of surgical pathology, including the role of history, physical examination, and appropriate investigation
- Experience in the assessment and management of the acute abdomen, and acute scrotum
- Education in the appropriate use, and interpretation, of investigations as applied to surgical conditions
- Awareness of the important factors in the peri-operative management of the surgical patient, particularly in relation to the minimisation of surgical complications; anti-coagulation, antibiotics, resuscitation etc.
- An ability to recognise early the presence of post-operative complications, and awareness of the appropriate investigation and treatment of these.

Non-technical competence (including, but not limited to);

- Improve communication skills
- Progress understanding of collaboration and teamwork
- Develop skills of health advocacy – e.g. breaking bad news, open disclosure, informed consent

Modules

The curriculum of the training program in Urology has been divided into a series of modules that have been collated into a Portfolio. This now transparently outlines the content and learning objectives of the training program.

This Portfolio is a mechanism to document the multitude of formal and informal teaching events that occur throughout the training period. It acts as not only a guide to learning objectives, but also as a log of conduct of educational encounters.

Each Section conducts a structured educational program. These include education meetings, Journal Club and sessions at Skills Labs. Trainees may be required to prepare presentations for these.

Local educational programs are conducted by each Hospital of training. These programs will include tutorials, uro-radiology meetings, uro-pathology meetings, journal club meetings, and quality assurance meetings.

Urology Trainees in SET will be expected to complete the College web-based modules on the 6 non-technical Competencies.

Urology is quite advanced in its initiative of producing an interactive web-based module for each of the subject chapters of the Portfolio. These are to include elements of both education and assessment. They are also to have an introductory level objectives, and advanced level objectives. The first trial module is to be uploaded shortly. This development is coincident with, and not stimulated by, the introduction of SET. All trainees are expected to have completed all introductory level modules prior to sitting their first Urological Mid-Term Assessment (November SET3), so are expected to commence the study process in SET1.

The mainstay of day-to-day education for trainees in SET1 Urology will be the education program of the surgical firm to which they are attached.

Documentation:

Modular Curriculum (Weblink)

Portfolio

Educational Training Program (typical for Section) (available for reference at the College)

Courses

In SET1 Trainees will be required to successfully complete:

- The Introductory Urology Skills Workshop
- ASSET (if not completed)
- CCrISP (if not completed)
- EMST (if not completed)

In SET2 Trainees will be required to successfully complete the CLEAR course.

Throughout the training program Urology Trainees are also require to participate in a number of scientific meetings and workshops.

Introductory Skills Workshop for Urology Trainees

This 2.5 day course is undertaken to familiarise new appointees with endoscopic instrumentation, and teach introductory endoscopic and surgical skills. It is delivered after appointment, and before commencement of first clinical rotation. This addresses introductory technical expertise.

The opportunity is taken to teach Radiation and Laser safety during this Course, as these potentially hazardous energy sources are in frequent use in Urology. Elements of professionalism and health advocacy are integrated.

The Critical Literature Evaluation and Research (CLEAR) Course

Attendance at the CLEAR course is mandatory during core training for all Urology Trainees. The Urological Foundation recognises the benefit of this course, and pays the course fees of all Urological Trainees. Medical expertise, judgement, and scholar factor in this course.

Annual Scientific Meeting – Urological Society of Australia and New Zealand

Attendance at this meeting is mandatory for all trainees. This meeting includes hands on skills training workshops and interactive education sessions (often with international guests). Medical expertise, technical expertise, judgement, communication, scholarship and professionalism can be found in components of this meeting.

Registrars' Training Week

Attendance at this Trainee meeting is mandatory for all trainees. This is a mixture of practice examinations (both written and oral), interactive presentations (often by trainees) and skills workshops. Medical expertise, technical expertise, judgement, communication, collaboration, leadership, scholarship, and professionalism feature in this course.

State Section Scientific Meeting

Attendance at the relevant meeting is mandatory for all Urological Trainees. In all Sections, a podium presentation at this meeting is mandatory every year for each Trainee. The construct, aims, and outcomes are similar to the ASM.

Anatomy of Complications Workshop

The Board also runs the Anatomy of Complications workshop at the CTEC Skills Centre in Perth for all trainees in their final year of core training. An advanced skills workshop, medical expertise, technical expertise, judgement, collaboration, teamwork, scholarship, and professionalism feature strongly in this course.

Research

Trainees in SET1 should be actively involved in the Quality Assurance activities of their Unit of employment, and should attend the education program and Journal Club of their surgical firm.

Trainees are reminded the CLEAR course must be completed before the end of SET2, so should consider preparation for this course, or completion of this course, during SET1.

Research projects are encouraged in SET1, but are not mandatory, and are not 'scored'.

Details regarding the research requirements of the Urology training program are contained in the Research Module of the Modular Curriculum Booklet. Please refer to Question 3c for information regarding the curriculum booklet.

All trainees must complete the CLEAR course and Level one of the Research module as described in the Portfolio prior to application to sit the Fellowship Examination.

All trainees are encouraged to present their research both at Section and National level. Urology encourages Trainee research by conducting a Registrar specific scientific session at the ASM (the Keith Kirkland/Villis Marshall Session) where prizes are awarded for the best presentation of research.

The Australasian Urological Foundation also offers the Abbott Registrar Scholarship, a research Scholarship to a Urology Trainee for an approved urological research project in Australia or New Zealand. Candidates undertaking higher degree research are especially encouraged to apply.

Urology encourages trainees to undertake a combined clinical/research qualification. At any one time, three-four Urology Trainees are typically undertaking a higher research degree in the Surgeons as Scientists program. A year of approved research is recognised as a year of training in the SST Urology program.

Additional requirements

All trainees must sit the European Board of Urology exam in their second and third years of SST. Trainee performance in this exam may assist the decision regarding Trainee readiness to sit the Fellowship Examination, but the result is not otherwise used. Trainee awareness they are to sit this exam is believed to stimulate Trainee study and reading.

All trainees must sit the American Urological Association exam in their first and second years of SST. Trainees must attain a criterion result in this exam to be enabled to sit the May Fellowship Examination in their exam year. This has been validated on the basis no Trainee failing to achieve a requisite score in this exam in November has ever passed the Fellowship Examination the following May.

Vascular Surgery Curriculum

The Vascular Surgery SET program is five years with three components.

Rotations for SET-1 will include four X 10-12 week terms in:

- Vascular Surgery (core);
- Six months in General Surgery in a hospital which is not a major tertiary teaching institution
- One of: Intensive Care, or ED, or General medicine/cardiology, or Radiology, or Cardiothoracic Surgery.

By the end of SET2^{+} Trainees are required to have completed a maximum of 6 months in vascular surgery and have demonstrated satisfactory performance in one 12-month rotation in surgery in General (not Vascular).

SET 3-5 consists of three 12-month rotations in approved Specialist Vascular Surgery Training Posts. The total training period will be 5 years and duration of training will depend on achieving competence.

Trainees will move into vascular posts at an earlier stage than in the SST program. The Board of Vascular Surgery will ensure posts in SET1 and two are providing clinical experiences which will contribute to the development of appropriate competencies for a vascular surgeon.

The Board in Vascular Surgery will also tailor posts to suit the Trainee's career plans, so that surgeons wishing to practice vascular and general surgery in rural and regional centres will have an appropriate program designed.

Many of the SET1 and two general surgical posts will be in regional centres and provide a broad general surgical experience and exposure to trauma.

For all rotations, trainees must accept the varying rotations assigned to them by the Board.

Ensuring Trainees attain the widest possible experience in Vascular Surgery

The minimum period of training is for one year of approved Specialist Surgical Training in General Surgery followed by four years of Specialist Surgical Training in Vascular Surgery. These four years will be spent in at least two different institutions approved by the Board in Vascular Surgery. Rotation of trainees between units is expected and will be coordinated by the Board. Surgical candidates must be prepared to be assigned to a unit anywhere in Australia, New Zealand or elsewhere overseas as there is an expectation that trainees will spend at least 1 year of their Vascular training either interstate in Australia or in New Zealand. Additionally, there is an expectation that all New Zealand based trainees will spend at least one year of their Vascular surgery training in Australia. Usually, one of the four years of Specialist Surgical Training in Vascular surgery, rather than the year of General Surgical training, will be spent either interstate or overseas.

Integrating curriculum components

Clinical experience is the core of the training program and it is during this experience that the knowledge, skills and attitudes that are articulated in the nine RACS competencies are developed and assessed. The modules, courses and examinations compliment this process by explicitly defining what is required, providing a planned learning context, and establishing the required standards.

During training in Vascular Surgery Trainees are employed in accredited hospitals where they are required to participate fully in the professional life of a surgeon. During all of this time they are under the supervision of an accredited supervisor. This apprenticeship training creates an environment where the trainees are constantly required to use and hone all of their knowledge, skills and attitudes as they work with patients, colleagues and other professionals. It is the Trainee's performance in the clinical environment that requires the integration of all of the curriculum elements.

The vascular curriculum modules have been divided into two levels. The level one modules are designed to be undertaken during the first two years of SST (one year of surgery in general and first year of vascular training. They cover the principles of vascular imaging, the pathophysiology of vascular disease, the pre and perioperative assessment of the vascular patient, and professional and ethical matters.

These modules/competencies are the foundation of contemporary vascular practice and these competencies must be achieved prior to undertaking the more clinically based topics and taking a more responsible role in patient management.

Clinical experience

In SET1 Trainees will need to achieve the clinical and operative competencies as defined in the SET1 curriculum. To ensure that SET1 Trainees are able to meet the required standards, it is planned that Vascular Surgery will introduce workplace assessment requirements for SET1 Trainees.

In-training assessment every three months will include:

- Satisfactory mid and end of term reports in all terms
- 360^0 assessment in all terms
- DOPS and PBA in each unit (3-monthly)
- Mini CEX every three month attachment

The Vascular Surgery 19 core modules define the clinical experiences required, including the operative management skills in that area which are essential for all trainees, and those that are desirable.

Because of the diversity of the program, primary operator experience will vary depending upon the year of training, the nature of the six-month rotation, and in particular the nature and complexity of the surgery undertaken in that training unit. It will also vary depending upon the inherent skills and ability of the individual Trainee.

It is the responsibility of the Board in Vascular Surgery, through the supervisors of surgical training and the individual surgeon trainers, to maximise the training experience for each Trainee. It is therefore considered imperative that the surgical trainer in the first instance duly instructs the Trainee in surgical technique and the specific requirements of individual operations, initially with the Trainee as assistant, but rapidly progressing the Trainee to a supervised primary operator role for part and then ultimately all of the operation.

The minimum operative experience to be gained in the four years is:

- 100 major Vascular Surgical operations, excluding renal access procedures, must be completed each 12 months with the Trainee as principal operator.
- 100 Renal accesses must be completed by the conclusion of training.
- During the four year period of vascular training the Trainee must complete 100 Arterial punctures and 50 Radiological Interventional procedures.
- Ultrasound requirements include spending 100 hours in a vascular laboratory. A logbook of this ultrasound experience signed by the surgical supervisor must be maintained. In addition, 10 case reports must be completed and sent to the Executive Officer at the College prior to presenting for the Fellowship Examination. These will be inspected by the Board.

Unsatisfactory performance as a primary operator should be identified by the supervisor of surgical training, appropriate enquiry undertaken, and a report forwarded to the regional subcommittee of the board for further discussion.

To guide the co-operation between surgical specialties, the Board in Vascular Surgery has developed the document titled “Educational Expectations for Non Vascular Specialist Surgical Trainees During a six-Month Attachment to a Vascular Unit“.

Documentation:
Educational Expectations for Non Vascular Specialist Surgical Trainees during a 6-Month Attachment to a Vascular Unit (Available for reference at the College)

Modules

The 19 core modules in Vascular Surgery are designed to integrate Medical Expertise; Judgement – Clinical Decision Making and Technical Expertise. In each module the essential and desirable operative management competencies have been stated. All modules are available on the web, with password access.

Each module has an on-line assessment component which trainees are encouraged to complete as they work through each module. They are expected to have completed all the modules prior to applying to sit the Fellowship Examination.

Level one addresses the areas of required knowledge in the areas of basic sciences, diagnosis and diagnostic tools, plus professional matters. Trainees are expected to cover Level one topic prior to completing the general surgical year or first year of vascular surgical training and to have completed Level 2 modules prior to sitting the Fellowship Examination.

Level One modules
Anatomical Approaches in Vascular Surgery
Endothelium and vessel wall
Haemodynamics and Biomaterials
Haemostasis / Thrombophilia
Ischaemia Reperfusion Injury and Systemic Inflammatory Response Syndrome (SIRS)
Pathophysiology of Aneurysm
Preoperative and Perioperative assessment of the vascular patient
Principles of Imaging
Professionalism and Ethics
Wound Healing

Level Two modules
Clinical infections in Vascular Surgery
Carotid and Vertebral Arterial Disease
Lower Limb Arterial
Miscellaneous Vascular disorders
Thoracic and abdominal aorta
Upper extremity disorders
Vascular conditions of the Abdomen and Thorax
Vascular medicine
Venous

The generic modules for the non-technical competencies are recognised as defining the standards in those areas for Vascular Surgery. They each include a self-assessment component

The relative percentages of the core modules are shown on the curriculum maps at the following links. The percentages reflect the relative importance of each topic and the relative time commitment.

Documentation:
Vascular Curriculum Map Level 1 (Weblink)
Vascular Curriculum Map Level 2 (Weblink)
Vascular Surgery – Level 1 and 2 Modules (Weblink)

Courses

The following courses and examinations must be satisfactorily completed by 30 June of SET2:

- ASSET
- CCrISP
- EMST
- BSE examination including OSCE
- Pass generic MCQ and OSCE
- Pass vascular specific MCQ

A compulsory Skills Acquisition Course for Vascular Trainees is held annually at the Brisbane Skills Centre at the Royal Brisbane Hospital during July/August. The Vascular Board is considering the possibility of the technical assessment of trainees during future courses.

A trial examination course sanctioned by the Executive Committee of the ANZSVS and Board of Vascular Surgery is held annually for final year trainees prior to them attempting the Fellowship Examination.

Research

All trainees in Vascular Surgery must have completed the mandatory research requirement prior to applying to present for the Fellowship Examination. Currently the minimum requirements are

presentation of a paper at a national peer-reviewed meeting, such as the Annual Scientific Congress of the College**,** and publication of an article in a peer-reviewed journal or preparation of a manuscript deemed of publishable quality by the Board. This research component must be undertaken during the vascular component of training.

Additional requirements

Satisfactory assessment must be achieved in the modular components of the curriculum before sitting the Fellowship Examination.

Trainees are required to satisfactorily complete level one modules during their first year of training in general surgery and to have completed level two modules prior to sitting the Fellowship Examination.

A rating of unsatisfactory in any two in-training assessment reports may result in automatic dismissal from the training program.

Unsuccessful completion of all components of assessment will result in counselling by Board, requirement to repeat SET2 or exclusion from program.

PROFESSIONAL DEVELOPMENT

Workshops and courses offered by the College

In 2007 the Professional Development Department is offering a new workshop in Supervisor Training and an improved workshop in Interviewer Training. Both of which are important to the successful implementation of SET.

Participation in these activities earns CPD points as well as assisting Fellows to maintain knowledge and skill base in training, mentoring and interviewing.

Supervisor Training

This is a new 3 hour workshop providing an opportunity for supervisors of surgical trainees to enhance their feedback and evaluation skills. It will complement the new Surgical Education and Training (SET) course and will explore the effective use of the new evaluation tools, provide practical insight into supporting and assessing trainees as well as outlining associated College policies, procedures and legal processes.

Documentation:

Draft manual for Supervisor Training (available for reference at the College)

Supervisor Training preparation for DVD (available for reference at the College)

Interviewer Training

This 2 hour workshop is designed specifically for Fellows who are conducting interviews for Trainee selection into Specialties. It incorporates practise in interview questions and techniques. Video-conferencing will be used to deliver the workshop to Interviewers in other capital and large regional centres. Fellows are required to participate as new interviewers then as a refresher after two years.

An important element of the selection process for applicants into the College's training programs is the interview, which is used to measure certain attributes in the behavioural domain that are deemed desirable for good surgical practice. A semi-structured interview has been developed to assess criteria which are difficult to assess via other methods.

Documentation:

Interviewer training (Weblink)

Interviewer training — Manual (available for reference at the College)

Specialty Specific Professional Development

Cardiothoracic Professional Development

The ASCTS has an Annual Scientific Meeting for the continuing professional development of its members. The Annual Scientific Meeting includes a session for Examination preparation, a Trainee satellite meeting and other sessions relevant to current developments in surgical education and training and cardiothoracic surgery.

General Surgery Professional Development

General surgeons are encouraged to attend the College Annual Scientific Congress
Interviewer training for selection has occurred in the past.
Supervisors of training are encouraged to attend the Surgeons as Educators courses.
Points are awarded for training of trainees, teaching, and education sessions.

Neurosurgery Professional Development

The Board of Neurosurgery has an interviewer briefing session prior to the commencement of the selection interviews where interviewing techniques and requirements are reviewed.

The Neurosurgical Society of Australasia has an Annual Scientific Meeting for the continuing professional development of its members. The Annual Scientific Meeting includes a session for supervisors training, a Trainee breakfast meeting and other sessions relevant to current developments in surgical education and training and neurosurgery.

Documentation:
Neurosurgery Annual Scientific Meeting (Weblink)

Otolaryngology Head and Neck Surgery Professional Development

Otolaryngology Head and Neck surgeons are encouraged to attend training courses for interviewers and surgical supervisors run by the College. The specialty does not deliver such courses at this time.

The Australian Society of Otolaryngology Head and Neck Surgery have an annual national scientific meeting for the continual professional development of its members.

Orthopaedic Professional Development

The AOA runs an interviewer training session for all Orthopaedic surgeons and JRs engaged in the selection process.

All supervisors are required to attend the appropriate Regional Training Committee meetings. The AOA Training Committee also intends to introduce conduct an information session for all Trainee Supervisors at the AOA Annual Scientific Meeting.

The AOA Continuing Orthopaedic Education (COE) Committee convenes 2 3-day instructional meetings per year.

Documentation:
Guidelines for AOA ASM
AOA Meeting Calendar 2007 (Weblink)
AOA Specialty Group Meetings 2007 (Weblink)
AORA Contacts (Weblink)

Paediatric Surgery Professional Development

Paediatric surgeons are encouraged to attend the College Annual Scientific Congress (ASC) and/or the Australasian Association of Paediatric Surgeons Annual Scientific Meeting held in alternate years separate to the College ASC. Paediatric surgeons are encouraged to attend all College operated professional development opportunities such as supervisor training and the Younger Fellows Forum. All selection committee members must have attended interviewer training prior to serving as a member.

Urology Professional Development

All USANZ members are encouraged to attend the Urology Annual Scientific Meeting, which from 2008 will include a session dedicated to Trainee Supervisor education. Topics of Trainee supervision will be covered in an annual rotating manner.

Vascular Surgery Professional Development

The Board of Vascular Surgery has an interviewer briefing session prior to the commencement of the selection interviews where interview techniques and requirements are reviewed.

4. ASSESSMENT

Assessment in the College encompasses a variety of activities including:

- Selection
- Formative assessment
- Summative assessment
- Accreditation of training positions
- Evaluation and Monitoring

Over recent years the College and each of the specialty boards have paid considerable attention to enhancing their assessment processes to ensure that they are:

- Fair and transparent
- Assessing specifically defined content
- Assessing competence
- Appropriately timed and implemented, and
- That they have clearly stated criteria, aligned with competence, defining the required standard

There has been a variety of workshops and programs to facilitate the enhancement of the College assessment process. Two examples are:

1. In October 2004 representatives of all of the surgical specialties meet for a workshop on the principles and practice of selection.

2. In May 2005 there was a combined workshop for members of BSST and the Court to come together to develop a shared understanding of formative and summative assessment in-line with curriculum content and competencies.

Documentation:
Combined Workshop: Board of Specialist Surgical Training and Court of Examiners (available for reference at the College)

Recognition of the progress towards achieving the above criteria is that in February 2006 the Manager of EDRD was invited to present an outline of the process which is used in the College to Blueprint assessment processes at the AMC/CPMC Workshop on Assessment Methods.

Documentation:
Blueprinting: Examples from the College's experience (Weblink)

4.1. SELECTION

Selection to the surgical training program at the Royal Australasian College of Surgeons occurs in some of the larger surgical specialties (General Surgery; Orthopaedic Surgery; Plastic and Reconstructive Surgery and Otolaryngology Head and Neck Surgery) as a national activity, and in the other surgical specialties as a bi-national activity.

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 which are outlined as follows.

- Selection processes for surgical education and training must comply with AMC and MCNZ accreditation requirements and the Brennan Principles
- Selection processes must be merit based, free of bias and, to the greatest possible extent, quantifiable
- 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 open to external scrutiny and conducted in an accountable manner using documented processes
- Selection processes must be conducted on a national or bi-national basis in Australia and New Zealand
- 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.

Selection in SET

With the introduction of SET there have been changes to the:

- level of postgraduate training at which medical graduates can apply for selection into specialist surgical training
- eligibility criteria and the number of times that people can apply
- the process of registering for selection
- the varying timing of selection between specialties and also between New Zealand and Australia

There has also been considerable discussion between the surgical specialties about the selection tools and weightings which they currently use.

Each of the nine surgical specialties administer their own selection processes, under the auspices of the Board of Specialist Surgical Training. Specialty Boards must receive approval from the Education Policy Board for the selection tools they use and the weighting given to them. A range of selection tools are used. The weighting of selection tools will be reasonable and fair to all applicants and will be determined prior to commencement of the selection process.

Each specialty decides:

- The number of trainees that they could accept into their program (based on the number of available accredited hospital posts)
- The selection tools they would use and their comparative weighting
- Any minimum acceptable score

The College continues to collaborate with the Jurisdictions to ensure effective inclusion of government appointed Jurisdictional Representatives on all College selection panels.

Selection into SET will commence in 2007 for the first intake of trainees in 2008. The current merit-based, national (or bi-national) selection processes, based on the Brennan principles will continue to apply.

Numbers to be selected

The number of trainees selected into each specialty each year has traditionally been based on the number of posts vacated in that specialty at the conclusion of the current year. Reasons for

vacancies include trainees progressing to Fellowship, withdrawals, transfer to another specialty program and taking leave of absence.

In 2007 the same formula will be applied to identify the number of trainees to be selected into SET2^{+} posts. There will be an additional cohort of trainees selected into SET1. The number of trainees selected into SET will be based on the posts expected to be vacant and available in 2009.

Documentation:
Numbers of SET1 and SET2 Trainees to be selected in each specialty (available for reference at the College)

Selection point

The proposed SET program would allow the earliest applications to be made from PGY2 for commencement in PGY3. It is not however assumed that all applicants will apply from that level of training. Applications can also be made by medical graduates (including BST Trainees and Fellows) at any time beyond PGY2.

Limits to the number of applications to SET

There will be no limit to the number of times that a person can apply to SET, and no limit to the number of specialties applied for. Unsuccessful applicants will be advised about their application, with counselling and strong career advice being given to any applicant who has made three unsuccessful applications to the same specialty.

Applications from International Medical Graduates

International Medical Graduates are eligible to apply to SET provided that they can satisfy the relevant eligibility requirements.

Eligibility criteria for the SET program

Any person wishing to apply for selection into the training program of one (or more) of the surgical specialties must fulfil all of the general eligibility criteria, plus the eligibility criteria for the specific specialty (or specialties) for which they are applying. If the applicant does not meet all of those criteria their application will not be considered.

General eligibility criteria

There are three eligibility criteria which apply across all nine specialties:

1. graduate of a medical school recognised by the Australian or New Zealand Medical Councils
2. unconditional registration to practice in Australia or general scope registration to practice in New Zealand. If training in New Zealand, applicants must also have Permanent Residency status or have been granted citizenship
3. satisfactorily completed internship and in PGY2 or later.

All general eligibility requirements must be completed prior to the closing of registration for selection on March 1 in each year.

Specialty specific eligibility criteria

A detailed list of the specific eligibility criteria for each specialty is provided in Appendix C of the SET document and the College website.

Unless specifically stated otherwise, an acceptable clinical rotation is a post-graduate experience with a minimum duration of 8 weeks, which has been under the supervision of an appropriately qualified clinician (surgeon, anaesthetist or intensivist depending on the type of term).

Applicants may apply for selection into SET if they can demonstrate, by the application deadline, that they will complete all the mandatory clinical requirements of the specialty to which they are applying by December 31st of that year.

Documentation:
On-line access to eligibility criteria for SET

Selection tools

Selection into surgical training is competitive. A detailed list of the tools and the weighting of the different components for each specialty will be made available on the College website prior to the opening of selection.

In 2007 most specialties will continue to use the same tools, with the same weightings that they used for selecting their trainees in 2006. However in 2008 these tools and weightings will be modified to become more standardised across the specialties.

Documentation: The Selection and Work-based Assessment of Surgical Trainees (see Attachment 5 in this document)

Registration for selection

Doctors intending to apply for selection must register for selection by March 1st in the year in which they are applying. The details on each candidate's registration will be used to determine if the minimum eligibility criteria have been met. Only those who meet these requirements will be allowed to progress to the next step of submitting a full application.

Applicants who do not already have a relationship with the College are charged a fee to cover the cost of processing applications. Information about that fee is published on the College website in association with the on-line registration for selection. In 2007 registration for selection is a single fee, regardless of whether it is for single or multiple specialties. In 2006, the Australian Orthopaedic Association and the Urological Society of Australia and New Zealand charged an application fee. For 2007, this can be ascertained on the website of the relevant specialty society.

A fee for registration for selection will be incurred each year.

Documentation:

Selection Registration (As Selection registration closes 1 March 2007, This link may not be available)

Applying for selection

Having registered for selection in their nominated specialty or specialties, applicants will then complete an application form.

There will be common application dates for all surgical specialties in both Australia and New Zealand. The opening date will be the first Monday in April, and the closing date, the last Friday in April. All of the selection processes, for all specialties will be completed by the end of July. Successful applicants will be given a two week time period in which to accept the offer.

Prior to the opening of selection, information about the requirements for selection and the weighting of the selection tools of the specialties will be published on the College website; and in the case of Neurosurgery; Orthopaedic Surgery; Plastic and Reconstructive Surgery; and Urology, on their websites of their respective Association or Society.

Conduct of the selection process

There will be one selection process for SET for all applicants and all specialties (Australia and New Zealand). Applicants will not be required to nominate whether they are applying for SET1 or SET2.

In allocating selected trainees to their training positions the Specialty Boards have the discretion to recognise successful applicant's level of prior learning and make the decision about whether to place selected trainees into either SET1 or SET2. Depending on the number of training positions available in the specialty to which they are applying, and their ranking according to that specialty's selection criteria, successful applicants may be offered places in SET1 or SET2.

Due to the anticipated number of successful applicants in 2007 and the number of positions to be filled (see Section three on Trainee numbers) it is not guaranteed that applicants eligible to commence in SET2 will be offered a training post at that level. Each successful applicant will be considered on their own merit with SET2 posts being offered to the highest ranked successful applicants eligible to commence at that level. Lower ranked applicants eligible to commence at SET2 but for which no post is available are likely to be offered a SET1 position.

Current specialist trainees and Fellows can also apply for selection in a different specialty. Provided they met the eligibility requirements for the specialty into which they are applying, and are successful, their prior learning will be considered by the specialty board in making a decision about the level at which they will commence training.

All Specialty Training Boards reserve the right to short-list applicants. Therefore application to a specialty does not guarantee an invitation for interview. As each specialty has a minimum standard for selection, interviews will not be offered to those applicants who, even with a maximum score in the interview, would not achieve this minimum standard. All others will be invited for interviews and will receive at least two weeks notice of the interview date.

If applicants apply to multiple specialties and interviews are scheduled such that attendance is not possible, the applicant will need to choose which interview to attend.

Stages in the selection process

The SET selection process can be divided into 11 stages:

Stage 1 – Registration

The potential applicant registers their intention to apply on-line on the College website

Stage 2 – Assessment of eligibility against the general eligibility criteria

The College administrative staff will screen registrants for eligibility.

Stage 3 – Submission of application

The applicant applies directly to the relevant Specialty Training Board of the College using a proforma Application Form.

Stage 4 – Assessment of eligibility against the specialty requirements

An assessment is undertaken by administrative staff who screen for eligibility.

Stage 5 – Scoring the Curriculum Vitae

The Curriculum Vitae is scored by the selection panel.

Stage 6 – Scoring other Selection Tools (excluding Interviews)

Administrative staff distribute referee reports to the nominated referees and score the completed reports when returned. Referees' reports are written in a standardised pro forma with a view to achieving objectivity, comparability and quantification.

Professional Performance Appraisals (PPA) entail telephone contact by a member of the selection committee with any person with whom the applicant has worked within a specified period. This feedback is recorded according using a standardised scoring tool. Professional Performance Assessments are recorded in a standardised pro forma with a view to achieving objectivity, comparability and quantification.

Stage 7 – short-listing (some specialties)

Specialties identify suitable applicants for interview — defined as an applicant who has met the defined minimum selection criteria for that specialty.

Stage 8 – Interview

Each Specialty Board nominates a selection committee to undertake the selection process, the size and composition of which is determined in accordance with the number of suitable applicants. Training sessions are run for interviewers on the College's selection principles and procedures In accordance with the ACCC determination of June 2003 (Authorisation No. A90765), a Jurisdictional Representative is invited to be present on all bi-national selection committees and on all Australian national selection committees.

Interviews are conducted by panels of interviewers, the majority of whom are surgeons. The composition of the interview panels is determined by the Specialty Board.

Stage 9 – Ranking and determining suitable applicants

Once interviews have been completed, the applicants are ranked according to the combined weighted score that they have been awarded for each selection tool.

Stage 10 – Offers made to selected applicants

Specialty Boards will make offers of a training position to selected applicants according to their ranking and the number of available training posts.

Stage 11 – Allocating Trainees to training positions

Allocation of accepting applicants to training positions is undertaken either by the Specialty Board or their Regional Subcommittees / Boards.

Training Boards are required to fill all training positions for which they have identified suitable applicants. If there are more available positions than suitable applicants, some training positions may be unfilled.

Feedback to unsuccessful applicants

All unsuccessful applicants, if they request, are provided with written feedback on their standing and performance in the application and selection process.

Any applicant who has had three unsuccessful attempts in applying to the same specialty will receive strong advice on their professional options.

Transition for Trainees currently in BST

The BST program will continue, in parallel with SET whilst there are trainees in the program. All Basic Surgical Trainees will continue their training until such time as they complete their BST training or are selected into the SET program.

All BST Trainees will be able to apply for the new SET program at any stage provided they have met the eligibility requirements for the specialty (or specialties) for which they are applying. At the time of selection the relevant training Board will assess the prior learning of each successful BST applicant and determine whether they will enter at SET1 or SET2.

SET2 will replace the first year of SST in 2008. The specialties of Orthopaedic Surgery, Paediatric Surgery and Plastic and Reconstructive Surgery currently have a specialty specific basic science examination which their trainees are required to pass. This requirement will continue for trainees selected into those specialties who have already completed the BST examinations.

Trainees who have completed all BST requirements may choose to withdraw from BST and register in PreSET. However, before making that decision trainees are advised to consult their employer on the implications of no longer being enrolled in a training program. They also need to take into consideration that when they are no longer trainees of the College they will not have access to the on-line library service and will be required to pay the SET application fee.

Former trainees seeking permission to reapply to surgical training in the same specialty, or in a different specialty, may do so by writing to the office of the Censor in Chief, in accordance with the policy titled 'Former Trainees Seeking Re-entry To Surgical Training' which is available on the College website.

Documentation: Former Trainees Seeking Re-entry to Surgical Training (Weblink)

Selection in the Cardiothoracic Surgery Program

The criteria for application for selection into Cardiothoracic Surgery have been published on the College website. Applications will be received from applicants who have successfully met all of the eligibility criteria. Besides the 'General eligibility criteria' the Cardiothoracic Surgery eligibility requirements are:

Mandatory:

Minimum of 2 surgical terms prior to application
Emergency term

Recommended:

Cardiology
Respiratory Medicine
Cardiothoracic Surgery
Research

Documentation:
Cardiothoracic Surgery eligibility criteria for SET

Selection tools and weightings

Tools	Number	Weighting
Structured CV	1	15%
Clinical Referee Reports	3	20%
Professional Performance Assessment	3	25%
Semi-structured Interview	1	40%

The CV assesses:

- Experience as a surgical registrar / resident
- Research experience and publications
- Skills and achievements outside of medicine

The clinical referee report assesses:

- Knowledge – medical expertise
- Clinical skills
- Operative technique
- Communication skills and Professionalism and ethics

The Professional Performance Assessment assesses:

- Communication skills
- Collaboration
- Professionalism and ethics

The semi-structured interview assesses:

- Communication skills
- Knowledge of the specialty
- Professionalism and ethics
- Management and Leadership
- Health advocacy
- Scholarship and Teaching

Documentation: (Note these are currently not accessible from the web and are available for reference at the College)

Proforma for on-line application and CV

Proforma of clinical referee report

Proforma of professional performance assessment

Proforma of semi-structured interview

Significant steps in the selection process

The selection process is a bi-national open ranked composite score process carried out in Australia and New Zealand, following which, vacant positions will be offered to candidates in order of national ranking.

The summation of the score from each segment of the selection process, known as the aggregate score, will allow ranking of candidates to be undertaken. Scores from the CV; clinical referee report; professional performance assessment and semi-structured interview for each applicant were added together to determine their ranking.

Ranking following application for training in Cardiothoracic Surgery will be only be taken for those candidates who have met the minimum selection criteria for selection.

Applicants must receive a 'Fair' or above in all of the criteria assessed in the semi-structured interview.

The offer of a position in the Specialist Cardiothoracic Surgical Training Program is determined by the level of ranking and the availability of a vacant training position in the year of application.

Note: rotations may occur at any approved post within the program and trainees must accept their assigned rotations.

Selection tools and processes reflecting the Brennan Principles

The Board of Cardiothoracic Surgery publishes details of selection regulations and processes on the college website prior to the opening of selection.

The Board of Cardiothoracic Surgery publishes details of quotas and limits relating to training positions on the college website prior to the opening of selection.

The CV's are all scored by a small subcommittee drawn from members of the Board.

The Board ensure that the people who interview each applicant are unbiased to the interviewees, by calling for declaration of conflict of interests, also by ensuring that each applicant is interviewed by two members who are required to reach consensus and this process is repeated. The Board attempts to ensure that at least one member of each interview panel has been trained as an interviewer.

The College publishes annual figures on numbers of applicants, status (BSTY/TST/OTD), and numbers of each category selected in the Annual Activities report:

The College has an appeals process which allows appeals from unsuccessful applicants who believe that the process was unfair.

Documentation:
College Annual Activities Reports (Weblink)
College Appeals Policy

Selection in the General Surgery Program

The criteria for application for selection into General Surgery have been published on the College website. Applications will be received from applicants who have successfully met all of the eligibility criteria. Besides the 'General eligibility criteria' the General Surgery eligibility requirements are:

- Minimum of two surgical terms prior to application.
- Satisfactory performance in an Emergency term
- Satisfactory performance in a Critical Care term (ICU, HDU or similar high intensity clinical area)

Documentation:
General Surgery eligibility criteria for SET (Weblink)

Selection tools and weightings

Tools	Number	Weighting
Structured CV	1	30%
Clinical Referee Reports	3	40%
Hospital Assessment Report	2	These do not contribute to the weighted score, but do contribute whether the applicant passes the minimum selection criteria
Semi-structured Interview		30%

The CV assesses:

- Experience as a surgical registrar / resident
- Research experience and publications
- Skills and achievements outside of medicine

The clinical referee report assesses:

- Knowledge – medical expertise
- Clinical skills
- Operative technique
- Communication skills and Professionalism and ethics

The hospital assessment report assesses:

- Communication skills
- Collaboration
- Professionalism and ethics

The semi-structured interview assesses:

- Communication skills
- Team work skills
- Leadership skills
- Verbal communication in English language
- Professional attitudes
- Medical Ethics

Documentation: (Note these are currently not accessible from the web and are available for reference at the College)
Proforma for on-line application and CV
Proforma of clinical referee report
Proforma of hospital assessment report
Proforma of semi-structured interview

Significant steps in the selection process during 2006 for the 2007 intake

The selection process is a national open ranked composite score process carried out in Australia and New Zealand, following which, vacant positions will be offered to candidates in order of national ranking.

The summation of the score from each segment of the selection process, known as the composite score, will allow ranking of candidates to be undertaken. Scores from the CV; clinical referee report; and semi-structured interview for each applicant were added together to determine their ranking.

There will be no score given to the information from the hospital assessment report, however this report is used to assess if there are critical flaws in the performance of the candidate such as attitude, ethical or work place performance issues. The categories are as for the mentor assessments with the exception of technical performance. If there are 2 or more unsatisfactory areas in the mentor and or hospital assessments that are in agreement then the candidate does not fulfil the essential criteria to be considered for selection.

Ranking following application for training in General Surgery will be only be taken for those candidates who have met the minimum selection criteria.

Applicants must receive a 'Fair' or above in all of the criteria assessed in the semi-structured interview.

The offer of a position in the Specialist General Surgical Training Program is determined by the level of ranking and the availability of a vacant training position in the year of application.

Note: rotations may occur at any approved post within the program and trainees must accept their assigned rotations.

Documentation:

General Surgery Regulations

Processes for determining applicants who meet minimum selection criteria (available for reference at the College) *documented in the out-come report from the workshop in Coogee in Feb 2006.*

Selection tools and processes reflecting the Brennan Principles

The Board of General Surgery publishes details of selection regulations and processes on the college website prior to the opening of selection.

The Board of General Surgery publishes details of quotas and limits relating to training positions on the college website prior to the opening of selection.

Applicants in each country are assessed on the same tools, and their scores are ranked nationally.

The de-identified CV's are all scored by a small subcommittee drawn from members of the Board. The members of the board score each 1 twice, and board members do not score applications from their own region to ensure they are truly blinded.

The regional board ensure that the people who interview each applicant are unknown to the interviewees. The regional subcommittee attempts to ensure that at least 1 member of each interview panel has been trained as an interviewer.

The regional board ensure that the people who interview each applicant are unknown to the interviewees. The regional subcommittee attempts to ensure that at least 1 member of each interview panel has been trained as an interviewer.

The College publishes annual figures on numbers of applicants, status (BSTY/TST/OTD), and numbers of each category selected in the Annual Activities report.

The College has an appeals process which allows appeals from unsuccessful applicants who believe that the process was unfair.

Documentation:

College Annual Activities Reports (Weblink)

College Appeals Policy

Selection in the Neurosurgery Program

The Board of Neurosurgery publish very detailed Selection Regulations on an annual basis. In addition to the generic eligibility criteria applicants must consent to a full criminal history check.

Documentation:
Selection Process Regulations (web link and paper based)

Selection tools and their weightings

The selection process for the SET program will use the following selection tools with the associated weightings:

Structured Curriculum Vitae 20%
Structured Referee Reports 35%
Semi-Structured Neurosurgery Panel Interview 45%

The Structured Curriculum Vitae is scored by two members of the selection committee using a predetermined structured scoring process for each of the following areas, each of equal weighting:

- Higher degrees
- Neurosurgery experience
- Other relevant clinical experience (defined by the Board)
- Publications
- Presentations
- Development activities

If there is any variance in the scores given by the two members for a particular applicant the Chairman of the Board of Neurosurgery will review the scores to identify the error and determine the correct score. In recognition that applicants will be more junior there is no minimum standard for this selection tool.

The Structured Referee Reports have been designed as competency based assessments. On the report the referee selects one of five options for each of the twenty assessment areas which they believe best describes the applicant. Each competency has a corresponding score. The categories and associated number of assessment areas are as follows:

- Technical Expertise and Patient care (3 assessment areas)
- Judgement and clinical decision making (3 assessment areas)
- Medical expertise and knowledge (3 assessment areas)
- Attitudes and professional conduct (6 assessment areas)
- Communication and collaboration (3 assessment areas)
- Overall potential (2 assessment areas)

In recognition that applicants may have limited experience prior to application, applicants will now be required to identify the two supervising consultants from each rotation they have worked in the four years prior to the closing date for applications who had the greatest period of supervision over their position in the four years prior to application. It is no longer a specific requirement that this include two neurosurgical consultants or the current head of department. From these referees the Board will select a minimum of five and a maximum of eight referees. In doing so the Board will endeavour to obtain at least one report from each including at least one from each neurosurgical rotation (where applicable) and a suitable cross section from the remaining surgical, neurology, intensive care or emergency department rotations, preferably undertaken in the two years prior to the closing date. . The report with the highest and lowest score will be excluded from the scoring process to provide a balanced assessment. The remaining reports are combined to provide an overall score. Applicants are required score 60% or above to be deemed suitable for selection and to be eligible to present for the interview.

The Semi-Structured Neurosurgery Panel Interviews will be held in Melbourne on the one day. The interview will consist of ten sections and will include reference to information obtained from the structured referee reports and structured curriculum vitae. Applicants will be asked the same initiating questions with follow-up probing questions relevant to the individual. The interview sections are:

- Neurosurgical Insight (A)
- Working Relationships (A)
- Stress Response (A)
- Personal & Performance Insight (A)
- Risk Management (A)
- Conflict Resolution and Communication (A)
- Ethical Behaviour (A)
- Research & Publications (B)
- Professional Development (B)
- Knowledge Acquisition & Recognition (B)

The interview will be conducted by interview panels, consisting of a minimum of three and a maximum of four members, with applicants rotating between panels. Applicants will be scored using a structured scoring system and scoring criteria which has been modified to reflect the anticipated decrease in the experience level of applicants. Applicants must score a rating of 4 (which is classified as "suitable") or above in each Class A section during the Neurosurgery Semi-structured Interview to be deemed suitable for selection.

Significant steps in the selection process

The selection process will be conducted on a bi-national basis. Submission of the Structured Curriculum Vitae will be via the College online application form.

Following the closing date for applications the Structured Curriculum Vitae and Structured Referee Reports will be distributed, processed and scored in accordance with the Selection Process Regulations to arrive at an overall percentage adjusted score for each selection tool.

Applicants must satisfy the minimum standard for the Structured Referee Reports to be deemed suitable for selection, being an overall percentage adjusted score of 60.00%. Applicants who satisfy this minimum standard will be notified of their interview time. Applicants who do not satisfy this minimum standard will be deemed unsuitable for selection and will not be eligible to present for interview. These applicants will be notified in accordance with the Selection Process Regulations. The interviews will be conducted in accordance with the Selection Process Regulations.

Applicants who achieve the minimum standard for the Structured Referee Reports and the Neurosurgery Semi-Structured Interview will be deemed suitable for selection and will be ranked applying the weightings for each of the three selection tools to provide a percentage adjusted score out of 100. In the event that two or more applicants achieve the same overall ranking, the score for the Structured Referee Reports will be the differentiating factor.

Converse to previous years there will be two entry points to the SET program being SET1 and SET2. To be eligible for the SET2 intake applicants must have completed published components of the previous BST program and have a minimum 26 weeks neurosurgical experience. All eligible and suitable applicants will be considered for SET1 positions.

Suitable and eligible applicants for SET2 positions, who rank high enough in comparison to the number of SET2 positions available, will be deemed successful for SET2 and allocated, according to their ranking. Suitable and eligible applicants for SET1 positions, who rank high enough in comparison to the SET1 intake, being 14 to reflect to the workforce requirements in Australia and New Zealand, will be deemed successful and allocated, according to ranking, to a SET1 position in a region designated by the Board of Neurosurgery. The regional allocation is based on population ratios.

All other suitable applicants not successful in being allocated to a SET1 or SET2 training position will be deemed unsuccessful.

All applicants will be notified of the outcome of their application in accordance with the Selection Process Regulations.

Selection Process Regulations (web link and paper based)
Selection Process Committee Regulations (paper based - **confidential**)
Application Form (web link to College online application form)
Structured Referee Form (paper based only)
Neurosurgery Training Website (www.neurosurgerytraining.org – username & password AMC)

Ways in which selection tools and processes reflect the Brennan principles

The Board of Neurosurgery publishes detailed Selection Process Regulations prior to selection opening which provide a clear and transparent description of the selection process, tools, principles and eligibility and selection criteria.

Standardised proforma and documented scoring criteria, scales and processes are used for each selection tool which provide quantifiable outcomes. The scoring for each selection tools is based on the published selection criteria.

The interview panels are limited to a maximum of four persons at any time, with applicants rotating between the panels. Each panel asks the same questions of each applicant and assesses the applicant against the documented scoring criteria to provide consistent scoring and comparability of applicants. Applicants who failed to achieve one or more of the minimum standards for selection, as published, will be deemed unsuitable for selection. The use of minimum performance standards deemed essential for neurosurgical training is used instead of a numeric overall cut off score as the standards could be validated against the selection criteria.

The final ranking of suitable applicants, and their appointment to the SET program, will be based on the overall score achieved by combining the scores for each selection tool and applying the published weightings. The limit to the number of successful applicants is determined by the number of vacant accredited training positions for SET2 and by published workforce requirements for SET1. Applicants are informed in advance of the number of anticipated positions.

The Board of Neurosurgery retains electronic copies of all selection documentation for all applicants for a period of not less than three years to enable re-construction and justification of selection decisions. At the conclusion of each selection process the Board of Neurosurgery conducts an extensive review of the selection process and finalises modifications for the following year.

Selection in the Orthopaedic Surgery Program

The selection guidelines for Specialist Surgical Training in Orthopaedic Surgery are published on the AOA website. The selection process is transparent and accountable. It explores the abilities, qualifications, experience, standard of work performance and personal qualities of applicants that would enable them to perform all the required duties of an Orthopaedic Registrar, achieve all the objectives of the training scheme as outlined in the document and become a skilled and highly competent orthopaedic surgeon.

This document details the selection philosophy, the required qualifications and attributes, the minimum criteria for eligibility, the information available to applicants, the selection procedure and the processing of applications, the details of assessment of the application documents, the interview process, and in-depth reports. It further details the ranking process and the handling of documentation. It describes in detail the feedback process, the review process of the selection, and the handling of complaints and appeals.

For selection into SET Eligibility criteria for application to SET will be at a less advanced level than has been required to progress from BST to SST. It would appear that BSTs will apply in the normal way for SST, and they will progress directly to SET2 and continue through the program as would have happened had SET not been in place. It is likely that BSTs who rank above minimum requirements, but are not offered a SET2 place will be offered a SET1 position.

The selection process has been put in place with attention to the Brennan principles. The weighting of the selection tools is as follows:

1. Structured application documents: 20% of final assessment - up to 10% academic qualifications and research, and up to 10% for professional and community involvement.
2. Semi-structured interview: up to 30% of the final score. The structure of the interview is detailed at length in the web document, and conforms to the Brennan principles.
3. In-depth reports from nominated referees and other medical and non-medical approached referees: up to 50% of the final assessment. These are provided from three nominated referees. In addition, five reports are solicited from medical practitioners who have worked with the applicant during the previous two years. The previous requirement to have all consultant reports from surgeons has been modified. The applicant may request that individuals be excluded from being approached. A minimum of six completed reports are required. In addition, two reports from para-medical, nursing, or administrative staff are solicited by a consultant nominated by the Regional Training Committee. For further details relating to this process, the web document should be consulted. The combined in-depth reports constitute 50% of the final assessment.

For selection in SET, applicants will be short listed for interview based on their application document score and the in-depth reports. As in previous years, it is envisioned that the interview process will appoint approximately 44 SET2 positions and an equal number of SET1 positions. Current BSTs are likely to be offered the majority of the SET1 positions as otherwise they would be disadvantaged.

The interview process takes place at the same time nationwide. Standardised questions and responses are used. JRs are incorporated into the process in every state and a JR is present at the subsequent national selection meeting in July. The data handling is carried out at the AOA main office in Sydney and details of the ranking process are available on the website. To avoid bias from previous assessments, unsuccessful applications are kept until the end of the calendar year. Following the selection meeting, all Regional Chairs report on the process and any difficulties or suggestions are made to the AOA Board.

Documentation:
AOA Selection Policy and Documentation(Weblink)

Selection in the Otolaryngology Head and Neck Surgery Program

The criteria for application for selection into Otolaryngology Head and Neck Surgery have been published on the College website. Applications will be received from applicants who have successfully met all of the eligibility criteria. Besides the 'General eligibility criteria' the Otolaryngology Head and Neck Surgery eligibility requirements are:

Mandatory:

Critical Care term (ICU, HDU or similar high intensity clinical area)

24 weeks of surgical rotations

8 weeks in Emergency Department (2008)

Recommended:

Completion of ASSET

Completion of CCrISP

Time in an OHNS rotation as part of the 24 weeks of surgery

Documentation:
Otolaryngology Head and Neck Surgery eligibility criteria for SET (Weblink)

Selection tools and weightings

Tools	Number	Weighting
Structured CV	1	20%
Professional Performance Appraisals	3	40%
Semi-structured Interview	1	40%

The CV assesses:

- Experience as a surgical registrar / resident
- Research experience and publications
- Skills and achievements outside of medicine

Professional Performance Appraisals assesses:

- Knowledge – medical expertise
- Clinical skills
- Operative technique
- Collaboration
- Professionalism and ethics

The semi-structured interview assesses:

- Communication skills
- Professionalism and ethics

Documentation: (Note these are currently not accessible from the web and are available for reference at the College)

Proforma for on-line application and CV

Proforma of Professional Performance Appraisals

Proforma of semi-structured interview

Significant steps in the selection process

The selection process is a national open ranked composite score process carried out in Australia and New Zealand, following which, vacant positions will be offered to candidates in order of national ranking.

The selection interview process for 2008 intake will be different form previous years. The selection interviews will be conducted in the one location as opposed to a state by state

interview process. This will involve all candidates and interviewers coming together in the one location (yet to be confirmed) and will allow us to have interviewers from different states on the same panels. We hope this will remove any perceived state bias that may have existed in the past.

The summation of the score from each segment of the selection process, known as the aggregate score, will allow ranking of candidates to be undertaken. Scores from the CV; clinical referee report; and semi-structured interview for each applicant were added together to determine their ranking.

Ranking following application for training in Otolaryngology Head and Neck Surgery will be only taken for those candidates who have met the minimum selection criteria for selection.

Applicants must receive a 'Fair' or above in all of the criteria assessed in the semi-structured interview.

The offer of a position in the Specialist Otolaryngology Head and Neck Surgical training program is determined by the level of ranking and the availability of a vacant training position in the year of application.

Note: rotations may occur at any approved post within the program and trainees must accept their assigned rotations.

Selection tools and processes reflecting the Brennan Principles

- The Board of Otolaryngology Head and Neck Surgery publishes details of selection regulations and processes on the college website prior to the opening of selection.
- The Board of Otolaryngology Head and Neck Surgery publishes details of quotas and limits relating to training positions on the college website prior to the opening of selection.
- Applicants in each country are assessed on the same tools, and their scores are ranked nationally.
- The de-identified CV's are all scored by a small subcommittee drawn from members of the Board.
- The regional subcommittees ensure that the people who interview each applicant are unknown to the interviewees. The regional subcommittee attempts to ensure that at least 1 member of each interview panel has been trained as an interviewer.
- The College publishes annual figures on numbers of applicants, status (BSTY/TST/OTD), and numbers of each category selected in the Annual Activities report:
- The College has an appeals process which allows appeals from unsuccessful applicants who believe that the process was unfair.

Documentation:

College Annual Activities Reports (Weblink)

College Appeals Policy

Selection in the Paediatric Surgery Program

The criteria for application for selection into Paediatric Surgery have been published on the College website. Applications will be received from applicants who have successfully met all of the eligibility criteria. Besides the 'General eligibility criteria' the Paediatric Surgery eligibility requirements are:

- must have completed (or be registered to complete by the end of the year of application) a minimum of one x six months or two x three months of paediatrics or surgery within the eighteen months prior to application.

Documentation:
Paediatric Surgery eligibility criteria for SET (Weblink)

Selection tools and weightings

Tools	Number	Weighting
Structured CV	1	10%
Professional Performance Appraisals	3	40%
360 Degree Evaluation	6	20%
Presentation	1	10%
Semi-structured Interview	4 panels	20%

Applicants must score at least 30.00 marks (out of a possible 70.00) from the Structured Curriculum Vitae, Professional Performance Appraisal and 360 Degree Evaluation Form in order to be eligible to give a presentation and attend an interview. An unsuitable response (mark of 1) for two or more questions during the Semi-Structured Interview will result in an applicant automatically being considered unsuitable for training.

The CV assesses:	• Experience as a surgical registrar/resident • Higher Medical Degrees • Publications and Papers • Research projects • Awards and Skills and Achievements Outside of Medicine
The Clinical Referee report assesses:	• Knowledge – medical expertise • Clinical skills • Operative technique • Communication skills • Professionalism and ethics
The Professional Performance Appraisal assesses:	• Knowledge – medical expertise • Clinical skills • Operative technique • Communication skills • Professionalism and ethics
The Presentation assesses:	• Judgement – clinical decision making • Communication Skills
The Semi Structured Interview assesses:	• Communication Skills • Professionalism and Ethics • Judgement – clinical decision making
The hospital assessment report assesses:	• Communication Skills • Collaboration • Professionalism and Ethics

Documentation: (Note these are currently not accessible from the web and are available for reference at the College)
Proforma for on-line application and CV
Proforma for professional performance appraisal

Proforma for presentation
Proforma for 360° evaluation
Proforma of semi-structured interview

Significant steps in the selection process

The selection process is a bi-national process carried out for positions within Australia and New Zealand, with applicants ranked in order and appointed to the training program based on the number of training positions available.

The composite score from each selection tool allowed ranking of candidates to be undertaken.

There will be no score given to the information from the hospital assessment report; however this will be used by the selection committee for ranking purposes in instances where candidates were otherwise considered equivalent.

The offer of a position in the Specialist Paediatric Surgical Training program is determined by the level of ranking and the availability of a vacant training position in the year of application.

Selection tools and processes reflecting the Brennan Principles

- The Board of Paediatric Surgery publishes details of selection regulations and processes on the College website prior to the opening of selection.
- The Board of Paediatric Surgery publishes details of quotas and limits relating to training positions on the College website prior to the opening of selection.
- All applicants are assessed by all selection tools.
- The College has an appeals process which allows appeals from unsuccessful applicants who believe that the process was unfair.

Documentation:
Please refer to the Selection Regulations into SET in Paediatric Surgery

Selection in the Plastic and Reconstructive Surgery Program

Eligibility requirements for selection

The criteria for application for selection into Plastic and Reconstructive Surgery have been published on the College website. Applications will be received from applicants who have successfully met all of the eligibility criteria. Besides the 'General eligibility criteria' the Plastic and Reconstructive Surgery eligibility requirements are:

Mandatory

- A Critical Care Rotation
- An Emergency Rotation
- A formal term of at least four weeks in a Plastic Surgery unit at either, a resident, registrar or final year medical school level.

Desirable

ASSET (must be completed in SET1 or earlier)

Documentation:
Plastic and Reconstructive Surgery eligibility criteria for SET (Weblink)

Selection tools – SET program

The selection tools utilised for selection into SET in Plastic and Reconstructive Surgery are

- A structured Curriculum Vitae completed on the Board of Plastic and Reconstructive Surgery application form
- Professional Performance Assessments
- Interview

Selection process – SET program

Further information will be advertised widely prior to the commencement of selection.

Selection tools and processes reflecting the Brennan Principles

The Board of Plastic and Reconstructive Surgery published the selection requirements prior to selection which provided a clear and transparent description of the selection process, tools, eligibility criteria and selection criteria.

Applicants supply their CV on the Board of Plastic and Reconstructive Surgery application form; CVs are scored on the criteria of academic performance, work experience, research, presentations and publications contributing to a weighting of 25%. A single, standard score sheet is used by the Board to assess CVs. The application form, score sheet, assessment tools and method of selection are reviewed by the Board on a yearly basis.

Candidates are advised at the time of application that the PPA assessment is weighted 50%; PPA assessments are conducted by the members of the Board and selected supervisors in each state, and requires personal contact or a telephone interview with any person that the applicant has worked with in the previous two years; and may include Consultant Medical Staff, Specialist Surgical Trainees, Basic Surgical Trainees, Ward Nursing Staff, Operating Theatre Nursing Staff and Hospital Administration Staff. Assessors are provided with guidelines for the completion of Professional Performance Assessments, which outlines staff members that may be contacted. The assessor is required to ask all those contacted if there is a conflict of interest in them providing an assessment and if they feel they are able to provide an assessment. Assessors are also provided with guidelines for scoring which outlines what type of performance corresponds to what score. All candidates interviewed are asked standardised interview questions, and assessed the applicant against documented scoring criteria.

The final ranking of suitable applicants and their appointment to the training program will be based on the overall score achieved by combining the scores achieved for each selection tool and applying the published weightings. The limit to the number of successful candidates is determined by the number of vacant accredited training posts. Applicants were informed in advance the number of anticipated positions.

Since 2006, the Board of Plastic and Reconstructive Surgery retains electronic copies of all selection documentation for applicants for a period of at least three years to ensure transparency and justification of the selection process. At the conclusion of the selection process the Board of Plastic and Reconstructive Surgery undertakes a review of the process, and undertakes any modifications to the selection process that are required based on this review.

Selection in the Urology Program

Eligibility requirements for selection

The criteria for application for selection into Urology have been published on the College website. Applications will be received from applicants who have successfully met all of the eligibility criteria. For 2007 Urology will only be applying the 'General eligibility criteria'. Due to the imposed timeframe, it was not possible to demand any specialty specific eligibility criteria for a 2007 application into SET1.

Eligibility criteria for applications to Urology in 2008 will include;

- A term (minimum of 8 weeks of work, not including any leave) of A and E at PGY2 seniority, or above.
- A term (minimum of 8 weeks of work, not including any leave) of Surgery at PGY2 seniority, or above.
- A term (minimum of 8 weeks of work, not including any leave) of Medicine, preferably Nephrology, General Medicine, Geriatrics, or Neurology.
- The ability to justify the decision to have chosen Urology as the preferred surgical career through undergraduate or postgraduate exposure to the specialty.

Though eligibility criteria for selection, the above do not need to be completed before the conclusion of the selection process, which is mid-year. Evidence an applicant is allocated to complete these terms prior to the date of commencement of SET will be accepted at the time of selection.

In the future, when the requirement is reasonable and feasible, the following will be eligibility criteria for selection:

- The ASSET course
- The CCrISP course

Again, these do not need to be completed prior to selection, but evidence must be provided at the time of selection these will be completed before commencement in SET.

Any criteria for eligibility to selection, once viewed and approved by the Board of Urology, take no further part in the selection or ranking of applicants to Urology.

Selection tools and weightings

Urology uses a bi-national selection process. With this, all applicants from Australia and New Zealand are assessed using a consistent process. At the conclusion of the selection process, all applicants are ranked in a consistent and equitable manner. This ensures all applicants an equal opportunity of success in selection, and ensures selection is criterion based. A justifiable weighting is applied to applicants in their Section of permanent residence.

There will be 3components used by the Board of Urology to rank applicants to Urology.

Curriculum Vitae The weighting will be 20%

In 2006 the components of the CV used for ranking purposes were publications in peer reviewed journals, presentations to a meeting for which abstracts were subject to review and selection, and higher degrees. Applicants needed to provide proof of each with their application. For SET experiences to be included in the CV will be adjusted to take account of the inexperienced nature of the anticipated applicant.

Referee's Reports The weighting will be 35%

In 2006 the Referees Reports were used to provide an insight into an applicant's performance in his/her surgical career to date. Applicants were asked to provide three referees, all of which were used. Referees must have had input into an applicant's surgical training for a period not less than three months. Referees must have been involved in an applicant's surgical training within the two years immediately preceding the date of application.

For SET Referee's Report will have a reduced five point (not seven point) scale for each attribute. Referees will be asked to include an example of behaviour if intending to use the extremes of the rating scale.

Interview The weighting will be 45%

The Urology interview is consistent, and conducted according to the College recommended framework and guidelines. The personal attributes assessed during the course of this interview are:

- interaction
- teamwork
- ethics
- empathy
- self assessment
- communication

The qualities and attributes assessed at interview are considered essential for an urologist. Applicants not achieving a criterion level at interview were not further considered for selection.

The structure of the interview will not change; the scenarios will all be new.

Interviews will be limited to the allocated time, and all candidates will be warned of this.

The interview panel will be reduced to three (plus a jurisdictional observer, where supplied), with the Urology Board Chair no longer travelling to all interviews.

Selection process

During the 2007 selection process, trainees will be considered for appointment to SET1, SET2, and SET3. Applicants who fail to reach the logbook criteria (evidence of a year of surgery in general) will not be excluded from consideration, but will be considered for appointment to SET1 or SET2, according to an evaluation of their experience and prior learning.

Applications are open for a finite and disclosed period.

Information regarding application will be available both on the USANZ website, and through the USANZ office. This information includes the nature of the selection tools used, and their relative weighting.

Applicants are required to return all documentation to the USANZ office.

Logbooks are multiply scored, and the final score used to confirm eligibility for selection. Individuals proving not eligible for further consideration will be notified promptly, with explanation.

CV's are multiply scored until consensus, and that score recorded.

Referees are contacted by post in a consistent manner. Returned Referees' reports are collated to give each applicant an average score, and this is recorded.

The Section Connection questionnaires are scored, and that score is recorded.

The semi-structured interviews are conducted in 4 sites in Australia, and 1 in New Zealand. All applicants are allocated an equal interview time. Each interview had 3 interviewers, all of whom had to reach consensus for the score for each component of the interview. At least 2 of the interviewers from each interview site conducted the interview at 2 or more sites. This was to ensure consistency of the conduct, and the scoring used, at all sites. All interviewers are blinded to the results of the remaining selection tools for each candidate being interviewed.

All applicants are ranked in a de-identified list following the collation of all selection tools scores. The appointability score is applied. Appointable applicants are sequentially allocated to the available training posts.

All applicants receive prompt written feedback regarding the result of their application, and their available courses of action.

Selection tools and processes reflecting the Brennan Principles

The Board of Urology provides applicants with a clear and transparent description of the selection process, selection tools used, and their relative weighting. Eligibility criteria are disclosed, the process is centralized and consistent, and the opportunities for selection bias are minimized (almost all of the process of evaluation of selection tools is undertaken by urologists from a different section to the applicant, and unknown to the applicant).

Interview panels are limited to four persons, the Board Chairman, TA and E Chairperson (local), TA and E Chairperson (interstate), TA and E Committee member (local). At least two of the interviewers are from a section remote to the applicant. Each interview is consistent, and assesses applicants against standardised scoring criteria to provide consistent scoring and comparability of applicants. Consensus is reached in all cases. Consistency of scoring is ensured by means of the process described above.

Each assessor is blinded to results of all other selection tools at the time of undertaking their part of the selection process.

The final ranking of suitable applicants, and their appointment to the Training program, is based on the overall score achieved by combining the scores of all selection tools. This ranking is undertaken with all applicants de-identified. The limit to the number of successful applicants is determined by the number of vacant accredited training positions assuming enough applicants are of appointable standard. Applicants are informed in advance of the number of anticipated positions.

At the conclusion of each selection process the Board of Urology conducts an extensive review of the selection process to determine whether any modifications are necessary for the following year.

Selection in the Vascular Surgery Program

The criteria for application for selection into Vascular Surgery have been published on the College website. Applications will be received from applicants who have successfully met all of the eligibility criteria. Besides the 'General eligibility criteria' the Vascular Surgery eligibility requirements are:

Mandatory:

- Portfolio of experiences to be maintained

Desirable experience:

- intensive care three months
- general surgery three months
- vascular surgery three months
- ED three months

Selection tools and weightings

The selection process for the SET program will use the following selection tools:

- CV
- Semi structured interview
- Professional performance appraisal x three (at least one from each of last three rotations
- 360º assessment x two – last two posts
- Satisfactory police check

Additional requirements in 2007 are the 360º assessment and the police check.
At the 2 December, 2006 meeting of the Board in Vascular Surgery it was agreed that the cut off score and weighting of selection components required consideration. All selection process documentation would be reviewed for finalization at the 3 March 2007 Board Meeting.

The CV assesses:

- Experience as a surgical registrar / resident
- Research experience and publications
- Skills and achievements outside of medicine

The professional performance assessment assesses:

- Clinical skills
- Technical skills
- Personality and inter-personal skills

Interview one – The vascular specific interview assessed prior knowledge of and commitment to training in vascular surgery

Interview two - The semi-structured interview assesses:

- Communication skills
- Team work
- Professional Standards and ethics
- Professional Performance
- Patient Support
- Professional Integrity
- Personal Well Being

Documentation: (Note these are currently not accessible from the web and are available for reference at the College)

Proforma for on-line application and CV

Proforma of Professional Performance Assessment

Proforma for vascular specific interview

Proforma of semi-structured interview

Significant steps in the selection process

The selection process is a bi-national open ranked composite score process carried out in Australia and New Zealand, following which, vacant positions will be offered to candidates in order of ranking.

The summation of the score from each segment of the selection process, known as the composite score, will allow ranking of candidates to be undertaken. Scores from the CV, professional performance assessment and semi-structured interview for each applicant will be added together to determine their ranking.

Ranking following application for training in Vascular Surgery will be only undertaken for those candidates who met the minimum selection criteria for selection. The selection process is Australasian and applicants are ranked regardless of whether they are from Australia or New Zealand.

The offer of a position in the Specialist Vascular Surgical Training program is determined by the level of ranking and the availability of a relevant vacant training position in the year of application.

Note: rotations may occur at any approved post within the program and trainees must accept their assigned rotations.

Selection tools and processes reflecting the Brennan Principles

The Board of Vascular Surgery publishes details of the selection process on the College website prior to the opening of selection.

Applicants in each country are assessed on the same tools, and their scores are ranked nationally.

The CV's are scored twice by two separate Board members.

The Board ensures that interviewers do not interview applicants who are based in the same state or country as the interviewer. The Board attempts to ensure that at least 1 member of each interview panel has been trained as an interviewer.

The College publishes annual figures on numbers of applicants, status (BST/TST/IMG), and numbers of each category selected in the Annual Activities report:

The College has an appeals process which allows appeals from unsuccessful applicants who believe that the process was unfair.

Documentation:
College Annual Activities Reports (Weblink)
College Appeals Policy

4.2. FORMATIVE ASSESSMENT

Formative assessment is ongoing and has the specific purpose of providing the Trainee (and supervisor) with immediate feedback with the intention of improving performance.

All specialties have mid-term in-training assessments with formative feedback and also a formal assessment at the completion of each six month term.

In the past three years specialties has gradually modified their in-training assessment forms to reflect their statement of required competence.

There is a variety of formative assessment processes being implemented. For example:

- Informal formative assessment is frequently given during ward-rounds and during surgery.
- Formal formative assessment is increasingly becoming part of the suite of assessment processes in each surgical specialty. It involves a variety of mid-rotation Trainee evaluation processes which can be the same form as the end-of-rotation assessment, a modified form and/or a 360 degree process.
- Three specialties also have an 'interim examination' which in each case is a hurdle requirement. These examinations are on basic sciences specific to their specialty.
- Some specialties have already introduced workplace competency assessment processes such as Direct Observation of Procedural Skills (DOPS).

The surgical supervisor and the regional committee of the relevant specialty board are responsible for the oversight of in-training assessment of specialist surgical trainees.

Documentation:
In-Training Assessment (Weblink)

Supervision and formative assessment during SET1

Formative assessment throughout training is essential in guiding trainees towards the effective and efficient achievement of competence. Frequent, accurate and directed feedback is an essential component in the development of any new skill or area of competence.

It is intended that there will be rigorous assessment during SET1 to ensure that trainees moving into SET2 are able to meet the requirements across all nine competencies. Any Trainee who is identified as unable to meet these assessment requirements will be given feedback including advice and support about their career options.

Workplace competency assessment

Experience in other countries has clearly demonstrated the benefits of using checklists and global rating scales as workplace assessment tools. Tools which have been thoroughly trialled and validated and which are under discussion include those available for the assessment of procedural skills, clinical examination of a patient, discussion of a case, clinical decision making, and teamwork. It is not intended that these assessment processes would add significantly to the time commitment for supervision. These assessment processes are designed to complement the time that trainees and supervisors are already working together in theatre, in wards, or on rounds. These assessments are expected to make the mid-term and end-of-term assessments more valid and reliable because the decisions can be based on documented evidence collected throughout the rotation.

Trainees, with the support of their supervisors, will be responsible for ensuring that they are assessed the required number of times during each rotation, and across the year, and for maintaining a record of those assessments in their portfolios.

To enhance the current range of formative assessment tools, the College is encouraging the Specialties to gradually introduce the following workplace competency assessment processes.

During 2007 a training program for supervisors is being initiated to provide guidance on workplace competency assessment and on managing underperforming trainees.

Technical Expertise

Direct Observation of Procedural Skills (DOPS) and Procedural Based Assessment (PBA)
DOPS and PBAs involve the observation of a surgical procedure by a supervisor. DOPS was designed to be both a formative and summative assessment process that was feasible, reliable and valid in assessing surgical skill in basic surgical procedures.

PBAs differ from DOPS in that they are generally used to assess intermediate and advanced surgical procedures.

In addition some specialties have developed specific tools to assess performance in key procedures.

Log books

All of the specialties have log books which have been reviewed to reflect the requirements of the modules defined for the current specialty training programs.

Because clinical experiences during SET1, in most specialties, will be across a number of specialties and clinical experiences, rather than being entirely focused upon the specific specialty, this will require a generic logbook that is currently being finalised.

Judgment – Clinical Decision Making and Communication

Mini Clinical Evaluation Exercise (Mini CEX)
The Mini-CEX is an assessment tool designed to assess the provision of good clinical care. The process involves an assessor observing the Trainee interact with one of their patients in a normal clinical encounter. The assessor uses a structured checklist to provide formative feedback to the Trainee.

Case–Based Discussion (CBD)

A CBD involves a discussion between a Trainee and their supervisor (or clinical group) about 1 of their clinical cases that challenge the Trainee (as opposed to a routine case).

Collaboration, Health Advocacy and Professionalism and Ethics

360° assessment or Mini Peer Assessment Tool (Mini PAT)
The 360° assessment, Mini PAT or Multi-source Feedback Assessment (MFA) is a widely used process to gain information about a Trainee from people other than their specialist supervisors. Assessors can include registrars, nursing staff, and other medical consultants.

In-training assessment forms

Most specialties have indicated that they intend to use their current in-training assessment forms for SET1. In each clinical rotation trainees will be assessed on these forms every three months throughout training.

Supervision and formative assessment during SET2^{+}

Specialties have indicated that they will continue to use their current formative assessment processes, gradually adding to their workplace competency assessment processes.

Management of underperforming Trainees

A feature of SET is the emphasis on the early identification and management of underperforming trainees.

During each rotation, trainees are required to meet the required standard of performance, in all of the nine competencies. Unless it is a breach of professional behaviour which could result in immediate dismissal from the program, a Trainee who is identified as not meeting those standards will be given a limited number of opportunities to attain the required standard. During that time they will be given clear guidance as to what is required. Failure to attain the required standard in the identified competence area, or poor performance against any other competence criteria could lead to dismissal from the program.

Specialties will apply their current processes for the management of underperforming trainees, at the same time taking opportunities to improve them.

Formative Assessment in the Cardiothoracic Surgery Program

Cardiothoracic Surgery is planning to maintain their current formative assessment process and to gradually introduce competency-based workplace competency assessment to their program to ensure that trainees will be more carefully monitored and assessed throughout training. A range of assessment tools, based on those which have already been validated by other Colleges and Educational Boards overseas, will be introduced.

Documentation:
Cardiothoracic Surgery assessment plan (available for reference at the College)
Draft of the Manual for Supervisor Training (available for reference at the College)

In-training assessment

The Cardiothoracic Surgery in-training assessment forms use each of the 'competency standards' as the definition of satisfactory performance.

The assessment of performance of the Trainee by each surgeon trainer is fundamental to continuing satisfactory progress through the training program.

The overall assessment process is based on satisfactory performance, satisfactory logbook numbers, satisfactory surgical case mix and primary operator experience, overall satisfactory endoscopy training and experience, and the achievement of the research requirements.

End-of-Term Appraisal

Just prior to the completion of each 6 month training period, an individual formal confidential face to face assessment of the Trainee by each surgeon trainer in the training unit, using the College's surgeon assessment form, is required to be undertaken. The basis of the assessment may take into account comments from other health professionals. It is the responsibility of the Trainee that this occurs.

The assessment form is to be signed by both the Trainee and the surgeon trainer on completion of the assessment.

The Trainee is required to forward copies of the assessment form to the College Executive Officer and their local Supervisor.

If the assessment form has not been received by the Executive Officer within two weeks of the end of the training period, unless reasonable circumstances exist, then that training period will be deemed unassessed, and therefore will not be accredited towards Specialist Surgical Training.

Documentation:
Cardiothoracic Surgery End-of-term In-training Assessment form

Logbook

The logbook focuses specifically on the development of technical competence.

It is mandatory that each Trainee maintains accurate and complete logbook data, which is submitted to the Surgical Supervisor for verification and signature by the both the Supervisor and the Trainee. The logbook must then be sent to the Cardiothoracic Executive Officer within two weeks of completing the term. The term will not be accredited towards Specialist Surgical Training if the above criteria are not met.

Documentation:
Requirements in relation to the recording of operative experiences (Weblink)
Cardiothoracic Surgery Logbook

All of these reports form part of the Trainee's portfolio that will be presented to the new Supervisor at the beginning of each rotation.

Current workplace competency assessments

The current logbook combined with the assessment form collected six-monthly form the basis of workplace competency assessment.

Preparation of Trainees prior to formative assessment

This is done by providing a structured education program at multiple levels.

1. On site in the hospital. Part of accreditation for a training unit is to demonstrate an active structured training program which is applied by the supervisor of training.
2. Supplementation by having two national training and education sessions at the scientific meetings
3. Structured Part two course commencing 2007

Ensuring that all Trainees receive regular feedback

Supervisors are advised to provide day by day feedback/assessment of the Trainee by each surgeon trainer. Feedback must be about both problem areas, and areas of above average performance, with instructive comment as to further improvement.

Identifying Underperforming Trainees

Unless each six-month period of training is deemed satisfactory according to the training assessment process, then that period of training will be deemed unsatisfactory for eligibility to present for the Fellowship Examination and/or eligibility to be granted the full Fellowship.

If areas of poor performance (score less than satisfactory) are determined, the Head of Unit will inform both the primary and secondary supervisors of surgical training.

When areas of poor performance (score less than satisfactory) are determined, then counselling and appropriate remedial action is required by the surgeons of the training unit on the advice of the primary and secondary supervisors of training.

If the overall performance is deemed unsatisfactory and agreed to by a majority of surgeons in the training unit, the Head of Unit and the primary surgical supervisor of training will undertake a further formal appraisal interview with the Trainee, at which time appropriate counselling and remedial action will be documented.

Unsatisfactory grades in any of the assessed categories in the mid-term evaluation will be reviewed by the Chair of the Board. If unsatisfactory grades are received in the same categories in a mid-term and/or end of term evaluation form, in more than one training term, the Trainee will be placed on Probation. If the Trainee is already on Probation, continuation in the training program will be discussed.

Processes for the management of Underperforming Trainees

An unsatisfactory evaluation form is defined by:

- an ‘overall’ unsatisfactory grade
- and/or unsatisfactory grades in the same category/ies in more than one mid-term and/or end of term evaluation form
- and/or unsatisfactory grades in any of the essential criteria
- and/or non-submission of the logbook or evaluation forms within two weeks of completing the term.

Upon receipt of one overall unsatisfactory evaluation form and/or receipt of repeat unsatisfactory grades in the same category and/or unsatisfactory grades in any of the Essential Criteria, a period of Probationary training will automatically commence in the following rotation. The continuation of this period of Probationary training will then be decided upon by the Board as soon as possible.

The Board, upon notification of one unsatisfactory assessment (defined by the above criteria) will conduct a review of the Trainee’s performance.

As soon as possible a formal interview is convened with the Trainee, the Chair of the Board (or representative) and the Surgical Supervisors. The Trainee may invite an advocate who is a Fellow of the College. The interview will address the following:

- details of any less than satisfactory performance

- the response of the Trainee, and
- remedial action advised.

The ensuring formal process shall be explained to the Trainee:

- A probationary period automatically commences in the term following the unsatisfactory term, subject to future ratification by the Board of Cardiothoracic Surgery.
- If it is agreed that the assessment is deemed unsatisfactory, the Board in Cardiothoracic Surgery will not recognise the unsatisfactory period of training toward completion of SST.
- This recommendation will be considered at the next meeting of the Board in Cardiothoracic Surgery. If agreed that the period of training is deemed unsatisfactory and therefore not accredited towards training time, the Board in Cardiothoracic Surgery through the Chairman will advise the Trainee of the decision.
- The Board in Cardiothoracic Surgery will determine the action required to correct the less than satisfactory performance. This may include attendance at a specific Course or the need to extend the period of training, in addition to repeating the unaccredited six month term.
- If the Trainee is on Probation, at the time of receiving an unsatisfactory evaluation, continuation in the Specialist Surgical Training program will be reviewed and dismissal from the training program will be discussed.
- Trainees that are on Probation are not permitted to change training States or Rotations.

Documentation:
College Policy for Dismissal from Surgical Training

Formative Assessment in the General Surgery Program

General Surgery is planning to maintain their current formative assessment process and to gradually introduce competency-based workplace competency assessment to their program to ensure that trainees will be more carefully monitored and assessed throughout training. A range of assessment tools, based on those which have already been validated by other Colleges and Educational Boards overseas, are being introduced.

Documentation:
General Surgery assessment plan (see Attachment 2 in this document)
Draft of the Manual for Supervisor Training (available for reference at the College)

In-training assessment

The General Surgery in-training assessment forms use each of the 'competency standards' as the definition of satisfactory performance.

The assessment of performance of the Trainee by each surgeon trainer is fundamental to continuing satisfactory progress through the training program.

The overall assessment process is based on satisfactory performance, satisfactory logbook numbers, satisfactory surgical case mix and primary operator experience, overall satisfactory endoscopy training and experience, and the achievement of the research requirements.

Information outlining the requirements for in-training assessment is published at:

Documentation:
General Surgery Evaluation Form

Mid-Term Appraisal

At the end of the first three months of the six-month training period, the head of the training unit, in consultation with other surgeon trainers in the unit, will undertake a face-to-face informal feedback/appraisal. It is the joint responsibility of the Trainee and supervisor that this occurs.

The Mid Term Evaluation Form must be completed and sent to the Regional Office within two weeks of the mid point of the term. Non-Submission of this form with the two week time frame will result in an automatic period of Probationary training and non-accreditation of the training term.

The College's Board in General Surgery Assessment Form must be used as the basis for the three month feedback/appraisal, highlighting positive and negative areas of performance.

Documentation:
Mid-term In-training assessment form

End-of-Term Appraisal

Just prior to the completion of each six month training period, an individual formal confidential face to face assessment of the Trainee by each surgeon trainer in the training unit, using the College's surgeon assessment form, is required to be undertaken. The basis of the assessment may take into account comments from other health professionals. It is the responsibility of the Trainee that this occurs.

The assessment form is to be signed by both the Trainee and the surgeon trainer on completion of the assessment.

The Trainee is required to forward copies of the assessment form to the Regional Office and their local Supervisor.

If the assessment form has not been received by the Regional office within two weeks of the end of the training period, unless reasonable circumstances exist, then that training period will be deemed unassessed, and therefore will not be accredited towards Specialist Surgical Training.

Documentation:
End-of term In-training assessment form

Logbook

The logbook focuses specifically on the development of technical competence.

It is mandatory that each Trainee maintains accurate and complete logbook data, which is submitted to the Surgical Supervisor for verification and signature by the both the Supervisor and the Trainee. The logbook must then be sent to the Regional Office within **two weeks** of completing the term. The term will not be accredited towards Specialist Surgical Training if the above criteria are not met. All of these reports form part of the Trainee's portfolio that will be presented to the new Supervisor at the beginning of each rotation

Documentation:
Recording of operative experiences (Weblink)
Logbook

Current workplace competency assessments

Workplace competency assessment will be gradually introduced, beginning in 2007. See the generic proforma for workplace competency assessment.

Preparation of Trainees prior to formative assessment

Local tutorials at training hospitals organised by the supervisors of training and the trainees.

Regional training sessions run by the individual boards as mentioned above.

Regional pre-examination courses as mentioned above.

Ensuring Trainees receive regular feedback

Supervisors are advised to provide day by day feedback/assessment of the Trainee by each surgeon trainer. Feedback must be about both problem areas, and areas of above average performance, with instructive comment as to further improvement.

Documentation:
General Surgery Regulations

Identifying underperforming Trainees

Unless each six-month period of training is deemed satisfactory according to the training assessment process, then that period of training will be deemed unsatisfactory for eligibility to present for the Fellowship Examination and/or eligibility to be granted the full Fellowship.

If areas of poor performance (score less than satisfactory) are determined, the Head of Unit will inform both the primary and secondary supervisors of surgical training.

When areas of poor performance (score less than satisfactory) are determined, then counselling and appropriate remedial action is required by the surgeons of the training unit on the advice of the primary and secondary supervisors of training.

If the overall performance is deemed unsatisfactory and agreed to by a majority of surgeons in the training unit, the Head of Unit and the primary surgical supervisor of training will undertake a further formal appraisal interview with the Trainee, at which time appropriate counselling and remedial action will be documented.

Unsatisfactory grades in any of the assessed categories in the mid-term evaluation will be reviewed by the Regional Chair. If unsatisfactory grades are received in the same categories in a mid-term and/or end of term evaluation form, in more than one training term, the Trainee will be placed on Probation. If the Trainee is already on Probation, continuation in the training program will be discussed.

Management of underperforming Trainees

An unsatisfactory evaluation form is defined by:

- an 'overall' unsatisfactory grade
- and/or unsatisfactory grades in the same category/ies in more than one mid-term and/or end of term evaluation form
- and/or unsatisfactory grades in any of the essential criteria
- and/or non-submission of the logbook or evaluation forms within two weeks of completing the term.

Upon receipt of one overall unsatisfactory evaluation form and/or receipt of repeat unsatisfactory grades in the same category and/or unsatisfactory grades in any of the Essential Criteria, a period of Probationary training will automatically commence in the following rotation. The continuation of this period of Probationary training will then be decided upon by the Regional Subcommittee as soon as possible.

The Regional Subcommittee upon notification of one unsatisfactory assessment (defined by the above criteria) will conduct a review of the Trainee's performance.

As soon as possible a formal interview is convened with the Trainee, the Chair of the Regional Board (or representative) and the Surgical Supervisors. The Trainee may invite an advocate who is a Fellow of the College. The interview will address the following:

- details of any less than satisfactory performance
- the response of the Trainee, and
- remedial action advised.

The ensuring formal process shall be explained to the Trainee:

- A probationary period automatically commences in the term following the unsatisfactory term, subject to future ratification by the Regional Subcommittee and the Board of General Surgery.
- If it is agreed that the assessment is deemed unsatisfactory, the Regional Subcommittee will recommend to the Board in General Surgery that the unsatisfactory period of training be deemed unsatisfactory.
- This recommendation will be considered at the next meeting of the Board in General Surgery. If agreed that the period of training is deemed unsatisfactory and therefore not accredited towards training time, the Board in General Surgery through the Chairman will advise the Trainee of the decision.
- The Board in General Surgery will determine the action required to correct the less than satisfactory performance. This may include attendance at a specific Course or the need to extend the period of training, in addition to repeating the unaccredited 6 month term.
- If the Trainee is on Probation, at the time of receiving an unsatisfactory evaluation, continuation in the Specialist Surgical Training program will be reviewed and dismissal from the training program will be discussed.
- Trainees that are on Probation are not permitted to change training States or Rotations.

Documentation:

Proforma for Managing an underperforming Trainee (See Attachment 6 in this document)

General Surgery Regulations

Formative Assessment in the Neurosurgery Program

In-training assessment

An in-training assessment report, in the prescribed format, must be submitted at the end of each three month clinical training rotation during SET1 and each six month clinical training rotation during SET2, SET3, SET5 and SET6.
The in-training assessment reports may also be completed more frequently at the request of the Board or at any time as determined by the supervisor where any area of marginal or unsatisfactory performance is identified.

The Board of Neurosurgery in-training assessment report has twenty assessment areas, each containing five competency statements. The supervisor ticks the box which corresponds with the statement they believe best describes the trainee's demonstrated attribute, skill or behaviour. This provides the trainee and supervisor with clear performance measures, standards and examples. The assessment areas relate to five key areas being technical expertise and patient care, judgement and clinical decision making, medical expertise and knowledge, attitudes and professional conduct and communication and collaboration. The trainee and the supervisor are required to have a performance assessment meeting to discuss the in training assessment and both must sign the form.

The requirements and performance standards for clinical rotations are as follows:

- SET1 trainees must satisfactorily complete four three month clinical rotations as allocated by the Board.
- SET2, SET3, SET5 and SET6 trainees must satisfactorily complete two six month clinical rotations for each year as allocated by the Board.

A trainee will not achieve the minimum performance standard for a clinical rotation if the in-training assessment report:

- has not been received or completed in accordance with the Board instructions; or
- has one or more ratings of unsatisfactory in any area; or
- has two or more ratings of marginal in any area; or
- has one or more ratings of unsatisfactory or marginal in any area while the trainee is on probation.

Documentation:
Selection Process Regulations (web link and paper based)
Web links and attachments list
In Training Assessment Report (web link and paper based)
Neurosurgery Training Website (www.neurosurgerytraining.org – username & password AMC)

Logbook Summary

A logbook summary, in the prescribed format, must be submitted at the end of each six month clinical training rotation during SET1, SET2, SET3, SET5 and SET6 and must be signed by the supervisor of surgical training as an accurate record. The logbook is used to assess whether the trainee has achieved the minimum standard for operative experience.
The requirements and performance standards for operative experience are as follows:

- During SET1, for each six months in clinical training rotations trainees are required to participate in a minimum of 75 major neurosurgical procedures or equivalent.
- During each year of SET2, SET3, SET5 and SET6, for each six month clinical training rotation trainees are required to participate in a minimum of 100 major neurosurgical procedures.
- Prior to completion of SET6, during a clinical training rotation accredited by the Board for paediatric neurosurgery trainees are required to participate in a minimum of 50 major paediatric neurosurgical procedures.

Documentation:
Logbook Summary Form (web link and paper based)
Neurosurgery Training Website (www.neurosurgerytraining.org – username & password AMC)
Neurosurgery SET Program Regulations (web link and paper based)

Workplace competency assessments

The Board has introduced workplace core and elective competency assessment forms as a mechanism for the continuous assessment of the suitability and progression of trainees. The competencies are focused on the assessment of skills that a generalist, undifferentiated neurosurgeon should possess and test the workplace application of the necessary knowledge, skills and behaviours. The forms include a self assessment, assessment by the supervisor and in some instances an assessment by applicable nursing staff.

The minimum performance standards for competency assessments are as follows:

- Trainees must satisfactory complete one core workplace competency assessment as designated by the Board by the end of SET1.
- Trainees must have satisfactorily completed a cumulative total of four (4) core workplace competencies by the end of SET2, eight (8) by the end of SET3, and twelve (12) by the end of SET5.
- Trainees must have satisfactorily completed two (2) elective workplace competencies by the end of SET6.

The competencies are:

Core Competencies

Performing a neurologic examination

Surgery for chronic subdural haematoma

Peri operative care (including complications)

Acute trauma craniotomy

Extra axial tumour including venous sinus or skull base

Tumour - Intra axial tumour, glioma or metastasis

Shunt surgery and ventricular drainage

Carpal Tunnel and peripheral nerve surgery

Lumbar Spine Surgery (discectomy and laminectomy)

Cervical Spine Surgery (discectomy and fusion)

Posterior Fossa Tumour / Chiari

Surgery for uncomplicated anterior circulation aneurysm

Elective Competencies

Intradural spinal tumour

Surgery for AVM's

Functional Stereotaxy

Pituitary surgery

Acoustic neuroma

Intraventricular tumour

Lumbar fusion

Temporal lobectomy for epilepsy

Performing a research project

Documentation:

Web links and attachments list

Competency assessment forms (web link and paper based)

SET Program Regulations (web link and paper based)

Ensuring that all trainees receive regular feedback

Trainees and supervisors are required to have a formal meeting prior to the submission of the in-training assessment form and logbook summary at the end of clinical rotation or when the trainee wishes to have the supervisor sign off on a workplace competency assessment form.

Supervisors and trainees are encouraged to meet on a more regular basis to discuss their performance.

The Board of Neurosurgery provides trainees with their score in the examination following each trainee seminar and a summary of the overall average scores for each year of training, including the highest score and the lowest. This feedback allows trainees to review their own performance in the examination.

The Board also provides regular feedback to trainees on developments relating to the training program by way of the trainee website. This includes changes to regulations, news from the Board and College and courses or learning activities which may be of interest.

Identifying and managing underperforming trainees

Underperforming trainees are identified by the supervisor of surgical training or by failure to complete the curriculum components at the required performance standard for each year of the SET program. The trainee seminar examination results are also reviewed by the Board and trainees who have performed poorly receive notification from the Board and a suggested remedial plan.

The Board has probationary regulations which apply to trainees who have been identified as having unsatisfactory performance which includes the development of a remedial plan.

Each year of the SET program has minimum performance based standards used to assess performance and make a determination on progression and suitability to continue training. The performance based standards are clearly documented in the regulations as summarised below.

- Trainees must satisfactorily complete each performance standard for a given year as detailed in the Regulations to progress to the next year.
- Failure to satisfactorily complete one of the performance standards for a given year as detailed in the Regulations will result in progression to the next year in a probationary status.
- Failure to satisfactorily complete any two or more of the performance standards for a given year as detailed in the Regulations will result in the automatic repeat of that year in a probationary status.
- Failure to satisfactorily complete any three or more of the performance standards for a given year as detailed in the Regulations will result in automatic dismissal.
- Notwithstanding any of the above, failure to satisfactorily complete any standard of performance or condition applied by the Board during any probationary period will result in automatic dismissal.
- Notwithstanding any of the above, failure to satisfactorily complete the same performance standard on three occasions at any time during training will result in automatic dismissal.
- Trainees may only repeat each given year of the SET program on one occasion before automatic dismissal occurs.

In accordance with the regulations the Board of Neurosurgery will issue a notice of pending action for any decision relating to any of the above. A process is documented to provide the trainee with an opportunity to submit a submission for consideration of any exceptional circumstances prior to the final decision being made. Where the final recommendation is for dismissal the trainee will have a further opportunity, in accordance with the dismissal regulations, to present a case before the Board.

Documentation:
SET Program Regulations (web link and paper based)

Formative Assessment in the Orthopaedic Surgery Program

The existing formative assessment process will be appropriate for trainees in SET2 through SET5. Trainees in SET1 will be required to complete an assessment report every three months, with feedback to be provided as for current SST Trainees. The Orthopaedic Procedure Assessment Report will be an appropriate measure of the development of surgical skill by SET1 Trainees, and has the advantage of being equally applicable to those SET1 Trainees rotating through a non-Orthopaedic specialty area.

The proposed examination in SET1 will combine generic and specialty elements, taking components from the current Primary examination and the OPBS module. As at present, the examination will be conducted by the Court of Examiners. Trainees would be given two opportunities to sit the examination during SET1. Failure to pass the exam would result in the Trainee being required to repeat SET1. Trainees will be allowed a total of three attempts to pass the examination. Ultimately, failure to achieve a satisfactory result in this examination would result in dismissal from the SET program.

In-training assessment

Each Trainee is required to complete a Quarterly in-training Assessment Report (QAR). The QAR is sent to the Trainee's supervisor, who is charged with evaluating the Trainee's performance across 10 criteria aligned to the nine RACS key competencies. The assessment outcome is discussed with the Trainee, who countersigns the assessment report as appropriate and assumes responsibility for its timely submission to the relevant Regional Training Committee.

The purpose of the assessment is to identify any area of weakness or concern in the Trainee's performance. Performance is rated against a seven-point scale, where a score of 3 or less indicates that the degree of competence attained is borderline, if not unsatisfactory. The criteria assessed cover:

1. Surgical Skill (Technical Expertise; Clinical Decision making)
2. Knowledge (Medical Expertise)
3. Decision Making Ability (Clinical Decision Making)
4. Patient Management (Judgement; Clinical Decision Making; Medical Expertise; Communicator; Collaborator; Manager; Health Advocate; Professional)
5. Patient Communication (Communicator; Manager; Health Advocate; Professional)
6. Interaction with Consultants, Registrars and Residents (Collaborator; Manager; Communicator; Professional)
7. Interaction with Nursing and Other Hospital Staff (Communicator; Collaborator; Manager; Professional)
8. Teaching Skills (Scholar)
9. Trainee's Independent Assessment of Patients and Communications to Senior Staff (Clinical Decision Making; Judgement; Medical Expertise; Communicator; Manager; Health Advocate; Professional)
10. General Attitude (Professional)

In addition, the supervisor is required to provide additional written comments and observations.

At the conclusion of a six-month or twelve-month attachment, the Trainee is required to complete a similar assessment form to evaluate the performance of the Orthopaedic Unit in which s/he has worked. The *Trainee Report on Hospital Posts* (TRHP) is submitted directly to the AOA Head Office and is confidential, in the first instance, to the AOA Education Officer.

In 2006, the AOA Federal Training Committee introduced an *Operative Procedure Assessment Report*. Trainees select a major case in their repertoire and arrange for it to be observed and assessed by their supervising consultant. This provides an opportunity for the Trainee to receive immediate feedback on his/her surgical and patient management skills. It is a particularly useful diagnostic tool with which to monitor the progress of an underperforming Trainee.

Under the present SST arrangements, trainees must pass a compulsory basic science module during the four-year training program. The Orthopaedic Principles and Basic Sciences (OPBS) module covers the basic sciences as they relate to Orthopaedics and is assessed by multiple-choice examination. The majority of trainees in Orthopaedics sit for and pass this examination

early in their first year of SST. The content of the OPBS will be incorporated into the generic exam to be sat in SET1.

Trainees appointed to the SST program in Orthopaedics are made fully aware of the assessment process and understand that it is an essential part of their training. The completion of the QAR is mandatory. It is the Trainee's responsibility to ensure that the QAR is completed and returned to the relevant Regional Training Committee. Failure to do so would indicate either (i) a problem with the Trainee's performance or (ii) a significant failure of the feedback process. In either case, the non-submission of a compulsory assessment form should alert the Regional Training Committee to the fact that the circumstances of a particular Trainee or SST post need to be evaluated carefully.

In addition to the regular assessment of clinical performance, the Regional Bone Schools provide immediate feedback to trainees during the course of lectures and tutorials. In-training and trial examinations allow for trainees to be assessed under more formal conditions.

Trainees in SST Year four whose performance is judged to be unsatisfactory will not be signed off to present for the Fellowship Examination.

Documentation:
AOA Quarterly Assessment Report (available for reference at the College)
AOA Orthopaedic Procedure Assessment Report (available for reference at the College)
AOA Trainee Report on Hospital Post (available for reference at the College)
AOA Assessment Procedures (available for reference at the College)
AOA Competency and Assessment Instrument Matrix (available for reference at the College)

Identifying and managing underperforming Trainees

A poor QAR score (defined as (i) under 40/70; or (ii) a score of three or less against one or more criteria) alerts the Regional Training Committee to potential problems with a Trainee. After an initial discussion with their Training Co-ordinator, the underperforming Trainee would be counselled by the RTC Chair and a plan for remediation and improvement formulated. A second poor assessment performance would see the Trainee placed on formal probation. Failure to satisfactorily complete probation would instigate a dismissal process.

The management of underperforming trainees in SET1 will require greater diligence. Trainees will enter SET having served less clinical time, and consequently less theoretical and practical experience. As such, it will be essential to identify and counsel the unsatisfactory Trainee very early in the SET program to ensure that s/he is not permitted to progress into SET2.

Documentation:
AOA Policy on Underperformance and Dismissal (available for reference at the College)

Formative Assessment in the Otolaryngology Head and Neck Surgery Program

Otolaryngology Head and Neck Surgery is planning to maintain their current formative assessment process and to gradually introduce competency-based workplace competency assessment to their program to ensure that trainees will be more carefully monitored and assessed throughout training. A range of assessment tools, based on those which have already been validated by other Colleges and Educational Boards overseas, are being introduced.

Documentation:

Otolaryngology Head and Neck Surgery assessment plan ((available for reference at the College)

Draft of the Manual for Supervisor Training (available for reference at the College)

In-training assessment

The Otolaryngology Head and Neck Surgery in-training assessment forms use each of the 'competency standards' as the definition of satisfactory performance.

The assessment of performance of the Trainee by each surgeon trainer is fundamental to continuing satisfactory progress through the training program.

The overall assessment process is based on satisfactory performance, satisfactory logbook numbers, satisfactory surgical case mix and primary operator experience, overall satisfactory endoscopy training and experience, and the achievement of the research requirements.

Information outlining the requirements for in-training assessment is published at:

Documentation:
Otolaryngology Head and Neck Surgery In-training assessment form (Weblink)

In training assessment for SET1 will be robust and aimed at detecting unsuitable candidates. During each of the four surgical rotations the Board will require satisfactory assessments as indicated in the SET documents and satisfactory log book assessments and assessments using the in-training assessment forms.

In SET2^{+} Trainees are required to provide evidence of successful completion of each 6 month training period. Just prior to the completion of each 6 month training, an individual formal confidential face to face assessment of the Trainee by each surgeon trainer in the training unit, using the College's surgeon assessment form, is required to be undertaken. The basis of the assessment may take into account comments from other health professionals. It is the responsibility of the Trainee that this occurs.

The assessment form is to be signed by both the Trainee and the surgeon trainer on completion of the assessment.

The Trainee is required to forward copies of the assessment form to the Regional Office and their local Supervisor.

If the assessment form has not been received by the Regional office within two weeks of the end of the training period, unless reasonable circumstances exist, then that training period will be deemed unassessed, and therefore will not be accredited towards Specialist Surgical Training.

Logbook

The logbook focuses specifically on the development of technical competence.

It is mandatory that each Trainee maintains accurate and complete logbook data, which is submitted to the Surgical Supervisor for verification and signature by the both the Supervisor and the Trainee. The logbook must then be sent to the Regional Office within two weeks of completing the term. The term will not be accredited towards Specialist Surgical Training if the above criteria are not met.

All of these reports form part of the Trainee's portfolio that will be presented to the new Supervisor at the beginning of each rotation.

Documentation:
Otolaryngology Head and Neck Surgery Logbook (Weblink)

Workplace competency assessment

The Board is in the process of introducing workplace core and elective competency assessment forms. These are being assessed in a few training institutions before wide distribution.

These include:

- Tonsilectomy assessment
- Middle ear ventilating tube insertion assessment.
- Endoscopic sinus surgery assessment
- Tympanoplasty audit

Ensuring Trainees receive regular feedback

Supervisors are advised to provide day by day feedback/assessment of the Trainee by each surgeon trainer. Feedback must be about both problem areas, and areas of above average performance, with instructive comment as to further improvement.

Identifying underperforming Trainees

Unless each 6-month period of training is deemed satisfactory according to the training assessment process, then that period of training will be deemed unsatisfactory for eligibility to present for the Fellowship Examination and/or eligibility to be granted the full Fellowship.

If areas of poor performance (score less than satisfactory) are determined, the Head of Unit will inform both the primary and secondary supervisors of surgical training.

When areas of poor performance (score less than satisfactory) are determined, then counselling and appropriate remedial action is required by the surgeons of the training unit on the advice of the primary and secondary supervisors of training.

If the overall performance is deemed unsatisfactory and agreed to by a majority of surgeons in the training unit, the Head of Unit and the primary surgical supervisor of training will undertake a further formal appraisal interview with the Trainee, at which time appropriate counselling and remedial action will be documented.

Unsatisfactory grades in any of the assessed categories in the mid-term evaluation will be reviewed by the Regional Chair. The National Board Chairman is also notified. It is usual that such candidates are then called before a specially convened State Subcommittee meeting if the problem is not resolved locally. They are also discussed at the next National Board meeting. If unsatisfactory grades are received in the same categories in a mid-term and/or end of term evaluation form, in more than 1 training term, the Trainee will be placed on Probation. If the Trainee is already on Probation, continuation in the training program will be discussed.

Management of underperforming Trainees

An unsatisfactory evaluation form is defined by:

- an ‘overall’ unsatisfactory grade
- and/or unsatisfactory grades in the same category/ies in more than one mid-term and/or end of term evaluation form
- and/or unsatisfactory grades in any of the essential criteria
- and/or non-submission of the logbook or evaluation forms within two weeks of completing the term.

Upon receipt of one overall unsatisfactory evaluation form and/or receipt of repeat unsatisfactory grades in the same category and/or unsatisfactory grades in any of the Essential Criteria, a period of Probationary training will automatically commence in the following rotation. The continuation of this period of Probationary training will then be decided upon by the Regional Subcommittee as soon as possible.

The Regional Subcommittee upon notification of one unsatisfactory assessment (defined by the above criteria) will conduct a review of the Trainee’s performance.

As soon as possible a formal interview is convened with the Trainee, the Chair of the Regional Board (or representative) and the Surgical Supervisors. The Trainee may invite an advocate who is a Fellow of the College. The interview will address the following:

- details of any less than satisfactory performance
- the response of the Trainee, and
- remedial action advised.

The ensuring formal process shall be explained to the Trainee:

- A probationary period automatically commences in the term following the unsatisfactory term, subject to future ratification by the Regional Subcommittee and the Board of Otolaryngology Head and Neck Surgery.
- If it is agreed that the assessment is deemed unsatisfactory, the Regional Subcommittee will recommend to the Board in Otolaryngology Head and Neck Surgery that the unsatisfactory period of training be deemed unsatisfactory.
- This recommendation will be considered at the next meeting of the Board in Otolaryngology Head and Neck Surgery. If agreed that the period of training is deemed unsatisfactory and therefore not accredited towards training time, the Board in Otolaryngology Head and Neck Surgery through the Chairman will advise the Trainee of the decision.
- The Board in Otolaryngology Head and Neck Surgery will determine the action required to correct the less than satisfactory performance. This may include attendance at a specific Course or the need to extend the period of training, in addition to repeating the unaccredited 6 month term.
- If the Trainee is on Probation, at the time of receiving an unsatisfactory evaluation, continuation in the Specialist Surgical training program will be reviewed and dismissal from the training program will be discussed.
- Trainees that are on Probation are not permitted to change training States or Rotations.

Documentation:
Proforma for Managing an Underperforming Trainee (See Attachment 6 in this document)

Formative Assessment in the Paediatric Surgery Program

Paediatric Surgery is planning to maintain their current formative assessment process and to gradually introduce competency-based workplace competency assessment to their program to ensure that trainees will be more carefully monitored and assessed throughout training. A range of assessment tools, based on those which have already been validated by other Colleges and Educational Boards overseas, are being introduced.

Due to the shortening of training in Paediatric Surgery, the assessments describe below will be utilised to assist trainees and surgical supervisors identify early areas of deficiency in order to provide the opportunity to improve performance. By assessing performance every three months, identification of any deficiencies will occur earlier than the usual 6 months formal assessment in SET2^{+}.

Documentation:

Paediatric Surgery assessment plan (available for reference at the College)

Draft of the Manual for Supervisor Training (available for reference at the College)

In-Training assessment

SET1 Trainees will complete in-training assessments every three months during SET1 and must be assessed as satisfactory in each. Assessments will take the form of DOPS, PBAs, Mini-CEX and 360 Degree Review Forms. *These forms are currently being developed with the College EDRD.*

In SET2^{+} Paediatric Surgery in-training assessment forms (Trainee Evaluation Form) are required to be submitted at the end of each 6 month rotation and are completed by the surgical supervisor in consultation with other paediatric surgeons in the department. The Trainee acknowledges the assessment and comments by signing the form.

The assessment of performance of the Trainee by each surgical supervisor is fundamental to continuing satisfactory progress through the training program. Trainees are marked on a scale consisting of Well Above Average, Satisfactory, Minor Issue – Needs Attention and Major Issue – Likely to be a Problem by the surgical supervisor in the following categories:

- Clinical Knowledge/Medical Expertise: Acquisition and Application
- Clinical Skills: Acquisition and Application of Clinical Information
- Clinical Decision-Making
- Technical Skills
- Scholarship
- Medical Communication Skills
- Attitudes

As per section 8.3.6 of the Training Program Regulations, the Trainee and the surgical supervisor (or nominee) must have a face to face assessment meeting in which any deficiencies or areas of potential improvement should be discussed with mechanisms to correct these identified. Positive feedback is equally advisable in the assessment process. Areas of above or below average performance should be highlighted by the surgical supervisors with constructive comment as to further improvement.

All Trainee Evaluation Forms are reviewed by the Board twice a year. Any marks in the Minor Issue or Major Issue columns for all trainees are discussed with the Trainee and the surgical supervisor. If deemed applicable, trainees with multiple marks in the Minor Issue or Major Issue column will be placed on probation in accordance with the College SST Dismissal from Surgical Training Policy.

Documentation:

Paediatric Surgery Trainee Evaluation form

Logbook

The logbook focuses specifically on the development of technical competence.

It is mandatory that each Trainee maintains accurate and complete logbook data, which is submitted to the Surgical Supervisor for verification and signature by the both the Supervisor

and the Trainee. The logbook must then be sent to the Executive Officer by 14 February and 14 July each year. The term will not be accredited towards Specialist Surgical Training if the above criteria are not met.

Documentation:
Paediatric Surgery Summary of Operative Experience

Trainee Progress Overview Form

As per the Paediatric Surgery Assessment Plan, the Trainee Progress Overview Form provides the opportunity for trainees to demonstrate to the Board and reflect to themselves their progress in elements of Medical Expertise, Technical Expertise, Management and Leadership and Learner and Teacher. Trainees provide Board members with an update on courses and workshops completed, papers presented at scientific meetings, publications in peer reviewed journals and other areas, unpublished studies and ongoing projects, attendance at scientific meetings, clinical exposure, and operative experience.

All of these reports form part of the Trainee's portfolio that will be presented to the new Supervisor at the beginning of each rotation.

Documentation:
Paediatric Surgery Trainee Progress Overview form

Workplace competency assessment

Within the past 12 months, Procedure Based Assessments (PBAs) have been introduced on a trial basis.

Examinations during SET2^{+}

The Board conducts the Paediatric Anatomy Examination (see section 8.8.1 of the Training Program Regulations) and the Paediatric Pathology Examination (see section 8.8.2 of the Training Program Regulations). These are hurdle requirements.

Ensuring Trainees receive regular feedback

There are no formal pre-examination courses. The CATs and DOGS are designed to assist trainees to prepare for the examinations. Trainees also utilise the time at the RATS to participate in educational activities directed at studying for the examinations and are given practice questions.

Supervisors are advised to provide day by day feedback/assessment of the Trainee. Feedback must be about both problem areas, and areas of above average performance, with instructive comment as to further improvement. The Board also meets with Surgical Supervisors twice per year to discuss improvements in the training program and reinforce the requirement for ongoing feedback. The Board also meets with the trainees at the Registrar Annual Training Seminar as a group and as individuals, providing the opportunity for two-way feedback regarding training.

Identifying underperforming Trainees

Unless each six-month period of training is deemed satisfactory according to the training assessment process, then that period of training will be deemed unsatisfactory for eligibility to present for the Fellowship Examination and/or eligibility to be granted the full Fellowship. The processes from section 5.2 of the College SST Dismissal from Training Policy are implemented when a Trainee's rotation has been identified as unsatisfactory.

Management of underperforming Trainees

The processes from section 5.2 of the College SST Dismissal from Training Policy are implemented when a Trainee's rotation has been identified as underperforming. As a trial in 2007, trainees identified as underperforming will also be required to complete, in addition to standard Trainee documentation and assessment tasks, 360 Degree Review Forms in order to obtain feedback from the health care team on their performance and to improve on the areas of deficiency identified.

Formative Assessment in the Plastic and Reconstructive Surgery Program

In-training Assessment

Completion of the Board of Plastic and Reconstructive Surgery Professional Performance Assessment on the proscribed form must be undertaken at the conclusion of each 6 month rotation. The assessment forms must also be completed more frequently on the request of the Board of Plastic and Reconstructive Surgery, or as determined by the Supervisor of Training where any areas of underperformance are identified.

Documentation:

Board of Plastic and Reconstructive Surgery Professional Performance Assessment form (available for reference at the College)

Board of Plastic and Reconstructive Surgery Logbook

Workplace competency assessment

Workplace competency assessments are undertaken continually throughout the Specialist Surgical Training in Plastic and Reconstructive Surgery, with a mid-term and end of rotation assessment, completed on the Board of Plastic and Reconstructive Surgery Professional Performance Assessment form.

Examinations during SET2^{+}

Currently the Plastic and Reconstructive Surgery Surgical Sciences and Principles exam must be undertaken in the first year of SST, and must be successfully passed to progress into the fourth year of SST. To successfully complete this examination requires a good knowledge of the surgical sciences and principles that at the basis of good practice in Plastic and Reconstructive Surgery.

There is no proposal to change the SET2+ examinations, however the Surgical Sciences and Principles Examination, now undertaken in SST1 (SET2) may be taken with the generic BSE and OSCE during SET1, must be taken by the end of SET2 and trainees must pass the exam to progress beyond SET3. As a transition arrangement, those who have successfully completed the Part 1 BST Exam must sit Speciality Specific Surgical Sciences and Principles Exam in SST1 (SET2) and must pass the examination to progress beyond SST3 (SET4).

Documentation:

Examination in Plastic and Reconstructive Surgery (available for reference at the College)

Preparing Trainees prior to formative assessment

Each region has a compulsory teaching program, and trainees gain exposure to their peers and feedback from surgical supervisors on a regular basis.

In preparation for the Fellowship Examination, trainees undertake a trial examination in SST3 and SST4 at the Registrar's conference which provides feedback, and allows trainees to review their performance prior in preparation for the examination.

Ensuring Trainees receive regular feedback

Surgical Supervisors undertake mid-term and end of rotation assessments during each surgical rotations. Trainees are required to have a formal meeting at the conclusion of each rotation, or when needed. Each region has a compulsory teaching program, and trainees gain exposure to their peers and feedback from surgical supervisors on a regular basis.

In preparation for the Fellowship Examination, trainees undertake a trial examination in SST3 and SST4 at the Registrar's conference which provides feedback, and allows trainees to review their performance in preparation for the Fellowship Examination.

Identifying underperforming Trainees

Surgical Supervisors identify underperforming trainees during formal and informal workplace assessments. Trainees that do not pass the Surgical Sciences and Principles Exam are also counselled regarding their performance.

Management of underperforming Trainees

1. Supervisor schedules a meeting with the Trainee as soon as practical after the identification of deficiencies in performance.
2. Trainee is appropriately and constructively counselled, and a PPA assessment completed signed by the Trainee and supervisor of training. A letter outlining the meeting is sent to the Trainee.
3. The letter and PPA assessment are forwarded to Regional supervisor and ASPS/the College New Zealand for the trainees file.
4. Supervisor schedules a meeting 1 month after initial meeting
    a. If the Trainee's performance has improved to the required standard this is discussed at the meeting. PPA completed and signed by supervisor and Trainee. The supervisor of training sends the PPA and a letter outlining the improvement in performance to the Trainee, Regional Chair and ASPS/ NZ RACS for the Trainee's record. No further action is taken
    b. If the Trainee does not meet the required standard, this is discussed in the meeting with the Trainee, a PPA is completed and signed by the supervisor and Trainee; the matter is referred to the Regional Chair and an appropriate plan of management is devised in consultation with the Chairman of the Board.
5. Trainee send a letter from Regional Chair/ Chairman of the Board outlining areas of deficiency, probationary status and the implications if the required standard of performance is not achieved.
6. Regular reviews undertaken by the Supervisor of training during the remedial period. These reviews should be appropriately documented.
7. At the end of the remedial period, a meeting is scheduled with the Trainee and a formal PPA assessment is undertaken by the Supervisor of training.
    a. If the Trainee meets the required standard the supervisor of training sends letter outlining the improvement in performance to the Trainee, copies to the Regional Chair and ASPS/ NZ RACS for the Trainee's record. No further action is taken
    b. If required standard has not been reached and the rotation is not considered satisfactory by the supervisor of training, the supervisor discusses the deficiencies of performance in the performance review. Supervisor sends a letter to the Trainee outlining the issues discussed in the formal assessment meeting, copies to the Chairman of the Board, Regional Chair and ASPS/NZ RACS.
8. The Trainee's performance is considered by the Board of Plastic and Reconstructive Surgery. The rotation may not be accredited as training time by the Board of Plastic and Reconstructive Surgery.

Documentation:

Draft Supervisor's Handbook – in the process of being finalised by the Board of Plastic and Reconstructive Surgery (available for reference at the College)

Formative Assessment in the Urology Program

In-training assessment for SET1

SET1 has no comparable equivalent in SST. It is more comparable to current BST, and in-training assessment will be more consistent with processes currently used in that program. Supervisor reports and logbooks will remain the mainstay of in-training assessments at this stage. It is likely a stipulated number of in-training competency assessments (mini-CEX, CBD, DOPS) will be introduced.

In-training Assessment

Formative assessments constitute the major progress evaluation of trainees. Regular informal and semiformal assessments between trainers and Trainee are encouraged. The mandatory form of formative assessment is the **Supervisor Report**, a copy of which is available from the Society website. This document is structured around the nine RACS competencies. This report is completed at a frequency according to year of training, or more often if directed by the Board of Urology.

Supervisor Report

Supervisor Reports should be completed in an unhurried manner during a session scheduled solely to achieve this. The report should be completed in the presence of the Trainee, with discussion and reasoning for each grading given. A Supervisor Report should never be completed in isolation, and then handed to the Trainee.

A variety of technical and personal attributes are evaluated through this form. It is expected that these reports in sequence will document the progressive development of personal attributes and technical skills to a level of competence consistent with the criteria of a graduating Fellow in Urology .

Documentation:
Supervisor Assessment Report – Clinical (available for reference at the College)
Supervisor Assessment Report – Research Trainee (available for reference at the College)

Workplace competency assessment

Supervisor reports and logbooks will remain the mainstay of in-training assessment, at this stage.

Examinations during SET2^{+}

Urological Mid-Term Assessment (UMTA)

This examination is conducted during Trainee Week (November) for all trainees who have not yet undertaken the FRACS (Urology) examination. A criterion mark must be attained for eligibility to the May sitting of the Fellowship Examination in a Trainee's examination year. This criterion has been achieved in SST1, or SST2 (SET2 or SET3). The result in this examination is also used to gauge a Trainee's academic progress. Knowledge of the imminence of this exam, and the importance of the mark received, stimulates Trainee reading and learning.

European Board of Urology Examination

This examination is conducted at the ASM for all trainees in SST2 and SST3 (SET3 or SET4). The result assists trainees and the Board to assess the progress of acquisition of clinical knowledge and judgement of each individual Trainee.

Preparation of Trainees prior to formative assessment

Trainees are encouraged to access and work through the College web based modules on the non-technical competencies.

Trainees are expected to prepare for each clinical session, each teaching session, and each workshop they attend, as it is during these that assessments are performed.

Trainees are instructed to access the logbook template, and Supervisor report template, to ensure they are aware of the contents of both, and thereby the qualities and attributes being measured.

The Urological Society provides each Trainee with the American Urological Society Updates regularly throughout training. These updates are a current review of a breadth of urological topics.

Trainees are provided with a copy of the definitive text of the Urology curriculum. The reading of this is guided by the aims and objectives of the Portfolio (see above).

Ensuring that all Trainees receive regular feedback

Trainee feedback is provided on a regular basis through the mandatory use of the supervisor reporting process.

Supervisors of trainees are encouraged to provide regular feedback throughout training, in as many circumstances as it is possible to achieve this.

Supervisors of trainees are updated in the necessity and methods of giving feedback at the Supervisor education sessions at each ASM.

Identifying underperforming Trainees

Trainee Supervisor reports provide information about Trainee performance, and identify the underperformer.

Logbooks are reviewed regularly, and identify the underperformer.

The EBU and UMTA in-training exams assist in the identification of the underperformer.

All Supervisors are encouraged to openly discuss any Trainee about whom they have concern with a member of the Board of Urology.

Management of underperforming Trainees

After identification of areas of performance causing concern, they are discussed with the Trainee. At that interview, a focused plan is developed providing means of addressing the relevant issues, how progress is to be measured, and the time frame within which rectification is expected.

A transcript of issues, goals, and plan for rectification is forwarded to the Board of Urology through the relevant section TA and E Committee.

Progress meetings with the local supervisor are scheduled monthly. Progress is measured, and feedback is given. Each of these meetings is minuted. The Trainee must sign a copy as a true record of discussion and progress. A copy must be forwarded to the Board of Urology through the relevant section TA and E Committee.

All Urology Trainees have access to a Mentor, who should prove beneficial during this period.

If a Trainee fails to redress the issues of concern within the designated time, an extension of the training period may be recommended, or, where appropriate, the individual may be counselled to seek an alternate career.

Formative Assessment in the Vascular Surgery Program

Vascular Surgery is planning to maintain their current formative assessment process and to gradually introduce competency-based workplace competency assessment to their program to ensure that trainees will be more carefully monitored and assessed throughout training. A range of assessment tools, based on those which have already been validated by other Colleges and Educational Boards overseas, are being introduced.

In addition to the existing requirements, SET1 Trainees must satisfactorily complete the following as designated by the Board in Vascular Surgery:

- Satisfactory mid and end of term reports in all terms
- 360^0 assessment in all terms
- Direct Observation of Procedural Skills (DOPS) and Procedure Based Assessment (PBA) in each unit (three-monthly)

Mini Clinical Evaluation Exercise (CEX) every 3 month attachment

Documentation:
Vascular Surgery assessment plan (available for reference at the College)
Draft of the Manual for Supervisor Training (available for reference at the College)

In-training Assessment

Completion of the in-training assessment report, on the prescribed form, must be undertaken at mid term and again at the end of the training year.

The Board of Vascular Surgery in training assessment report has 10 assessment areas, each containing eight competency statements. The supervisor ticks the box which corresponds with the statement they believe best describes the Trainee's demonstrated attributes, skills or behaviour. This provides the Trainee and supervisor with clear performance measures, standards and examples. The assessment areas relate to 8 key areas being surgical skill, knowledge, decision making ability, patient management, patient communication, interaction with consultants, registrars and residents, interaction with nursing and other hospital staff, teaching skills, Trainee's independent assessment of patients and communications to senior staff and general attitude.

Mid-Term Appraisal

At the end of the first three months of the six-month training period, the Trainee is required to submit a completed in-training assessment form as outlined above.

An individual formal confidential face to face interview is conducted annually by the Board to discuss with trainees their mid term appraisal and any other issues that may arise.

The Mid Term Evaluation Form must be completed and sent to the Executive Officer at the end of the term. Non-Submission of this form with the two week time frame will result in non-accreditation of the training term.

End-of-Term Appraisal

Just prior to the completion of each training position, a copy of the assessment form is completed by the supervisor of training after discussion with his/her colleagues in the vascular unit. The assessment should be discussed with the Trainee before being signed by all parties. Comment from the unit's ancillary staff is also invited.

It is the responsibility of the Trainee that this occurs.

The assessment form is to be signed by both the Trainee and the surgeon trainer on completion of the assessment.

The trainee is required to forward signed copies of the assessment form to the Executive Officer and their local Supervisor.

If the assessment form has not been received by end of the training period, unless reasonable circumstances exist, then that training period will be deemed unassessed, and therefore will not be accredited towards Specialist Surgical Training.

Documentation:
Vascular Surgery In-Training Assessment form

Logbook

The logbook focuses specifically on the development of technical competence.

It is mandatory that each Trainee maintains accurate and complete logbook data, which is submitted to the Surgical Supervisor for verification and signature by the both the Supervisor and the Trainee. The logbook must then be sent to the Executive Officer at the completion of the term. The term will not be accredited towards Specialist Surgical Training if the above criteria is not met.

Documentation:
Vascular Surgery Logbook

Vascular Ultrasound Logbook

The Vascular Board has introduced a compulsory Ultrasound Logbook for completion by all trainees. Completed logbooks should be received by the end of the year for those trainees wishing to sit the Fellowship Examination in the following year. Completed logbooks are approved by the New Zealand representative to the Vascular Board.

Documentation:
Vascular Surgery Ultrasound logbook

Workplace competency assessment

Workplace competency assessment will be gradually introduced, beginning in 2007.

Preparing Trainees prior to formative assessment

Trainees and supervisors are required to have a formal meeting prior to the submission of the in training assessment form and logbook at the end of each 6 month rotation or when the Trainee wishes to have the supervisor sign off on a workplace competency assessment form. Supervisors and trainees are encouraged to meet on a regular basis to discuss their performance.

Ensuring Trainees receive regular feedback

Supervisors are advised to provide day by day feedback/assessment of the Trainee by each surgeon trainer. Feedback must be about both problem areas, and areas of above average performance, with instructive comment as to further improvement.

Identifying underperforming Trainees

Unless each six-month period of training is deemed satisfactory according to the training assessment process, then that period of training will be deemed unsatisfactory for eligibility to present for the Fellowship Examination and/or eligibility to be granted the full Fellowship.

If areas of poor performance (score less than satisfactory) are determined, the Head of Unit will inform both the primary and secondary supervisors of surgical training.

When areas of poor performance (score less than satisfactory) are determined, then counselling and appropriate remedial action is required by the surgeons of the training unit on the advice of the primary and secondary supervisors of training.

If the overall performance is deemed unsatisfactory and agreed to by a majority of surgeons in the training unit, the Head of Unit and the primary surgical supervisor of training will undertake a further formal appraisal interview with the Trainee, at which time appropriate counselling and remedial action will be documented.

Unsatisfactory grades in any of the assessed categories in the mid-term evaluation will be reviewed by the Board Chair. If unsatisfactory grades are received in the same categories in a mid-term and/or end of term evaluation form, in more than one training term, the Trainee will be

placed on Probation. If the Trainee is already on Probation, continuation in the training program will be discussed.

Management of underperforming Trainees

An unsatisfactory evaluation form is defined by:

- an 'overall' unsatisfactory grade
- and/or unsatisfactory grades in the same category/ies in more than one mid-term and/or end of term evaluation form
- and/or unsatisfactory grades in any of the essential criteria
- and/or non-submission of the logbook or evaluation forms following completion of the term.

Upon receipt of one overall unsatisfactory evaluation form and/or receipt of repeat unsatisfactory grades in the same category and/or unsatisfactory grades in any of the Essential Criteria, a period of Probationary training will automatically commence in the following rotation. The continuation of this period of Probationary training will then be decided upon by the Vascular Board as soon as possible.

The Vascular Board, upon notification of one unsatisfactory assessment (defined by the above criteria) will conduct a review of the Trainee's performance.

As soon as possible a formal interview is convened with the Trainee, the Board Chair (or representative) and the Surgical Supervisors. The Trainee may invite an advocate who is a Fellow of the College. The interview will address the following:

- details of any less than satisfactory performance
- the response of the Trainee, and
- remedial action advised.

The ensuring formal process shall be explained to the Trainee:

- A probationary period automatically commences in the term following the unsatisfactory term, subject to future ratification by the Vascular Board.
- If it is agreed that the assessment is deemed unsatisfactory, the Vascular Board will recommend that the unsatisfactory period of training be deemed unsatisfactory.
- This recommendation will be considered at the next meeting of the Vascular Board. If agreed that the period of training is deemed unsatisfactory and therefore not accredited towards training time, the Board in Vascular Surgery, through the Chairman, will advise the Trainee of the decision.
- The Board in Vascular Surgery will determine the action required to correct the less than satisfactory performance. This may include attendance at a specific Course or the need to extend the period of training, in addition to repeating the unaccredited 6 month term.
- If the Trainee is on Probation, at the time of receiving an unsatisfactory evaluation, continuation in the Specialist Surgical training program will be reviewed and dismissal from the training program will be discussed.
- Trainees that are on Probation are not permitted to change training States or Rotations.

Documentation:

Vascular Surgery probation documents

Dismissal Policy

Proforma for Managing an underperforming Trainee (See Attachment 6 in this document)

4.3. SUMMATIVE ASSESSMENT

The most significant summative assessment, at the end of SST in all of the surgical specialties, is the Fellowship Examination.

For many years examinations have been clearly identified as the key summative assessment processes. However, within the training programs there has been some uncertainty about other assessment procedures in understanding whether they are formative or summative.

The following definition was provided in a discussion paper for a meeting of the College Court of Examiners in 2004.

Summative assessment can occur at any stage of a training program although it usually occurs towards the end of a defined area of study or course. This process can be used to provide both feedback for the Trainee and information for reporting to people outside of the training situation.

The distinction between formative and summative is not clear-cut. The difference between the two is more closely related to the intention and purpose, than the timing or type of task. For example, the completion of the end of rotation Trainee Evaluation Forms can be interpreted as either a formative or summative assessment. If there is no opportunity for trainees to improve their performance after the assessment, and no flow-on process into the following rotation, then each separate rotation could be seen as a separate summative assessment. Informal formative assessment is frequently given during ward-rounds and during surgery. Formal formative assessment occurs in some surgical specialties where mid-rotation Trainee evaluation is required. However, without any formal formative assessment, the four^{+} years could be seen as a series of separate summative experiences, culminating in the Fellowship Examination, which is another, separate summative assessment experience.

Since that meeting in 2004, there has been significant progress in restricting summative assessment to those processes and times which are most appropriate within the training programs.

SET1 Examinations

Basic Sciences Examination and Clinical Examination

Building on the extensive work which has been carried out over several years to establish the BST examination, the SET1 examinations will use a number of different assessment methods and tools to assess the knowledge, skills, and attitudes of trainees and to ensure that the processes are of a very high standard.

The Basic Sciences Examination (BSE) uses MCQ format to test knowledge of Anatomy, Pathology and Physiology. Currently this written examination is conducted over three consecutive days with one session of two and a half hours each day.

The second formal examination is the Clinical Examination. In this practical examination, using OSCE format, trainees are assessed on their clinical skills – examination, history-taking, communication and procedure skills. Currently the Clinical Examination is a single two- to three-hour session using a series of 16 examination stations at which candidates are observed by examiners. The Clinical Examination is offered twice per year at locations around Australia and New Zealand

Trainees must attempt the MCQ Examination before or in conjunction with the Clinical Examination.

In SET the BSE and Clinical examinations will be held twice yearly in April and October. The purpose of these examinations is, as part of the continuum of learning and assessment, to assure both the trainees and their supervisors that they have achieved a standard of knowledge and clinical decision making that enables them to begin to function at a registrar level within their specialty.

BST Exams held up to and including March 2008 would satisfy the BSE requirements of SET, with the specialty specific exams in Orthopaedics, PRS and Paediatrics still being required in addition (in those 3 specialties only). Once selected into SET, BST trainees who have successfully completed the BST examinations will not be required to sit them again. However, completion of the current BST examination is not an eligibility requirement for any of the specialties.

Unlike the current BST examinations, from October 2008, the MCQ examination will consist of two basic science components, one which will have generic questions and the other will be specialty specific questions. The first component will be completed by all SET1 Trainees whilst the second will require different papers for trainees in each specialty.

The content of the specialty specific component will be determined by each specialty.

In those specialties which already have an MCQ examination early in specialty training (Orthopaedic Surgery, Plastic and Reconstructive Surgery, and Paediatric Surgery) components of those examinations may be incorporated into the SET1 examination, or maintained as a separate examination.

In some specialties failure to pass the examination will restrict a Trainee from progressing into SET2. In those specialties where a Trainee is permitted to progress for SET1 to SET2 without having passed some, or all of the examination, if that Trainee has not successfully completed the examination component by the middle of their SET2 year, they will be placed on probation (see Attachment 4). This will be under the direction of each specialty board. To offer trainees the maximum number of opportunities to pass the examinations, once selected, and having accepted an offer for training in a specialist surgical program, they may sit the MCQ component of the examination.

Documentation: BST Examinations (Weblink)

Sharing knowledge and resources

The discipline subcommittees which currently prepare the BST examinations in the College data-base have had one workshop with members of the specialty boards, and will continue to assist then in developing their specialty specific components of the SET1 MCQs.

On-line practice examination bank

Online Resources are designed to provide a context for trainees to learn and apply the basic sciences of surgery. Case studies and examples of MCQs are presented on the College

website. Trainees can practise answering MCQs online to prepare for the BSE. They include information on the Trainee's performance, answers and explanations, allowing trainees to self-correct their responses.

Fellowship Examination

A pass in the Fellowship Examination is the summative assessment requirement for all specialties. Trainees must be approved as eligible to sit by the relevant specialty board on each occasion that they present for the examination.

The Court of Examiners is appointed by the Council of the College to conduct the Fellowship Examination and to assess the knowledge, clinical skills, judgement and decision making, and professional competencies of candidates, in order to ensure that they are safe and competent to practice as surgeons.

The Court is comprised of surgeons representing the nine different specialties in which the College conducts the Examination. The Number of Examiners varies in each specialty in line with the number of trainees and Examination Candidates.

The clinical/oral examinations are usually conducted during May and October each year and are rotated between four centres in Australia; and between four centres in New Zealand. They are also held in Hong Kong.

Written exams are normally conducted in April and September each year in each of the capital cities in Australia (except Darwin); three centres in New Zealand and also in Hong Kong.

Court of Examiners - Terms of Reference

1. To conduct the Fellowship Examination
2. To examine the candidates and test their competencies
3. To review the content (based on the surgical curriculum) of the Fellowship Examination
4. To investigate, set standards, and prepare and provide guidelines for effective and varied methods of examining
5. To ensure that appropriate specimens, x-rays and technology are used
6. To optimise the use of advanced technology techniques for examination purposes
7. To review and discuss the exam results of individual candidates
8. To regularly review historical examination results to ensure quality standards of the examination process are maintained
9. To set standards and provide guidelines for the training of Examiners

Documentation:
Court of Examiners- Terms of Reference

Conduct of the Fellowship Examination

Details about the conduct of the Fellowship Examination; the roles and responsibilities of members of the Court; the marking system, and the requirements for providing feedback to candidates, who fail the examination, are all set out in the policy.

Note: Because all of these processes are governed under a common policy they are not detailed in the information from each specialty.

Documentation:
Conduct of the Fellowship Examination

Eligibility criteria

To sit the Fellowship Examination, trainees must have:

- *successfully completed all components of Basic Surgical Training*
- been registered as an accredited Specialist Surgical Trainee of the College
- satisfied the specialty specific requirements of Specialist Surgical Training
- completed an investigative project approved by the specialty board
- completed any training modules to the satisfaction of the relevant specialty board.

Trainees must be approved as eligible to sit by the relevant specialty board on each occasion that they present for the examination.

In making a decision as to the eligibility of a trainee to sit for the examination, the specialty board chair may take into account a letter of support from the surgical supervisor for the trainee

to sit the examination.

Cardiothoracic Surgery Summative Assessment

SET1 Examination

The Basic Science Examination

Starting in October 2008, the SET1 examination will have three components:

- Generic MCQ
- Specific MCQ for Cardiothoracic Surgery. This will have specific questions about the management of acute and elective Cardiothoracic surgical conditions, sepsis, specific surgical anatomy, specific questions on the management of relevant co-morbidities (eg: diabetes, hepatic disease, coagulopathy etc).
- An OSCE with generic stations. These would include clinical examination, history taking, obtaining consent, resuscitation and trauma. A specific OSCE for Cardiothoracic surgery would be difficult to resource.

All three components will need to be completed successfully for the trainee to pass.

The Clinical Examination

Trainees must attempt the SET1 clinical examinations prior to the end of the 1st year of SET.

The must pass all components of the examination before advancement beyond SET2. The maximum time for passing is two years. Failure to pass the SET1 examinations will result in dismissal from the program.

Documentation:
See Appendix E in the SET Discussion document

Fellowship Examination

Cardiothoracic Surgery Fellowship Examination has seven components — two written papers, two clinicals and three vivas.

Documentation:
Cardiothoracic Surgery Fellowship Examination (Weblink)

The content of the Fellowship Examination

All of the content of the Fellowship Examination is drawn from the modules. The main focus of the Fellowship Examination is on Medical Expertise and Judgement - clinical decision making. However, across the seven different exams that make up the Fellowship Examination some competency standards of Communication, Professionalism, Management and Leadership, and Scholarship are also assessed.

Preparing trainees for the examinations

Cardiothoracic surgery offers three courses to assist trainees in preparing for examination:

- A new inaugural College Cardiothoracic Training Course, Melbourne
- Training half day at the College ASC, Christchurch
- Full day training course, including Wetlab at ASCTS Annual Scientific Meeting (ASM), Queensland

Apart from didactic sessions at the FRACS run courses above, each cardiothoracic hospital based training program should run a structured training program, during which core curricula subjects are to be presented by the trainee and other surgical staff. Further advice with regard to preparation for the FRACS Fellowship will be taught by hospital based cardiothoracic surgical supervisors.

General Surgery Summative Assessment

SET1 Examination

The Basic Science Examination

Starting on October 2008, the SET1 examination will have three components:

- Generic MCQ
- Specific MCQ for General Surgery. This will have specific questions about the management of acute and elective general surgical conditions, sepsis, specific surgical anatomy, specific questions on the management of relevant co-morbidities (e.g.: diabetes, hepatic disease, coagulopathy etc).
- An OSCE with generic stations. These would include clinical examination, history taking, obtaining consent, resuscitation and trauma. A specific OSCE for general surgery would be difficult to resource.

All three components would need to be completed successfully for the trainee to pass.

The Clinical Examination

Trainees can sit the clinical examination once they have commenced their training. If necessary, they must attempt the SET1 examinations twice prior to the end of the 1st year of SET.

They will pass all components of the examination before advancement from SET1 into SET2. The maximum time for passing is two years of SET1. Failure to pass the SET1 examinations will result in dismissal from the program.

Documentation:
SET Discussion Document

Fellowship Examination

General Surgery Fellowship Examination has seven components — two written papers, two clinicals and three vivas.

Documentation:
General Surgery Fellowship Examination (Weblink)

Content of the Fellowship Examination

All of the content of the Fellowship Examination is drawn from the modules. The main focus of the Fellowship Examination is on Medical Expertise and Judgement - clinical decision making. However, across the seven different exams that make up the Fellowship Examination some competency standards of Communication, Professionalism, Management and Leadership, and Scholarship are also assessed.

A Guide for Candidates has been published on the web. This document explains all of the different segments of the General Surgery Fellowship Examination and provides examples of questions and answers.

The General Surgery Court is developing a statement of criteria, based on the General Surgery competency statement that can be used by all examiners.

Documentation:
General Surgery Guide for Candidates (Weblink)
Fellowship Examination Criteria
General Surgery Draft examination planning proforma (available for reference at the College)

Preparing Trainees for the Examinations

Local tutorials at training hospitals organised by the supervisors of training and the trainees.

Regional training sessions run by the individual boards as mentioned above.

Regional pre-examination courses as mentioned above.

Neurosurgery Summative Assessment

SET1 Examinations

The Basic Science Examination

Trainees must satisfactorily complete the Basic Science Examination during SET1. The Examination will include a basic generic component and a neurosurgery specific component. Trainees may be granted exemption from this component in accordance with the Board regulations for recognition of prior learning.

The Clinical Examination

Trainees must satisfactorily complete the Clinical Examination in Neurosurgery during SET1. This will remain unchanged from current BST program examination. Trainees may be granted exemption from this component in accordance with the Board regulations for recognition of prior learning.

Proposed examination for SET2

The Board is considering the introduction of the Neurosurgical Anatomy Examination focused on the knowledge and understanding of relevant neurosurgical anatomy. The introduction of this Examination will depend on the level of specialisation that can be accommodated in the Basic Science Examination. If it is felt that the Basic Science Examination can be appropriately adapted to assess neurosurgical anatomy the Neurosurgical Anatomy Examination may not be developed. If the Neurosurgical Basic Examination proceeds trainees must satisfactorily complete the Examination during SET2.

Documentation:
Neurosurgery SET Program Regulations (web link and paper based)
Training Program Regulations

The Fellowship Examination

The Fellowship Examination will remain in its current format and must be completed during SET6. The seven components to the Fellowship Exam in Neurosurgery are made up of the following:

Writtens:

- Written Paper 1 & 2 - these are 2 hours each in duration.

Clinicals/vivas:

- Clinical Cases 1 - with patients, approx. 30mins in duration
- Clinical Cases 2 - with patients, approx. 30mins in duration
- Surgical Anatomy - with specimens, approx. 25 mins in duration
- Surgical Pathology - approx. 25 mins in duration
- Operative Surgery - approx. 25 mins in duration

Preparing trainees for the examinations

Trainees prepare for the Fellowship Examination by way of the tutorial programs in the hospital or region in which they are allocated, which is a condition for the accreditation of training positions. In addition the trainee seminars are designed to assist senior trainees in preparing for the Fellowship Examination. The Board has a learning resource webpage which provides trainees with past examination papers to assist them in their preparation.

Documentation:
Training Website Neurosurgery learning resource webpage (Weblink)

Orthopaedic Surgery Summative Assessment

SET Examination

As detailed earlier in this report, a combined generic and Orthopaedic basic science examination will be required in SET1. Completed BSTs appointed to the SET program would be exempt from this requirement but would need to pass the OPBS module. It will be a requirement of the SET program to have passed the basic science examination before progressing to SET2. Trainees would be allowed to repeat SET1, with a maximum of three attempts at the basic sciences examination permitted.

Documentation:
AOA Competency and Assessment Instrument Matrix (available for reference at the College)

Fellowship Examination

The Fellowship Examination will remain in its current form. Registrars who, for one reason or another, have reached a high level of competency in SET4 would be encouraged to sit the Fellowship Examination then and, providing all competencies have been met, could finish their training at the end of SET4 rather than progressing on to SET 5. It is not thought likely that this will be a frequent occurrence.

The summative assessment in Orthopaedics is the Fellowship Examination conducted by the College Court of Examiners. The Chair of the court of examiners in Orthopaedics is also on the AOA Federal Training Committee and is made fully aware of developments in the orthopaedic curriculum and syllabus. The content of the Fellowship Examination is therefore aligned carefully with course content of the SST program.

The AOA Training Committee is responsible for ensuring that trainees presenting for the Fellowship Examination have reached an appropriate level of both clinical and non-clinical competence. Orthopaedics has maintained a very high pass rate in the Fellowship Examination, suggesting the match between the content of the program and the formal examination is appropriate.

Trainees prepare for the Fellowship Examination throughout the SST program in that all Bone School material is appropriate to the final assessment, just as the Fellowship Examination is an appropriate assessment of the competencies required in a graduating orthopaedic surgeon. A national Pre-Exam Course is offered annually. In addition, the trainees run their own association, The Australian Orthopaedic Registrars Association (AORA), and many trainees form study groups and use Internet-based resources to access national and international material.

Candidates who fail the Fellowship Examination are usually successful within their fourth year of training. Those trainees who sit unsuccessfully in May and are thought likely to pass, are encouraged to sit again in October. This means that it is unusual for SST Trainees in Orthopaedics to not have completed the Fellowship Examination by the end of SST Year 4. Those few trainees that fail to pass the exam are usually found an additional position for the following year. Conversely, trainees who are performing at an exceptional level are encouraged to sit the exam in their third year of SST.

Otolaryngology Head and Neck Surgery Summative Assessment

SET1 Examination

The Basic Science Examination

Starting on October 2008, the basic science exam will be sat in SET1 and will have three components

- Generic MCQ
- Specific MCQ for Otolaryngology Head and Neck Surgery. This will have specific questions about the management of acute and elective Otolaryngology Head and Neck surgical conditions.
- An OSCE with generic stations. These would include clinical examination, history taking, obtaining consent, resuscitation and trauma.

All three components would need to be completed successfully for the trainee to pass. However, the generic component of the BSE is required to be passed before progression to SET2, and the specialty specific component can be carried into SET2 and completed before SET3.

The Clinical Examination

Trainees can sit the clinical examination once they have commenced their training. If necessary, they must attempt the SET1 examinations twice prior to the end of the 1st year of SET. The generic component of the BSE is required to be passed before progression to SET2. The specialty specific component can be carried into SET2 and completed before SET3.

Documentation:
SET Discussion Document

Fellowship Examination

Otolaryngology Head and Neck Surgery Fellowship Examination has seven components:

- Two written papers. Each paper with one long question and one question compromising four areas of shorter responses. Each question is of equal value.
- one viva in pathology
- one viva in anatomy
- one viva in operative surgery
- Clinical 1 consisting of five clinical scenarios of 10 minutes duration each
- Clinical 2 consisting of a number of short cases where patients are examined by the candidate.

Documentation:
Otolaryngology Head and Neck Surgery Fellowship Examination

Content of the Fellowship Examination

All of the content of the Fellowship Examination is drawn from the modules. The main focus of the Fellowship Examination is on Medical Expertise and Judgement - clinical decision making. However, across the seven different exams that make up the Fellowship Examination some competency standards of Communication, Professionalism, Management and Leadership, and Scholarship are also assessed.

Documentation: Otolaryngology Head and Neck Surgery Draft examination planning proforma (available for reference at the College)

Preparing Trainees for the Examinations

Trainees are prepared for exams at the National Registrars conference annually where trial exams are held.

Each State holds regular tutorial programs at which trainees are prepared for examinations.

Documentation: Otolaryngology Head and Neck Surgery Regional tutorial program (available for reference at the College)

Paediatric Surgery Summative Assessment

SET1 Examinations

- SET1 trainees must complete the Clinical Examination/OSCE Examination with generic stations. These would include clinical examination, history taking, obtaining consent, resuscitation and trauma. A specific OSCE for paediatric surgery would be difficult to resource.
- Should a SET1 trainee not pass the BSE after 3 attempts, they will be placed on probation but allowed to progress into SET2 and have one further attempt at the examination in April.
- Should the trainee fail the examination at the extra attempt, they will be automatically dismissed from SET in Paediatric Surgery.
- Training in SET2 post will not be accredited until the trainee passes the examination.
- The Paediatric court of examiners will identify from the current BSE those questions common to all specialties, those specific to paediatric surgery and those not relevant. Paediatric Surgery specific questions will be included in the Paediatric Anatomy and Paediatric Pathology Examinations to be undertaken by trainees during SET2^{+}.

Documentation:
SET Discussion Document

Content of the Fellowship Examination

All of the content of the Fellowship Examination is drawn from the modules. The main focus of the Fellowship Examination is on Medical Expertise and Judgement including clinical decision making. However, across the seven components that make up the Fellowship Examination some competency standards of Communication, Professionalism, Management and Leadership, and Scholarship are also assessed.

Preparing trainees for the Examinations

There are no formal pre-examination courses organised by the Board. There is one course that is held in Christchurch, New Zealand between three and six weeks prior to the examination. The CATs and DOGS are designed to assist trainees to prepare for the examinations. Trainees also utilise the time at the RATS to participate in educational activities directed at studying for the examinations and are given practice questions.

Practice examinations can be made available on request from the Executive Officer to the Board of Paediatric Surgery. This lists all the written examination questions for the previous five years. There is also a list on the College website of the operative procedures and conditions that have been examined in recent years in the operative viva. The RATS provides direct access to the trainees as a group, and individually, to meet members of the court of examiners and provides the opportunity for them to be briefed by the Senior Examiner on the exam and be given up to date information about the examination process.

Documentation:
Paediatric Surgery Fellowship Examination

Plastic and Reconstructive Surgery Summative Assessment

SET1 Examinations

The existing Speciality specific Plastic and Reconstructive Surgical Sciences and Principles Exam will continue to be a requirement of training.

The Basic Science Examination and the Clinical Examination are also requirements of training. Trainees must successfully pass Basic Sciences Primary (BSE and OSCE) in order to progress to SET2.

The Surgical Sciences and Principles Examination (SSPE), now undertaken in SST1 (SET2) may be taken with the generic BSE and OSCE during SET1. It must be taken by the end of SET2 and trainees must pass the exam to progress beyond SET3. As a transition arrangement, those who have successfully completed the BST Exam must sit the Speciality Specific SSPE in SST1 (SET2) and must pass the examination to progress beyond SST3 (SET4).

Current rules will apply to BSTs who have successfully completed the BST examinations.

Fellowship Examination

Preparing candidates for the examinations

Practice examinations are held during the Registrar Conference for SST3 and SST4 year trainees to practice their exam techniques and knowledge, and gain feedback. Each region has a regular tutorial program during which trainees cover the knowledge required for the Fellowship Examination.

Documentation:

Plastic and Reconstructive Surgery Regional tutorial program (available for reference at the College)

Urology Summative Assessment

SET1 Examinations

The Basic Science Examination

The BSE exam is expected to be successfully completed before the end of SET1. Applications to progress to SET2 prior to success at this examination will be considered on an individual basis. At this point in time, it is anticipated Urology, Vascular Surgery and General Surgery (at least) will undertake a common BSE.

Clinical Examination

The Clinical Examination (OSCE) is expected to be completed before the end of SET1. Applications to progress to SET2 prior to success at this examination will be considered on an individual basis.

Fellowship Examination

Content of the Fellowship Examination

The Urology Fellowship Examination is a criterion-based assessment. If a candidate reaches the prescribed criterion they pass. There is no quota. The criterion is that of a safe practicing clinical urologist. The exam is administered twice a year, at a site according to a rotating pattern.

The exam consists of seven parts. Two written papers are taken four to six weeks before the exam viva weekend. Five vivas are administered, as outlined below.

The principles applied to assessing candidates are those of the College. General surgical principles as they apply to urology may be asked in the written section or in any of the five vivas.

Written papers

There are two written papers. Each is of two hours' duration, and includes eight short answer questions. In addition to medical expertise, aspects of judgement, communication, and health advocacy are assessed in this format.

Clinical Vivas

Vivas are of 40 minutes' duration, or of 25 minutes' duration. The five vivas are;

- Structured Oral exam (40 minutes)
- Diagnostic viva (40 minutes)
- Anatomy and Operative surgery 1 (25 minutes)
- Anatomy and Operative surgery 2 (25 minutes)
- Pathology (25 minutes)

During the course of these examinations, the intention is to evaluate medical expertise, judgement, communication, and health advocacy. Aspects of scholarship and professionalism may also be explored.

The aim of the examination is to determine whether the candidate can demonstrate to the examiners the requisite competencies to be a sound and safe clinical urologist. Further details of the structure, conduct, and philosophy of this examination are available on the USANZ website.

Criteria established and applied to examinations in Urology

Each examination is a newly written examination (no use of old questions), and it is developed at a workshop conducted for this specific purpose. By producing the examination as a whole (rather than combining a series of independently developed pieces), it is ensured the breadth of the curriculum is assessed, and a variety of competencies (as outlined above) are assessed in a variety of settings.

Preparing trainees for the examinations

Local education programs include relevant tutorials, and viva practice. It is also at a local level the trainee will avail most learning opportunities, as outlined in the learning Portfolio.

Trainee Week provides education sessions, workshops, practice written papers, and vivas.

Section Education sessions provide a structured education program, workshops, and practice vivas.

In-training exams act as a gauge of progress for the benefit of all trainees

Proposed changes to the format and/or content of the Fellowship Examination

No immediate changes are anticipated to format and/or content of the Fellowship Examination. The successful introduction of regular mini-CEX may enable the elimination of tests of basic knowledge from this exam, to allow the inclusion of more focus on complex clinical decision making, communication, collaboration, health advocacy, and professionalism.

Vascular Summative Assessment

SET1 Examinations

Starting on October 2008, the SET1 examination will have three components:

- Generic MCQ
- Specific MCQ for Vascular Surgery.
- An OSCE with generic stations. These would include clinical examination, history taking, obtaining consent, resuscitation and trauma. A specific OSCE for general surgery would be difficult to resource.

All three components would need to be completed successfully for the trainee to pass.

The SET1 examination will cover topics deemed relevant to the principles and practice of vascular surgery and will not cover topics of minimal relevance to vascular surgery.

The Board in Vascular Surgery requires satisfactory completion by 30 June of SET2 of:

- Generic BSE and OSCE
- Vascular specific MCQ

Documentation:
SET Discussion Document

Fellowship Examination

Content of the Fellowship Examination

All of the content of the Fellowship Examination is drawn from the modules. The main focus of the Fellowship Examination is on Medical Expertise and Judgement - clinical decision making. However, across the seven different exams that make up the Fellowship Examination some competency standards of Communication, Professionalism, Management and Leadership, and Scholarship are also assessed.

Documentation:
Vascular Surgery Draft Examination Proforma (available for reference at the College)
Vascular Fellowship Examination (Weblink)

Preparing trainees for the examinations

A trial examination course sanctioned by the Executive Committee of the ANZSVS and Board of Vascular Surgery is held annually for final year trainees prior to them attempting the Fellowship Examination.

4.4. ACCREDITATION OF TRAINING POSITIONS

In 2005, following an extensive review of the accreditation process by the ACCC the College developed generic accreditation criteria to be used by all surgical specialties.

The underlying principle of the accreditation process is to ensure that hospitals and training posts provide learning environments which facilitate the training of safe and competent surgeons. The College, with the help of its boards, the various specialty associations/societies and the jurisdictions, has developed a hospital accreditation process and set of accreditation criteria. The criteria are based around seven core educational, clinical and governance standards required to provide training in a range of clinical contexts. The standards and criteria have been produced to enable trainees acquire the competencies and fulfil the roles identified as necessary by the College.

The process of accreditation may be initiated by a hospital which wishes to undertake surgical training for the first time, or by the College where re-accreditation needs to occur at the completion of a previous period of accreditation. Normally hospitals are accredited, or re-accredited for a period of five years.

The criteria for accreditation were available on-line for hospitals to carry out a self assessment which they could provide the Specialty accreditation team prior to the inspection.

Documentation:
Accreditation of Specialist Surgical Training Posts (Weblink)

In the latter part of 2006 the accreditation criteria were reviewed and the revised criteria will be published early in 2007.

Documentation:
2007 Accreditation Criteria (available for reference at the College)

Accreditation of positions for SET1

SET1 Trainees will complete clinical placements in hospitals accredited for training. Specialty Boards will allocate trainees to accredited hospitals in the same way as they now do in allocating SST Trainees to accredited posts. Within the hospital the Trainee will nominate their preferred rotations, and the hospitals will arrange the rotations in consultation with the College when necessary (as is done for BSTs).

The nature and specialty educational requirements of the training environments are being defined by each specialty. Clinical placements will be career aligned in accordance with the requirements of each specialty.

Taking into account the difference between jurisdictions, specialties have defined their expectations for SET1 rotations with some flexibility so that SET1 positions can be no less than 10 weeks and no more than 26 weeks in duration.

In the SET program existing SST accredited posts will be designated as $SET2^{+}$ posts, and will be allocated to trainees who have completed their first year of surgical training. First year Trainees, i.e. SET1 Trainees, will be allocated to career aligned positions at an accredited training hospital. The Specialty Boards of the College are developing the experiences required by a SET1 Trainee.

The process for the identification of potential SET1 positions in hospitals that are currently accredited for SST has been developed and letters inviting expression of interest have been sent out. To ensure that SET1 positions would be in hospitals in which already meet hospital accreditation standards in a specified discipline, the letter identified which surgical specialties already had accredited posts in their hospital. In their response, they were asked to indicate which of those specialties they wished to be considered for, and the number of positions in each specialty they were able to offer.

Documentation: Example of the letter sent out to hospitals (available for reference at the College)

4.5. EVALUATION AND MONITORING

Each of the specialties, divisions of the College, and individual courses have the responsibility to evaluate and monitor the effectiveness of their processes and/or programs.

Courses

ASSET

The participants conduct a post course evaluation survey at the completion of each day. The survey seeks feedback on course content, methodology, learning experiences and outcomes. This information assists the ASSET Committee to continually improve course deliverables.

CCrISP

The participants conduct a post course evaluation survey at the completion of each day. The survey seeks feedback on course content, methodology, learning experiences and outcomes. This information assists the CCrISP committee to continually improve course deliverables.

The committee convene for at least two face to face meetings/workshops annually to oversee the review of curriculum and materials necessary to the CCrISP Course program.

EMST

The participants conduct a post course evaluation survey at the completion of seeks feedback on course content, methodology, learning experiences and outcomes. This information assists the EMST Committee to continually improve course deliverables.

Assessment processes — BST Examinations

Examination components

The aim of the BST examinations is to use a number of different assessment methods and tools to assess the knowledge, skills, and attitudes of trainees. There are two examinations, the Basic Science Examination and the Clinical Examination, that are each held twice a year.

The Basic Sciences Examination tests knowledge of Anatomy, Pathology and Physiology. This written examination is conducted over three consecutive days with one session of two and a half hours each day.

The second formal examination for Basic Surgical Trainees is the Clinical Examination. In this practical examination trainees are assessed on their clinical skills – examination, history-taking, communication and procedure skills as they relate to RACS Competencies of Medical Expertise, Judgement – Clinical Decision Making, Communication and Professionalism.

Trainees must attempt the MCQ Examination before or in conjunction with the Clinical Examination.

The web links below provide detailed information on special consideration and the appeals mechanisms for the BST examinations.

Web links
BST Examinations Information
Special Consideration
Appeals Mechanisms

Basic Sciences Examination

Criterion Referenced Pass Standards

In 2005 the pass/fail standard setting process for the Basic Sciences Examination changed. A standard setting process which included members of the Board of Basic Surgical Training and committees was carried out and a criterion-referenced pass/fail standard was implemented at the June 2005 examination. Rasch scaling of the examination is used to analyse the results of the examination and maintain the constancy of the pass standard over time.

The model that was implemented in defining the pass standard for the Basic Sciences Examination is a modified version of the *Angoff Method* and includes the following parameters:

- Minimum acceptable pass standard: lowest pass mark calculated from the item judgement exercise (by one or more item judges).
- Maximum acceptable pass standard: highest pass mark calculated from the item judgement exercise (by one or more item judges).
- Minimum acceptable failure rate: set at 0% (criterion referenced).

Marking Process

The Basic Sciences Examination is externally marked at the Assessment Result Centre at the University of Melbourne. Performance data provided by the Assessment Result Centre is reviewed by discipline sub-committees. The performance data can identify questions which may have been keyed incorrectly, in general approximately three questions are deleted and three questions are re-keyed. These questions are omitted from the scoring and further analysis of the data.

Reliability estimates of the Board's examinations have been consistently high (Kuder-Richardson reliability more than +0.90), with correspondingly small standard errors of measurement.

In each examination there are questions that have been used in previous examinations and therefore there is performance data available on these questions. Each examination is linked by a chain of questions. The pass mark for each examination can thus be adjusted to allow for slight fluctuations in examination difficulty, keeping the overall pass standard constant.

A minimum standard, which is somewhat lower than the aggregate pass mark, is set for each of the components in the examination: Anatomy, Physiology and Pathology. A candidate whose aggregate mark is above the pass standard but whose mark in one or more components is below the pass mark in that component fails the examination. Candidates are advised to refrain from neglecting any discipline in preparing for the examination.

Clinical Examination

The Clinical Examination is conducted in OSCE format.

Marking

Candidates undertaking the Clinical Examination are marked on a checklist and a global rating scale at each station. The mark for each station is scaled with the checklist contributing to 75% of the pass mark and the global rating scale contributing to 25% of the pass mark for each station.

Analysis

Currently analysis is performed on the stations to monitor the stations used in the examination. The analysis performed includes the following:

- The mean performance of candidates at each station is assessed for any major differences between assessment centres.
- Reliability analysis is performed using Cronbach’s alpha to asses the internal consistency of the examination, which in the last four examinations has fallen between 0.55 and 0.65
- The corrected item total correlation to look at the relationship between each item (station) and the overall score.

Review of the Pass Mark

The Clinical Examination pass mark is currently set at 59.5%, however this is undergoing review. Currently research is being undertaken to see whether using the Borderline Group Method will be a more reliable and feasible method of determining the pass mark.

Also, in 2007 the introduction of a requirement to pass a certain number of stations in order to receive a pass overall will be considered.

Pass rates for the Fellowship Examination are reported every year in the activities reports
In 2006 a review of the annual, eventual and individual pass rates was produced which looked at differences and similarities between and within the specialties. This process also analysed the differences between candidates in terms of:

- Gender
- Region
- Trainee status, specifically IMG

Evaluation of the Fellowship Examination will continue to occur to monitor the performance of trainees within all the specialties.

Documentation:
College Activities reports (Weblink)
An analysis of Fellowship Examination pass rates (available for reference at the College)

Plans for monitoring and evaluation in SET

Monitoring and evaluating the selection processes

There will be two parallel processes of monitoring and evaluating the SET selection processes.

- Because selection into specialist surgical training will be at an earlier stage than in the current programs, it will be important to monitor the progress of selected trainees who enter SET program without previous experience as a BST.
- Whilst there will be little change to the selection tools and processes used by the specialties in 2007, there is agreement that in preparation for selection in 2008 selection tools and processes will be modified so that:
    - the 9 RACS competencies be the guiding principles for all selection tools
    - there be more standardisation of tools, and
    - selection across all specialties is more aligned with the principles outlined in Attachment 6 'The Selection and Work-based Assessment of Surgical Trainees'

  The changes in the selection tools and process, and any impact of those changes will be carefully monitoring.

Monitor and evaluating the assessment processes

The introduction of competency workplace assessment processes will be monitored and evaluated in terms of:

- their effectiveness to more clearly identify Trainee's level of performance, and in particular the underperforming trainee
- the response of supervisors and trainees to the additional assessment processes

As the BST examination is modified into the SET1 examination, consideration will be given to how the detailed and on-going evaluation of the BSE and clinical examination can be implemented.
Monitoring and evaluation of the SET1 examination will pay careful attention to pass rates, the number of unsuccessful attempts, and the impact which that may have on the capacity of Trainees to progress through the program, as well as the number being dismissed due to failure in the examination.

The processes of analysing the results of the Fellowship Examination will continue. The results of that analysis could lead to additional attention to specific areas.

Monitor and evaluating curriculum and supervision

The surgical specialties review their curriculum on an annual or bi-annual basis to ensure that the content is current and relevant. This process will continue.

Monitoring feedback from supervisors and Trainees

At this stage the surgical specialties do not have additional plans to monitor their feedback from supervisors and trainees.
The current processes will be reviewed to identify how they can be improved.

Cardiothoracic Surgery

Evaluation and monitoring of selection processes

The Board conducts an annual review of the selection tools and processes.

As a result of feedback from previous selection the processes have be gradually refined to make them more evidence based and more aligned with the nine RACS competencies.

Evaluation and monitoring of modules and courses

The content of the modules is reviewed and revised on an annual basis by the Board of Cardiothoracic Surgery.

Evaluation and monitoring of assessment processes

The formative assessment processes are reviewed and revised on an annual basis by the Board of Cardiothoracic Surgery.

Evaluation and monitoring of accredited training environments

Quinquennial audit visits by two Board members usually from a different state.

General Surgery

Evaluation and monitoring of selection processes

The Board conducts an annual review of the selection tools and processes. The regional representatives on the Board make a significant contribution to this because, whilst the CV's; Referee Reports, Hospital reports, ranking and final selection are national, the interviews are conducted regionally.

As a result of feedback from previous selection the processes have be gradually refined to make them more evidence based and more aligned with the nine RACS competencies.

Web links and attachments list

Relevant minutes from BiGS meeting February 2006

Evaluation of the program

Prior to the introduction of the four year General Surgery program in 2004 — replacing the previous three+two year program, an extensive evaluation of that program was carried out.

Documentation:
Evaluation of the General Surgery 3+2 training program

Evaluation and monitoring of modules and courses

The content of the modules is reviewed and revised on an annual basis by the Board of General Surgery.

The content of the courses is reviewed by the Regional board on an annual basis to ensure that they are in line with the content of the modules.

Evaluation and monitoring of assessment processes

The formative assessment processes are reviewed and revised on an annual basis by the Board of General Surgery.

Evaluation and monitoring of accredited training environments

Log book assessments for each six month term. Each Trainee submits log books for the six months. These are reviewed by the regional board and any that are not providing satisfactory clinical exposure are assessed by the board. If need be these terms may be formally inspected and may enter a period of provisional accreditation. If they remain unsatisfactory accreditation may be removed.

All newly accredited terms are provisionally accredited for 12 months. They are re-inspected prior to this to ensure the training exposure and experiences are satisfactory.

All terms are inspected on a five year rotating basis. This is divided up into regions including NZ and HK. The hospitals provide written information as per the 43 categories on the accreditation document. This document should be submitted. The recent inspection reports form Vic/Tas, SA, WA and HK could also be included as they demonstrate the issues examined and the outcome of the inspections. They also demonstrate the rigor of the inspection process.

Review of communication strategies to and from Trainees, Supervisors, Mentors, Trainers

Web based
Each region communicated directly to trainees via email

Neurosurgery

Evaluation and monitoring of selection process

The Board of Neurosurgery conducts an annual review of the selection process and makes changes to the existing process in response to the feedback received and observations made during the process.

As a result of feedback from previous selection the processes have be gradually refined to make them more evidence based and more aligned with the nine College competencies. Changes include the introduction of a new competency based structured referee form, modification of interview questions and change to the structured curriculum vitae scoring process. The Selection Process Regulations are updated on an annual basis.

The Board is also conducting a long term evaluation of the selection process in comparison to the learning outcomes of successful trainees to ensure there is appropriate alignment.

Evaluation and monitoring modules and courses

The Board of Neurosurgery has a Neurosurgery Education Development Committee which undertakes the continuous review and development of all components of the SET program, excluding the final Fellowship Examination. The Neurosurgery Education Development Committee meets on a number of occasions each year to update the curriculum , review trainee seminars and to continue to develop new initiatives such as the workplace competency statements.

Evaluation and monitoring assessment processes

Formative assessment processes and minimum performance standards are reviewed on an annual basis by Education Development Committee and the Board of Neurosurgery with input from surgical supervisors and trainees. The College manages the Fellowship Examination process and review of the pass rates facilitating evaluation.

The workplace competency assessment forms which have recently been introduced will be subject to continuos monitoring with trainees, supervisors and other stake holders encouraged to provide feedback and suggested modifications.

Evaluation and monitoring accredited training environments

The Board of Neurosurgery has comprehensive regulations for the accreditation of training positions. The criteria are focused on ensuring that the training positions provide workplace hands on service learning and exploration in a range of training environments providing the opportunity for the trainee to develop, with supervision, the requisite experience, knowledge, skills and attributes necessary to become a competent independent specialist neurosurgeon.

The Board of Neurosurgery is currently in the process of introducing an online Rotation Evaluation Form. The Rotation Evaluation Form will be completed by all accredited trainees at the end of each clinical rotation and is designed to assess areas aligned with the learning outcomes and the accreditation criteria for training positions such as the level of supervision, facilities, working hours, educational program and operative experience. The data will be provided directly to the Board of Neurosurgery in confidence and will be analysed and used in the training position accreditation process in the future.

Review of communication strategies to and from trainees, Supervisors, mentors, trainers

The Board seeks feedback on its communication strategies from all involved stakeholders by way of supervisor and trainee meetings during the NSA Annual Scientific. The communication strategies also include online feedback mechanisms email communication and an annual trainee survey. The Board also provides updates on changes and processes in the NSA Newsletter and encourages feedback from all parties.

The composition of the Board of Neurosurgery has been designed to include an elected representative from each region in which training is conducted, a trainee representative, a jurisdictional representative, the Specialty College Councillor and the NSA President. This composition has been designed to ensure that communication is widely communicated at all levels related to training.

Changes to evaluation and monitoring of selection processes

All applicants to the 2008 selection intake conducted during 2007 will be encouraged to complete an online feedback form following the immediate closing date for applications. The feedback form will focus on the information available to applicants prior to and during the application process selection including suggested changes and its general usefulness.

Applicants who present for the Neurosurgery Semi-Structured Interview will be required to complete a confidential feedback form following their interview on their overall perception of the selection process and the interview.

All feedback on the selection process will be considered during the annual selection process reviewer.

Changes to evaluation and monitoring of curriculum and/or assessment processes

The Neurosurgery Education Development Committee is currently undertaking a review of the syllabus modules and curriculum to ensure competencies and learning outcomes for SET1 trainees have been adequately included.

Feedback on the workplace competency assessment forms will be sought on a regular basis from all stakeholders and the forms will be subject to continuous review and refinement.

Changes to evaluation and monitoring of communication strategies

The Board of Neurosurgery is currently undertaking an expansion of the trainee website to include additional information relevant to university students, medical graduates, international medical gradates and other potential applicants. Feedback will be sought by way of a confidential survey form at each trainee seminar on information relating to the curriculum and information provided by the Board. The Board will continue to provide updates to members and trainees by way of articles in the NSA newsletter and online. A confidential electronic feedback form will also be set up on the website to allow users to provide contemporaneous feedback on the communication available.

Orthopaedic Surgery

Evaluation and monitoring of the selection process

The process is detailed in the selection documents on the AOA website. The AOA Director of Training reviews the selection process each year and a formal review is carried out every five years. The AOA Federal Training Committee amends the selection process in response to feedback received from the Regions and the JRs. It should be noted that the JRs have, universally, been favourably impressed with the AOA selection process and have taken aspects of the process away to use in other medical areas. We have been extremely fortunate in having Dr Helen Beh as CEO of the AOA. Dr Beh has a deep understanding of selection processes and statistics.

All statistical methods employed in the selection process have been validated.

Evaluation and monitoring of modules and courses

Each Regional Committee has developed its own 'Bone School' program based on the core curriculum set down by the AOA Training Committee and the web-based modules that are being developed presently. Trainees are actively involved in providing feedback on the training program. Each Region convenes a feedback session at the end of the academic year where the content of the training program is reviewed and suggestions from the trainees are taken on board.

The OPBS module has been well received by the trainees. Although the study required for this module is quite extensive, and required early on in the training program, all trainees who complete it agree that the content is extremely useful at this early stage of the training process. It is very unusual for a Trainee not to have passed OPBS by the end of first year.

The AOA's Modularisation and Curriculum Review Project is reviewed at each AOA Federal Training Committee Meeting.

Evaluation and monitoring of the assessment processes

The content of the *Quarterly Assessment Report* has been refined in order that it refers specifically to the RACS/CanMEDS competencies. The QAR form is reviewed annually by the AOA Training Committee. For example, the QAR has been amended to include assessment of the Trainee's performance by the nursing supervisors in theatre and on the orthopaedic ward. This has proved useful in identifying trainees with communication and behavioural difficulties.

The *Orthopaedic Procedure Assessment Report* is also reviewed regularly by the AOA Training Committee.

Evaluation and monitoring accredited training environments

At the end of each attachment, the Trainee completes an evaluation of the Unit in which s/he has worked. The difficulty in keeping this material de-identified, and so confidential, has been largely overcome by (i) forwarding the forms to the AOA Head Office; and (ii) not acting on a sole assessment.

The AOA conducts quinquennial inspections of all SST posts in Orthopaedics. Should a Regional Training Committee become aware of any alteration to the structure or staffing levels of an SST position between inspections, it is brought to the attention of the Federal Training Committee.

Processes to communicate with Trainees, Supervisors, Mentors

The chain of command and communication within the SST program in Orthopaedics is as follows:

There is no doubt that, as in any major organisation, communication difficulties can arise. Effective communication strategies are particularly important as the majority of specialist surgical training is conducted by VMOs on a voluntary basis. The *AOA Bulletin* publishes information related to the SST program and is distributed to the entire AOA membership. The Trainee's newsletter, *Bare Bones*, conveys important information to all trainees, both in hard copy format and on the AOA website. The registrars' association, AORA, is very active. It holds an Annual General Meeting and facilitates interaction between all AOA Trainees. All AOA supervisors and trainees can be contacted via email. In addition, a comprehensive database of contact details is maintained at the AOA Head Office in Sydney.

Otherwise, there has been no substantive analysis of the communication strategies employed by the AOA in relation to supervision and training.

Documentation:
AOA Trainee Report on Hospital Post (available for reference at the College)
AOA Hospital Inspection Policy (available for reference at the College)
AOA SST Accreditation Criteria (available for reference at the College)

Proposed changes to evaluation and monitoring for SET

As for current SST Trainees, it will be essential to have accurate email addresses and phone contacts for all SET1 Trainees. Contact information for all supervisors involved with SET1 Trainees will need to be gathered and managed appropriately.

Otolaryngology Head and Neck Surgery

Evaluation and monitoring selection processes

The Board conducts an annual review of the selection tools and processes.

As a result of feedback from previous selection the processes have be gradually refined to make them more evidence based and more aligned with the nine RACS competencies.

Documentation:
Relevant minutes from meeting February 2006 (available for reference at the College)

Evaluation and monitoring modules and courses

The content of the modules is reviewed and revised on an annual basis by the Board of Otolaryngology Head and Neck Surgery

The content of the courses is reviewed by the Regional subcommittees on an annual basis to ensure that they are in line with the content of the modules.

The Board has recently started to use a Trainee Feedback Form for evaluation of training positions and educational content of same.

Evaluation and monitoring of assessment processes

The formative assessment processes are reviewed and revised on an annual basis by the Board of Otolaryngology Head and Neck Surgery.

Evaluation and monitoring accredited training environments

State training subcommittees continually monitor training positions. Trainees are interviewed at the end of each six month rotation by the State subcommittee and Trainees are asked for feedback on the immediate past rotation. Trainees are usually forthright about bringing deficiencies to the attention of the Subcommittee. Trainee feedback forms are useful here also.

The State chairmen are required to report to the Board any deficient training positions.

Processes to communicate with Trainees, Supervisors, Mentors

Trainee feedback form. Filled out and de-identified at central collection.

Board Chair meets with supervisors of training at the National conference.

Regular state meetings of subcommittees and Trainee interviews by state subcommittees twice per year.

Issues discussed at National Board meetings of which there are three per year.

Paediatric Surgery

Evaluation and monitoring selection process

The Board conducts an annual review of the selection tools and processes. As a result of feedback from previous selection the processes have be gradually refined to make them more evidence based and more aligned with the nine RACS competencies. The College also receives feedback and assistance from the College EDRD to improve selection processes in line with policy.

Documentation:
SET - Selection into Surgical Training

Evaluation and monitoring modules and courses

The content of the modules is reviewed and revised on a biennial basis by the Board of Paediatric Surgery with input from the trainees via the Trainee Representative on the Board and the Manager, EDRD for educational principles and alignment to the RACS competencies.

Evaluation and monitoring assessment processes

The formative assessment processes are reviewed and revised on an annual basis by the Board of Paediatric Surgery with input from surgical supervisors and trainees.

Evaluation and monitoring training environments

Accredited training hospitals are reviewed on a quinquennial basis or on a shorter time frame if issues are identified in the scheduled accreditation visits. The hospitals must prepare a submission using the College-developed proforma and processes.

Review of communication strategies to and from Trainees, Supervisors, Mentors

Trainees are represented on the Board of Paediatric Surgery by a Trainee Representative, who although not present or privy to information for discussions regarding individual trainees, actively participates in discussions regarding all training issues. The Trainee Representative then reports back to trainees via e-mail following Board meetings.

The Board also meets as a group with the trainees and in individual interviews to discuss current training and future training plans at the Registrar Annual Training Seminar.

Any changes or initiatives associated with the training program are communicated to trainees and surgical supervisors via mail following the applicable Board meeting.

Surgical Supervisors meet with the Board twice per year to discuss training program issues and this group also has their own e-group on the College website for training documentation accessible by user name and password. This forum has already resulted in some positive changes to communication with surgical supervisors and trainees.

The Chair also presents a Board of Paediatric Surgery report at the Annual General Meeting of the Australasian Association of Paediatric Surgeons and provides the opportunity for consultants to ask questions and discuss elements of the training program in this forum. Training program information is also included in the Australasian Association of Paediatric Surgeons newsletter produced three times annually.

Analysis of the content of communication strategies

Verbal, qualitative feedback has suggested that the Board communicates adequately with trainees and surgical supervisors.

Analysis of the efficiency of communication strategies

Verbal, qualitative feedback has suggested that the Board communicates adequately with trainees and surgical supervisors. It is anticipated that e-mail and website communication will increase in the future. For example, trainees would be able to submit training documentation online rather than submitting paper copies.

Plastic and Reconstructive Surgery

Evaluation and monitoring Selection Process

The selection process is reviewed annually by the Board of Plastic and Reconstructive Surgery, selection documents, and changes in College policy are incorporated in to the selection process, documents and practices.

The Board of Plastic and Reconstructive Surgery monitors the selection process, and assesses the selection tools and outcomes at the conclusion of the selection process. The results of this program evaluation are incorporated in to the selection tools and process the following year.

Evaluation and monitoring modules and courses

The Board of Plastic and Reconstructive Surgery curriculum is currently being reviewed by a Curriculum Review Committee chaired by the Senior Examiner as part of a regular curriculum review timeframe.

Evaluation and monitoring assessment processes

The Board of Plastic and Reconstructive Surgery monitors the assessment tools and processes as part of continual program evaluation.

Evaluation and monitoring accredited training environments

Each accredited training post is inspected by the Board of Plastic and Reconstructive Surgery at least every five years. These formal hospital inspections are undertaken using the College Criteria for Hospital Accreditation and evaluate the learning environment for trainees. If any issues are identified, either in these formal accreditation visits, or through the regional training committees; a more regular reviews are undertaken.

Review of communication strategies to and from Trainees, Supervisors, Mentors, Trainers

Since 2006, communication to trainees and supervisors has been centralised through the Executive Officer to the Board at the Australian Society of Plastic Surgeons. Information is provided consistently to trainees and supervisors of training, and this position allows a single point of contact.

Plastic and Reconstructive Surgery Trainee handbook is available on the College website, information in this handbook is updated regularly. A Supervisors Handbook is currently in the process of being finalised to ensure consistent and accurate communication to all supervisors and trainees.

In 2006 the Plastic and Reconstructive Surgery Trainees Association was formed. The executive of this Association meets twice a year. A face to face meeting with the members of the trainee association, the Chairman of the Board of Plastic and Reconstructive Surgery and the Executive Officer – Education – Australian Society of Plastic Surgeons to allow Trainee feedback to the Board was undertaken in October 2006. The trainee representative on the Board of Plastic and Reconstructive Surgery is also the RACSTAR representative on the College trainees committee, this allows trainee feedback from both the specialities and the College.

Analysis on the content of communication strategies

Strategies for communication are regularly being reviewed by the Board of Plastic and Reconstructive Surgery, and the Executive Officer – Education Australian Society of Plastic Surgeons.

Urology

Evaluation and monitoring selection process

The Board of Urology conducts an annual review of the selection process and makes changes to existing processes in response to feedback received and observations made during the process.

Correlation between selection tools and success at selection has been undertaken, but no analysis has been undertaken comparing selection tools to later Trainee or consultant performance.

Evaluation and monitoring modules and courses

Trainee satisfaction feedback is obtained at all Trainee Week sessions, the Introductory Urology Skills Workshop, and Anatomy of Surgical Complications Workshop. This information is used to constantly improve these.

Evaluation and monitoring accredited training environments

Trainees must submit a logbook summary every 6 months. The results of these, particularly first surgeon status, is used to monitor this aspect of a post's performance.

Trainees and Supervisors are encouraged to report to the Board of Urology any deficiency, issue, or change that is felt to be impacting on the quality of training delivered, or the ability to deliver adequate training.

Supervisor reports provide the opportunity to monitor not only the progress of trainees, but can also provide insight into the training environment they are experiencing.

The Board of Urology has a consistent process of confidential Trainee feedback, where every post is assessed by trainees every year, and a report is provided for the Society office.

All posts undergo a consistent and transparent accreditation inspection on a quinquennial basis.

Results at the Fellowship Examination are monitored, and any patterns of poor results are explored to determine whether this reflects any defect in training of any region or institution

Review of communication strategies to and from Trainees, Supervisors, Mentors, Trainers

Reliance is placed on reporting of any issues.

Vascular Surgery

Evaluation and monitoring selection processes

The Board conducts an annual review of the selection tools and processes.

As a result of feedback from previous selection the processes have been gradually refined to make them more evidence based and more aligned with the nine RACS competencies.

Documentation:
Relevant minutes from Vascular Board meeting February 2006 (available for reference at the College)

Evaluation and monitoring modules and courses

The content of the modules is reviewed and revised on an annual basis by the Board of Vascular Surgery.

The Vascular Board regularly considers trainees' attempts at the modules and their percentage scores and trainees are required to complete all modules prior to being approved to sit the Fellowship Examination.

The Vascular Board considers that mid SET-2 is an appropriate time to assess trainees' completion of modules. Completion of Level one Module is required prior to a Trainee progressing into SET4.

Evaluation and monitoring assessment processes

The formative assessment processes are reviewed and revised on an annual basis by the Board of Vascular Surgery.

Evaluation and monitoring accredited training environments

Vascular Trainees are required to complete a mandatory reporting system to comment on their experience in the various vascular units at the completion of each annual rotation.

Trainees are encouraged to report any incidents or problems in their unit to the Chairman of the Board in order to ensure a rapid resolution.

Review of communication strategies to and from Trainees, Supervisors, Mentors, Trainers

Communication to Vascular Trainees is via the Trainee representative to the Vascular Board and the quarterly Trainee newsletter. Members of the Board in Vascular Surgery are involved in teaching during the annual Trainee skills acquisition course and the Vascular Board Chairman will meet with trainees in each state during the year to discuss any training concerns.

A mentor program facilitated by the Board Chair is offered to Vascular Trainees who wish to have a mentor during their training.

In addition to the College surgical supervisor meetings, regular meetings for Vascular surgical supervisors are held during the College ASC and Vascular conferences, together with teleconferences during the year.

5. DELIVERY

External stakeholders and interaction

Fellows and staff of the College maintain formal and informal relationships with government, and external medical, educational organisations and individuals. Interaction with external stakeholders occurs both through external representation in College activities and College collaboration as well as participation in the activities of other organisations' activities.

Formal recognition of external stakeholders includes representation on College boards, committees and panels, invitation to the ASC and other medical conferences, named lectures and awards and sponsorship of training activities.

The College maintains communication links with many local and international colleges, societies and associations, government health departments, and national and regional health organisations.

International

Representatives of the College maintain strong links with international colleges, societies and associations. The Dean of Education, President, CEO other College staff attend international conferences and receive invitations to speak at international events. Similarly, representatives of institutions such as Royal College of Physicians and Surgeons of Canada, The American College of Surgeons, and the Royal College of Surgeons of Edinburgh, have recently spoken at the ASC and other College activities. In 2004 the College initiated The American College of Surgeons Travelling Fellow Lecture. The College also invites representatives of other Colleges and international surgical organisations to attend as observers at the Fellowship Examination.

Australia and New Zealand

Key stakeholders in specialist surgical training are the hospitals/jurisdictions who employ surgical trainees. Specific external stakeholders recognised by the College include the National Health Workforce Secretariat, the Australian Health Ministers' Advisory Council (AHMAC) health workforce advisory committees, and the AMC and ACCC.

The College invites jurisdictional representation to ensure effective inclusion of government appointed Jurisdictional Representatives on all College educational matters including boards of governance, assessment and selection panels. As members of the Specialist Training Boards, jurisdictional representatives have full voting rights and are therefore collectively responsible for the decisions of the Board. A key activity of the Boards is the regulation of the trainee selection process. Some boards also invite the participation of jurisdictions in the interviewing of applicants for training.

The College, with the cooperation of its boards, the various specialty associations/societies and the jurisdictions, has developed a hospital accreditation process and set of accreditation criteria.

The College seeks feedback on its communication strategies from all involved stakeholders through meetings, discussion forums and encourages feedback from all parties.

Documentation:
List of links to other organisations (Weblink)

Governance, relationships and related policies

The relationship between the College and the Specialty Societies and Associations is defined in Memoranda of Association and Agreements with the Specialty Societies and Associations.

Delivery of the surgical training programs is undertaken through a contractual relationship between the College and 12 specialty groups who represent the nine surgical disciplines in Australia and New Zealand. General Surgeons Australia is not a party to the Service Agreement.

Surgical training is delivered in accordance with a "user pays" and cost neutral philosophy. The income derived from Trainee fees is pooled and shared between the College and the Societies/Association in accordance with the agreed funding formula. The Service Agreements have three core funding components:

College Component – for College expenses associated with the provision of the training program. These include the educational administrative infrastructure of the College, the appeals process and services provided directly to trainees (website, online library, etc).

Base Services Component - Expenses that fall into this category are:

- representation by the specialist group at the BSST meetings
- meetings of the Specialty Board
- general office expenses related to administration of the training program, and
- Board Chair allowance.

Service Activity Component - Expenses that fall into this category have been broken down into six core activities:

- Course Development
- Trainee Selection
- Hospital Post Accreditation
- Course Delivery
- Records Management
- Program Management

The core activities are performed by either the College or the Society/Association and the performing body is funded accordingly.

Governance

Education Board

The efficient and effective leadership and management of any Board require that it have clear and comprehensive terms of reference. The Education Board (EB) is the peak Board responsible for the management and administration of the Educational activities of the College. The authority for the EB to regulate educational activities is delegated by Council of the Royal Australasian College of Surgeons. EB is accountable directly to Council for fulfilment of the duties and responsibilities outlined in its terms of reference. All other Boards and Committees within the Education Portfolio are accountable to the Education Board.

Board of Specialist Surgical Training (BSST)

The BSST is responsible for the regulation and administration of the College's Specialist Surgical Training Programs in Australia and New Zealand and in some regions of Asia.

Specialty Boards report directly to the BSST on their delegated responsibilities as specified in the Terms of Reference for Specialty Boards and their Regional Subcommittees. The BSST also advises the Education Board on policy matters relating to Specialist Surgical Training.

Specialty Boards

The Specialty Boards of the College are responsible for the delivery of the Specialist Surgical Training Programs, accreditation of hospital posts, and assessment and supervision of specialist surgical trainees. Specialty Boards are appointed for each of the nine surgical specialties and are responsible for advising Council on training and accreditation via the Board of Specialist Surgical Training and the Education Board.

For some specialties, the administration of the surgical education and training program is delegated to the corresponding external Society or Association in accordance with the Service Agreements. The administration of surgical education and training for all other training programs is undertaken by the College. The process of implementation undertaken by the Specialist Society or Association in line with the Service Agreements may vary between the Specialties.

Specialty Boards are governed by the Articles of Association and the Policies of the College. Where Specialty Boards have Regional Subcommittees, the Specialty Board is responsible for the activities of those Subcommittees.

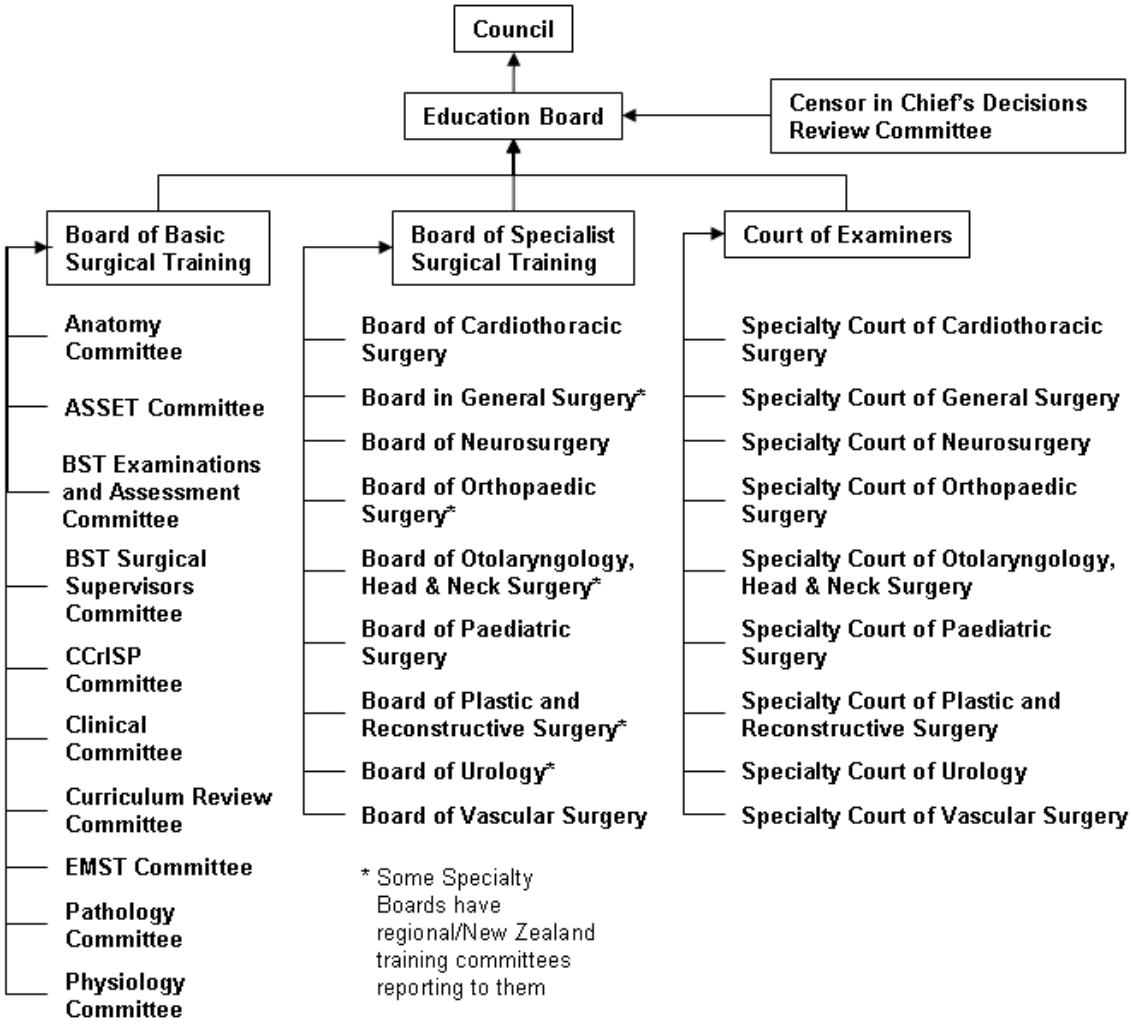
Board of Basic Surgical Training (BBST)

The Board of Basic Surgical Training oversees BST and will continue to support some elements of SET (see Attachment 7). The Board is responsible to Council via the Education Policy Board

All educational boards include in their membership jurisdictional and Trainee representatives with full voting rights and responsibilities. For detailed information on the role and composition of the College's educational boards, refer to the following links:

Documentation:
SST Education Board Terms of Reference
SST Board Terms of Reference
SST Specialty Boards and Regional Subcommittees Terms of Reference
SST Censor In Chief's Review Committee Terms of Reference
BST Board Terms of Reference

The College Education – Committee Structure and Reporting Pathway



Boards regulate training in accordance with the approved policies of the College. To date, the following policies apply:

Training

SST Council's Guidelines for Requirements of Fellowships in New Specialties
SST Court of Examiners Terms of Reference
SST Deferral of Surgical Training
SST Dismissal from Surgical Training
SST Endorsement of Occupational Training Visas in Australia
SST Former Trainees Seeking to Re-Apply to Surgical Training
SST Full-Time Training
SST Appointments to the Court of Examiners Policy
SST Conduct of Fellowship Examinations Policy
SST Authority to Approve Admission to Fellowship Pursuant to Article 19 Policy
SST Authority to Approve Admission to Fellowship Pursuant to Article 21 Policy
SST Identification and Management of Academic Misconduct Policy
SST Interruption of Training
SST Observers of Fellowship Examinations Policy
SST Part-Time Training
SST Specialist Assessment of International Medical Graduates in Australia
SST Surgical Education and Training (SET) Working Party
SST Surgical Training Fees
SST Trainee Registration Status of Surgical Trainees

The College's policies are written to provide a generic framework for training, and are developed in consultation with specialty societies and associations. Individual boards apply the framework when determining the training regulations for their specialty.

Documentation:
Policies (Weblink)

Jurisdictional Representation

The College has Jurisdictional Representation on a number of its Boards, Committees and Working Parties including the Board of Basic Surgical Training, the Board of Specialist Surgical Training, Education Board and Specialty Boards. In addition, Jurisdictional Representatives participate in selection panels for Surgical Trainees, assessment interview panels for International Medical Graduates and accreditation inspections for Hospital and Post Accreditation.

The College invites jurisdictional representation on educational matters, however the extent of participation it at the discretion of the jurisdictions.

Australian jurisdictional representatives for College Boards are nominated by the Health Workforce Principal Committee (HWPC). In 2006 New Zealand also nominated jurisdictional representatives for the Education Board, Board of Basic Surgical Training and Board of Specialist Surgical Training. The right of nomination is shared by the New Zealand Ministry of Health (for the Education Board) and District Health Boards New Zealand (all other boards).

As members of the Specialist Training Boards, jurisdictional representatives have full voting rights and are therefore collectively responsible for the decisions of the Board. A key activity of the Boards is the regulation of the Trainee selection process. Some boards also invite the participation of jurisdictions in the interviewing of applicants for training.

Trainee Representation

In 2005 an interim committee was established to set up the College Trainees' Association. It was established to better represent trainees' interests within the institution and to fully understand Trainee's perspectives on the surgical profession.

The structure of the Trainee Association includes a bi-national committee and regional groups.

Representation on Council boards at all levels has been achieved.

Documentation:
Trainees' Association (Weblink)
Committee Contacts

Trainee Feedback

Feedback from trainees is received through a number of avenues. The Board of Specialist Surgical Training includes two Trainee representatives who are able to raise and discuss issues of concern to trainees. The Australian Orthopaedic Registrars Association is an avenue for Orthopaedic Trainees to raise issues related to training in general or specific to the Orthopaedic Surgery training program.

Each Specialty website contains an area for trainees to participate in a discussion forum related to common training issues *(Trainee access only).*

Support for the On-Going Development of Training

The College has an education and training structure which incorporates the best of the traditional apprenticeship model of training with high levels of professional and academic rigour and educational expertise.

- The day to day training of surgical trainees is under the direct guidance of surgical supervisors in BST and within each of the nine specialties.
- To ensure that trainees, regardless of geographical location, are meeting the same standards of competence the boards monitor the progress of trainees in each rotation.
- The examinations in BST are under the stewardship of the discipline sub-committees of the Board of Basic Surgical Training whilst the Court of Examiners has the responsibility to oversee the Fellowship Examination.
- Several of the courses, such as EMST and CCrISP provide training for their Faculty members.
- There is a Board of Surgical Research and a section of Academic Surgery
- The Surgeons as Educators committee implement the Surgical Teachers Course and the Surgeons as Educators Workshop and oversee the Surgical Education section of the Annual Scientific Congress.

Documentation:
Surgeons as Educators Committee
Section of Academic Surgery
Board of Surgical Research
BST Supervisors
EMST Faculty
CCrISP Faculty

The Board Structure of the College provides another layer of educational insight and guidance.

Education Board

Professor Ian Gough	Censor-in-Chief
Dr Rob Black	Chair, Court of Examiners
Associate Professor Bruce Waxman	Chair, Board of Specialist Surgical Training
Professor Spencer Beasley	New Zealand Censor
Mr Ian Civil	Chair, Board of Basic Surgical Training
Mr Ian Dickinson	Chair, Professional Development and Standards Board
Ms Deborah Hyland	HWPC representative (NSW)
Mr Peter Carver	HWPC representative (Victoria)

Board of Specialist Surgical Training

Associate Professor Bruce Waxman	Chair, Board of Specialist Surgical Training

Mr Ivan Thomson	Deputy Chair
Professor Spencer Beasley	New Zealand Censor
Professor Ian Gough	Censor-in-Chief
Dr Michael Cox	Specialty Board Chair General Surgery
Mr Alan Scott	Specialty Board Chair Vascular Surgery
Dr Robert Black	Chair, Court of Examiners
Mr Allan Panting	Deputy Chair, Court of Examiners
Mr Philip Sprott	Specialty Board Chair Orthopaedic Surgery
Mr Peter Skillington	Specialty Board Chair Cardiothoracic Surgery
Mr Anthony Sparnon	Specialty Board Chair Paediatric Surgery
Mr David Robert Theile	Specialty Board Chair Plastic and Reconstructive Surgery
Mr Neil Vallance	Specialty Board Chair Otolaryngology Head and Neck Surgery
Associate Professor Michael Weidmann	Specialty Board Chair Neurosurgery
Ms Susanne le Boutillier	Jurisdictional Representative
Professor Mark Bassett	Jurisdictional Representative
Mr Ian Civil	Chair, Board of Basic Surgical Training
Mr Ian Brown	New Zealand Jurisdictional Representative

Board of Basic Surgical Training

Mr Ian Civil	Chairman, Board of Basic Surgical Training
Dr Julie Mundy	Deputy Chair, Board of Basic Surgical Training
Professor John Blennerhassett	Chair, Pathology Committee
Associate Professor David Hardman	Chair, Anatomy Committee
Mr Michael Hollands	Chair, EMST Committee
Associate Professor Jenepher Martin	Chair, Curriculum Review Committee
Mr Garth Poole	Deputy Chair Supervisors Committee
Mr Bruce French	Chair, Clinical Committee
Mr Iain Skinner	Chair, ASSET Committee
Professor Michael Stacey	Chair, Examinations and Physiology Committees
Mr Adrian Anthony	Chair, CCrISP Committee
Dr Patrick Bolton	Jurisdictional Representative
Professor Richard Vaughan	Jurisdictional Representative
Ms Natasha Cole	Jurisdictional Representative
Dr Paul Bumbak	Trainee Representative
Dr Maree Weston	Trainee Representative
Mr John Crozier	Australian Defence Force Representative

Court of Examiners

The Court is appointed by the Council of the College. Its purpose is to conduct the Fellowship Examination and to assess the knowledge, clinical skills, judgement and decision making, and professional competencies of candidates, in order to ensure that they are safe and competent to practice as surgeons.

The Court is comprised of surgeons representing the nine different specialties in which the College conducts the Examination. The Number of Examiners varies in each specialty in line with the number of trainees and Examination Candidates.

Documentation:
Education Board (Weblink)
BSST (Weblink)
BBST (Weblink)
Court of Examiners (Weblink)

Court of Examiners

Dr Robert Black	Chair, Court of Examiners
Mr Allan Panting	Deputy Chair, Court of Examiners

Cardiothoracic Surgery
Mr Peter W Brady

General Surgery
Mr James L Sweeney

Neurosurgery
Associate Professor Gavin C Fabinyi

Orthopaedic Surgery
Associate Professor Elton R Edwards

Otolaryngology Head and Neck Surgery
Mr Neil A Vallance

Paediatric Surgery
Professor Spencer W Beasley

Plastic and Reconstructive Surgery
Mr Sean G Hamilton

Urology
Mr Peter S Heathcote

Vascular Surgery
Dr Russell G Bourchier

Within the College
Dean of Education, Professor John Collins MD MCH FRCS FRACS FRCSED

The Educational Development and Research Department (EDRD) provides curriculum advice for BST; SST, Fellowship, and in the development of SET.

It has a staff of five, all of whom are very well qualified.

Manager, EDRD	Dr Wendy Crebbin, PhD, M Ed.Ad GDEA BA TSTC MACE
Curriculum Developer	Zaita Oldfield, Med, Ad.Dip.Management Dip.Art & Design, Cert. IV Assessment and Workplace Training
Website Content Coordinator	Bill Mezzetti, BFA, Boston (USA) Grad Dip ED
Evaluation Coordinator	Joanna Creswell, BA
Research/Admin Assistant	Anita Siggins, BEd

Documentation:
EDRD (Weblink)

Management of SET and the Consultative Processes

Under the direction of the College Council the Education Board established the Surgical Education and Training Working Party (SET – WP) to explore issues related to such a program and to develop a workable integrated surgical training program.

SET – WP is chaired by the CiC and supported by a Secretariat based in the College EDRD.

The Working Party has discussed the Governance of SET and has agreed to the model presented in the attached discussion document.

Documentation:

Surgical Education and Training Working Party – Terms of Reference

Selection to Surgical Education and Training

Governance of SET (see Attachment 7 in this document)

SET Development Time-line (see Attachment 8 in this document)

Consulting with key stakeholders

The College is very cognisant of the need to communicate with and consult all of the key stakeholders to ensure the smooth implementation of SET. Because of this there has been a several meetings at the College and in the regions. There have been two levels of briefing:

- Meetings (September 2006) at the College with all the senior jurisdictional people (AHWOC and others) to discuss the program and its key implementation steps. This was followed by a meeting with Directors of Medical Services and Health Administrators from each state and territory in Australia (October 2006).
- A series of Regional meetings co-ordinated through College Regional Offices were organised to enable local hospital representatives / local training groups to attend and ask the more detailed questions that need to be answered for successful implementation.
    - The first round of regional meetings were held October and November 2006 and were publicised from the College Regional Offices and on the College website
    - The second round of regional meetings will be held in February and March 2007 publicised from the College Regional Offices and on the College website

Communicating about SET

Beside the College website which is constantly being up-dated, information about SET has been published in:

- the Surgical News
- PowerPoint presentations, and
- a discussion document on the college website

Documentation:

Surgical News, March 2006, p8

Surgical News, July 2006 p.9

Powerpoint presentation – SET (August 2006)

Powerpoint presentation – SET (October 2006)

PowerPoint presentation – SET (March 2007)

SET Discussion document (the version which was current in October)

Powerpoint presentation – SET (March 2007)

SET Discussion document (the version which was current in October) (available for reference at the College)

SET Discussion document (current on December 1)

SET Information booklet (March 2007)

Cardiothoracic Surgery

The Board of Cardiothoracic Surgery has developed regulations governing specialty specific training requirements and the assessment and progression of trainees through out the program.

The Cardiothoracic Surgery Board and trainees are also governed by the policies of the College.

Documentation:
Board of Cardiothoracic Surgery (available for reference at the College)
College Policies (Weblink)

Selection and training of Supervisors and Examiners

Supervisors must be a member of the clinical unit and a Fellow of the College, excluding the Director (excepting in small two person units).

The Board of Cardiothoracic Surgery will encourage all of its supervisors to participate in the College Supervisor training program.

Examiners are selected by a voting process after calls for inclusion from the Fellowship.

Training materials available to Supervisors and/or Examiners

The College handbook and Information pack for Supervisors of Training.

Education programs provided by the College on educational provision.

When it is available, the Board of Cardiothoracic Surgery will encourage all of its supervisors to access the material relating to the College Supervisor training program.

Documentation:
Supervision (Weblink)

Overview of Trainee involvement in the governance structure

Trainee representative at general College level

Jurisdictional Representative involvement in the governance structure and in selection

JR present at all Board meetings and also at Audit reviews of accredited units.

Feedback mechanisms in place for key stakeholders

Through the College structure

Documentation:
Expert Community Advisors policy

Support for the on-going development of training

Staffing structure, and the expertise of the staff, involved in the Training Program

The Board of Cardiothoracic Surgery is wholly administered within the College. Therefore all aspects of curriculum development are supported by the College EDRD, and policy development is supported by the SSTA.

The administration for the Board and the bi-National program is carried out by one Executive Officer who is based in Melbourne.

General Surgery

Evaluation and monitoring of selection processes

The Board of General Surgery has developed regulations governing specialty specific training requirements and the assessment and progression of trainees through out the program.

The Board of General Surgery has developed terms of reference for the Board and the Regional board. The regional boards look after all issues, makes recommendations and then brings these to the federal board for discussion and implementation.

The General Surgery Board and Trainees are also governed by the policies of the College.

Documentation:
Board of General Surgery (available for reference at the College)
General Surgery Training RegulationsCollege Policies (Weblink)

Selection and training of Supervisors and Examiners

Supervisors are elected / appointed by the department of surgery in the training hospitals. All hospitals with one or more trainees has a supervisor of surgical training.

The Board of General Surgery will encourage all of its supervisors to participate in the College Supervisor training program.

Examiners are nominated by their peers and then elected by the Court of Examiners.

Training materials available to Supervisors and/or Examiners

Each supervisor is sent an information pack and descriptions of duties, roles and responsibilities.
In addition to written information one of the roles of the regional board is to provide mentorship, advice and help to new supervisors.

When it is available, the Board of General Surgery will encourage all of its supervisors to access the material relating to the College Supervisor training program.

Identifying a suitable mentor and arrangements for Trainees to access support, counselling and/or mentoring

The supervisors act as one of the mentors.
Trainees are encouraged to foster relationships with the surgeons they train with.
There is no formalised mentoring system.

Trainee involvement in the governance structure

The trainee is responsible for the provision of their own mentor reports and log books.
There is a Trainee representative on the regional boards and a separate representative on the federal board.

Supervisor involvement in the governance structure

The supervisor reviews the log book numbers and mentor reports.
The supervisor attends the regional board meetings.
They are involved in any counselling sessions related to poor performance and advise the Trainee about their responsibilities for poor performance.

Jurisdictional Representative involvement in the governance structure and in selection

There are JRs invited and attending for each of the regional board meetings. There is a JR at the federal board meetings.

All quinquennial inspections have a JR as part of the inspection team with the exception of Hong Kong, where each institution provided a JR from within their structure. This reflects the different organisational structure within Hong Kong. See the inspection reports for evidence of their involvement.

Feedback mechanisms in place for key stakeholders

TRAINEES: Trainees feed back is direct as they are involved in the mentoring. The mid term and of term assessments involve direct, personal feedback to the Trainee.

HOSPITALS: There is feed back with the quinquennial inspections and any additional accreditation procedures.

Support for the on-going development of training

Staffing structure, and the expertise of the staff, involved in the training program

The Board of General Surgery is wholly administered within the College. Therefore all aspects of curriculum development are supported by the College EDRD, and policy development is supported by the SSTA.

The administration for the Board and the bi-National program is carried out by two Executive Officers.

The Regional board are supported by staff in the College Regional offices.

Neurosurgery

Overview of training program regulations and related policies

The Board of Neurosurgery has detailed SET Program Regulations which provide a comprehensive reference from trainees and supervisors. The SET Program Regulations incorporate all policies relating to training and are compliant with generic College policies or make reference where appropriate. The SET Program Regulations are reviewed and modified at least twice yearly to ensure they remain compliant and consistent with generic College policies and terminology.

The Board of Neurosurgery recently approved revised SET Program Regulations which now include SET1. The Board of Neurosurgery has separate comprehensive Training Position Accreditation Regulations and Selection Process Regulations.

Documentation:

Board of Neurosurgery (web link and attached)
Trainee Representative on the Board)

Neurosurgery SET Program Regulations

SET Program Regulations
Selection Process Regulations

Selection and training of supervisors and examiners

Supervisors are selected by the hospitals in accordance with criteria set forth by the Board and then approved by the Board and College through the standard governance processes. The Board does not support a set tenure for supervisors but rather a focus on ensuring that the most committed and suitable person undertakes the role. Trainees will be providing confidential feedback on supervisors by way of the Rotation Evaluation Form. Supervisors participate in a workshop during the Neurosurgical Society of Australasia Annual Scientific Meeting each year to provide them with updates on the training program and to provide a forum for discussion. In addition, supervisors are provided with the regulations, assessments forms and other information relevant to their position on appointment including full access to the website.

In 2007 Supervisors will participate in a workshop during the Neurosurgical Society of Australasia Annual Scientific Meeting to prepare them for changes in the current processes with the introduction of SET. It has not yet been determined if the additional supervisors will be appointed specifically for SET1 positions.

Trainee involvement in the governance structure

Trainees have a trainee representative on the Board of Neurosurgery, elected by the trainees. In addition, trainees have been invited to put to the Board any issues they have relating to the SET program for discussion.

Supervisor involvement in the governance structure

Supervisors and all neurosurgeons in a particular region vote for their elected representative on the Board of Neurosurgery. In addition, supervisors have a meeting with the Chairman once a year to discuss issues relating to the SET program which are then discussed at a Board level.

Jurisdictional representative involvement in the governance structure and in selection

A jurisdictional representative is a full member of the Board of Neurosurgery and participates in all Board activities including the conduct of the selection interviews. Jurisdictional representatives are also invited to participate in all training position accreditation inspections.

Feedback mechanisms in place for key stakeholders

The Board of Neurosurgery Training Position Accreditation Regulations are provide to the jurisdictions for feedback on an annual basis. The Board of Neurosurgery has introduced mechanisms to obtain feedback on the Selection Process Regulations. Trainees are surveyed on an annual basis to provide feedback on the SET Program regulations and other issues relating to training.

The Board encourages feedback on all policies and procedures and is currently developing appropriate web based feedback forms in place accessible to all stakeholders and public individuals.

Support for the On-Going Development of Training

Staffing structure, and the expertise of the staff, involved in the training program

The Board of Neurosurgery and SET program has two support staff, the Executive Director, Stacie Gull (B.Bus, M.Bus, MBA) and the Executive Assistant, Louise Collins. Both are employed by the Neurosurgical Society of Australasia. The Executive Director has been working with the College in surgical education since 1999 and the directly with the Neurosurgical training program since 2001. The Executive Assistant commenced in 2006.

The Executive Director and Executive Assistant attend all Board of Neurosurgery meeting with full speaking rights and all associated activities and workshops. The Executive Director is responsible for the drafting of all policies relating to the ST program and ensuring consistency with the College policies.

Orthopaedic Surgery

Each Regional Training Committee operates within a Constitution and is further bound to act in accordance with those policies set down by AOA Federal Training Committee and the College in relation to surgical education and training.

Relationships with Supervisors, Assessors, Trainees and Others

Supervisors are selected from within an Orthopaedic Unit accredited to provide specialist surgical training in Orthopaedics. A supervisor is required to be a Fellow of the AOA. However, on occasion, and only with the permission of the AOA Director of Training, an Associate Member of the AOA (who must also be an FRACS) may be appointed as a supervisor.

At present there is no formal course for Supervisors available. The AOA would be very supportive of such a course being made available.

Examiners are selected from those orthopaedic surgeons who voluntarily apply for positions advertised as vacant on the Orthopaedic court of examiners. We have been extremely fortunate in having a large number of very high quality applicants put themselves forward as candidates. Successful applicants to the court of examiners are trained in examination techniques and begin by acting as observers to the Fellowship Examination. Examiners always examine in pairs, and independent observers monitor the examination process to ensure uniformity of both exam questions and the standard training material available to Supervisors and/or Examiners.

Training in specific operative techniques is widely available through the orthopaedic industry. However, because of commercial concerns, the AOA has been careful to avoid direct contact with industry and has developed guidelines as to how supervisors and trainees should interact with the trade. Some orthopaedic companies run Skills Labs, which include access to cadaver material.

Funds are made available to each Regional Training Committee from the AOA training budget to cover costs associated with materials required for 'Bone School'. This includes funding for video conferencing.

Trainees are encouraged to approach their current Supervisor as a first point of contact for advice, counselling and mentoring. If the Supervisor of Training is unable to help, or is not perceived as (i) supportive or (ii) neutral, the Trainee is advised to contact the Chairman of his/her Regional Training Committee. Trainees are also urged to take advantage of those HR and support services made available to them in the workplace.

Trainees play a very active role in the governance of the SST program. Trainees are entitled to representation on each of the five Regional Training Committees. Traditionally, the President of AORA has represented the interests of Orthopaedic Trainees on the AOA Federal Training Committee. The Registrar Representative on the Federal Training Committee is invited to submit and speak to a formal report. While s/he is invited to observe the majority of the Training Committee Meeting, those parts of the meeting that involve the discussion of other trainees are held *in camera*. The Federal Director of Training and the President of the AORA work closely together to facilitate events such as the AORA ASM.

Documentation:
Board of Orthopaedic Surgery (available for reference at the College)
AORA Contacts (Weblink)
Policy Relating to Administration of AOA Training Program (available for reference at the College)
AOA Guidelines re Industry
AOA Policy on Trainees, RTCs and Industry (available for reference at the College)

AOA Training Co-ordinators report to the appropriate Regional Training Committee, the Chair of which reports, in turn, to the AOA Federal Training Committee.

The Jurisdictions are now invited to send representatives to:

- all selection interviews;

- all hospital position inspections;
- the AOA Federal Training Committee;
- the AOA Selection Committee; and
- the Board of Specialist Surgical Training (Orthopaedics).

The AOA considers that Jurisdictional Representatives contribute extremely positively to all of these processes.

The key stakeholders in specialist surgical training in Orthopaedics are the hospitals/jurisdictions who employ SST Trainees. Therefore, many of the feedback mechanisms relevant to key stakeholders also relate to the status of the Trainee as a hospital employee. As an employer, the hospital can provide feedback directly to the AOA Training Co-ordinator, who has access to reporting mechanisms within the AOA Regional and Federal Training Committees.

Proposed changes to governance and relationship processes for SET

The AOA is in the process of revising the *Guide to Advanced Training in Orthopaedic Surgery* to incorporate those changes relating to the introduction of SET. It is proposed that a meeting of AOA Supervisors and Training Co-ordinators be held at the 2007 Annual Scientific Meeting of the AOA to discuss the changes that will be brought about by the inception of SET.

A mentoring scheme for SET1 Trainees is an item for discussion at a forthcoming AOA workshop on SET.

Support for the ongoing development of training

The current staffing includes:

1. Dr Helen Beh, AOA CEO
   BA (Hons) LLB (Hons) MSc PhD FASP FACSM
   Dr Beh has developed the current policies related to training and selection process. She was entirely responsible for the successful transition from a regional base selection to a national selection process in 2003.

2. Ms Robyn Westcott, AOA Education Officer
   BA (Hons 1)
   Ms Westcott is currently responsible for hospital inspection matters, educational policy matters and the management of the Training Committee boards and subcommittees.

3. Ms Kim Madison, AOA Training Officer
   BA Dip Ed
   Ms Madison is responsible for matters related to trainees, the SST program and the selection process.

Additionally, the Regional Training Committees are supported by staff in the state College offices. The educational staff of the College provide assistance with the development of generic processes and policies.

However, it is likely that the increasing demands placed on supervisors and other consultants involved in Orthopaedic teaching will result in further stress on the current pro-bono system. The ongoing trend is reducing surgeon contact with public hospitals such that the average number of sessions per week in the public sector is now only two, with many Orthopaedic surgeons employed for only one session per week or less. In these circumstances, the traditional role of the Supervisor will become more difficult to maintain.

Otolaryngology Head and Neck Surgery

The Board of Otolaryngology Head and Neck Surgery has developed regulations governing specialty specific training requirements and the assessment and progression of trainees throughout the program.

Documentation:
Board of Otolaryngology Head and Neck Surgery (available for reference at the College)
College Policies (Weblink)

The College collaborates with The Australian Society of Otolaryngology Head and Neck Surgery and the New Zealand Society of Otolaryngology Head and Neck Surgery, as agents of the College, to administer the training program.

The Specialist Surgical training program in Otolaryngology Head and Neck Surgery is designed to provide trainees with clinical and operative experience in order to learn special methods of investigation and become competent in techniques related to the discipline. At the conclusion of the training program it is expected that trainees will be able to perform as independent practitioners, meeting the requirements of all identified RACS competencies.

Documentation:
Contract between the College and the Australian Society of Otolaryngology
Memorandum of Understanding between the College and the Australian Society of Otolaryngology - Head and Neck Surgery
Contract between the College and The New Zealand Society of Otolaryngology - Head and Neck Surgery
Memorandum of Understanding between the College and The New Zealand Society of Otolaryngology - Head and Neck Surgery

Selection and training of Supervisors and Examiners

Supervisors: Selected at an institutional level The Board has little to do with this.

When it is available, the Board of Otolaryngology Head and Neck Surgery will encourage all of its supervisors to participate in, and access the material relating to the College Supervisor training program.

Examiners: selected by the current examiners in the specialty after consideration at an examiners meeting. Consideration is given to CV, personal references and discussion is often exhaustive before a decision is made. This decision then goes to the Society Council Executive for approval and finally the College Council.

New examiners are prepared for their role as examiners by observing at least one exam before actually examining. They arte paired with a more senior examiner.

Identifying a suitable mentor and arrangements for Trainees to access support counselling and/or mentoring

Each new Trainee is allocated a mentor at the beginning of the training program and keeps this mentor for the duration of training. There is an opportunity to change at the request of the Trainee or the mentor.

Trainee involvement in the governance structure

Trainees are represented on the National Board.

Supervisor involvement in the governance structure

Supervisors are represented by their state subcommittee chairman at the National Board.

Jurisdictional Representative involvement in the governance structure and in selection

'JRs' are invited to attend interviews and actively participate in Trainee selection interviews. A JR is invited to attend the Board meetings.

Paediatric Surgery

Overview of training program regulations and related policies

The Board of Paediatric Surgery has regulations for Specialist Surgical Training in Paediatric Surgery.
The Paediatric Surgery Board and Trainees are also governed by the policies of the College.
The regulations will be refined to reflect the requirements of SET1 and SET2^{+}. The Board will refer to any College SET policies governing training.

Documentation:
Board of Paediatric Surgery (available for reference at the College)
College Policies (Weblink)

Selection and training of Supervisors and Examiners

The Board of Paediatric Surgery follows the information contained in the College Surgical Supervisors Handbook and the College SST Appointment to the Court of Examiners Policy.

The Board of Paediatric Surgery will encourage all of its supervisors to participate in the College Supervisor training program.

Training materials available to Supervisors and/or Examiners

The Board provides surgical supervisors with the College Surgical Supervisors Handbook.

New appointments to the Court participate in their first examination as an observer only in order to provide practical training. Examiners are also provided with the relevant College policies which outline the conduct of the examination and the meetings and workshops held throughout the year for education and development.

When it is available, the Board of Paediatric Surgery will encourage all of its supervisors to access the material relating to the College Supervisor training program. The Board will also encourage supervisors who have not already done so to attend the College Surgeons as Educators Course.

Identifying a suitable mentor and arrangements for Trainees to access support counselling and/or mentoring

There are no formal processes at this stage however trainees also have access to mentoring programs through their workplace.

The Board will explore the possibility of absorbing the current Basic Surgical Training Mentor Program.

Documentation:
Appointment to the Court of ExaminersSurgical Supervisors' Handbook (Weblink)
Appointment to the Court of Examiners
Surgeons as Educators Course (Weblink)
Basic Surgical Training Mentor Program (Weblink)

Trainee involvement in the governance structure

The trainees elect a Trainee Representative for the Board of Paediatric Surgery at each Registrar Annual Training Seminar. The Trainee Representative is not present or privy to information for discussions regarding individual trainees but actively participates in discussions regarding all training issues. The Trainee Representative then reports back to trainees via e-mail following Board meetings.

Supervisor involvement in the governance structure

Surgical supervisors report to the Board via the Trainee Evaluation Form and Logbook but have no formal place on the Board. The Board meet with surgical supervisors twice per year.

Jurisdictional Representative involvement in the governance structure and in selection

A Jurisdictional Representative (JR) was appointed to the Board and is invited to attend all Board meetings, including selection meetings and observe the conduct of the presentations and semi-structured interviews, however the appointed has not attended a meeting since July 2005.

Support for the on-going development of training

Staffing structure, and the expertise of the staff, involved in the Training program

The Board of Paediatric Surgery is wholly administered within the College. Therefore all aspects of curriculum development are supported by the College EDRD, and policy development is supported by the Specialist Surgical Training and Assessment division.

The administration for the Board and the bi-National program is carried out by an Executive Officer who:

- Provides strategic advice and input to the development of materials, policies and procedures
- Manages all aspects of the application and selection process for the training program in accordance with College policies and procedures
- Monitors the progress of each Trainee in Paediatric Surgery and advises the Chair of any potential problems
- Coordinates and obtains assessment tasks from trainees and forwards onto relevant consultants for marking
- Manages accurate reporting of data and information relating to the training program requirements to a variety of internal and external bodies
- Organises the Registrar Annual Training Seminar
- Monitors International Medical Graduate activity
- Assists the College Hospital Coordinator to arrange hospital inspections to accredit training positions

Plastic and Reconstructive Surgery

The Training program is governed by the policies of the Board of Specialist Surgical Training at the Royal Australasian College of Surgeons. A Trainee Handbook outlines the requirements of the program.

Documentation:
Board of Plastic and Reconstructive Surgery (available for reference at the College)
Trainee handbook (available for reference at the College)
College Policies (Weblink)

Trainee involvement in the governance structure

There is a Trainee representative on the Board of Plastic and Reconstructive Surgery. In 2006, the Plastic and Reconstructive Surgery Trainees Association was formed, this body provides feedback to the Board via the Trainee representative.

Supervisor involvement in the governance structure

The Board has a regional subcommittee in each Australian region and in New Zealand, chaired by the representatives from each region who sit on the Board. Supervisors of training are members of the Regional Subcommittees of the Board and are expected to be an active member of the regional subcommittee.

The Board is responsible for the activities of the regional subcommittee, and the regional subcommittees are responsible for the activities delegated to it by the Board of Plastic and Reconstructive Surgery. Each Regional subcommittee should consist of the surgical supervisors of the accredited training posts in the region and a chair who should have experience in supervising surgical trainees, however does not have to be a current surgical supervisor.

Jurisdictional Representative involvement in the governance structure and in selection

A Jurisdictional Representative is a member of the Board of Plastic and Reconstructive Surgery and are invited to participate in all Board Meetings, training post accreditation and selection committee meetings.

Feedback mechanisms in place for key stakeholders

Trainee feedback is facilitated via the Trainee representative on the Board of Plastic and Reconstructive Surgery. Jurisdictional representation is facilitated via membership on the Board, as well an invitations from Jurisdictional Representatives to attend training post accreditation inspections undertaken by the Board. Surgical Supervisors have input into the Board via the regional Chair, who is also the regional representative on the Board of Plastic and Reconstructive Surgery.

Support for the on-going development of training

The Executive Officer – Education Rosemary Allsopp (M Ed. BA (Hons)) at the Australian Society of Plastic Surgeons supports the Board of Plastic and Reconstructive Surgery. The Executive Officer – Education has experience with educational administration in both the Vocational Education and Training (VET) sector and the University Sector. The Executive Officer – Education attends all meetings of the Board of Plastic and Reconstructive Surgery.

Urology

Overview of training program regulations and related policies

The requirements of trainees are outlined in the Urology brochure.

The year to year requirements of trainees are summarized in the Trainee log.

Training program regulations and related policies with the introduction of SET

There is optimism that in due course, the following will become mandated as components of the training program;

- The College web-based modules on the six non-technical competencies
- Completion of the Urology web-based learning modules
- Attendance at a regulated program of surgical skills workshops
- Completion of a stipulated number of in-training assessments, notably mini-CEX's
- Attendance at stipulated College workshops including but not limited to;
    - Communication,
    - Teamwork and leadership,
    - Risk management

Documentation:
Board of Urology (available for reference at the College)
Urology brochure (available for reference at the College)
Trainee log (available for reference at the College)

Selection and preparation of Supervisors and Examiners

Supervisors are elected by members of their Urology department. All accredited posts with one or more trainees has a supervisor of urological training.

It is expected that the new information and education packages being developed by the College for Supervisors will assist their preparation for this role. The Board of Urology will continue to encourage all of its supervisors to participate in the College Supervisor training program, and the Supervisor training sessions at the USANZ ASM.

Examiners self-nominate after invitation, and are selected on the basis of their CV, past performance, and CPD compliance. Each examiner must be acceptable to the Board of Urology, and the Executive of the USANZ.

Training materials available to Supervisors and/or Examiners

The Supervisor education session at the ASM is available to all Supervisors.

When it is available, the Board of Urology will encourage all of its supervisors to access the material relating to the College Supervisor training program.

The session at the annual Urology ASM is new material for Supervisors.

The Senior Examiner is responsible to ensure his/her own currency of knowledge, and mentors other examiners in urology.

For most other situations, individuals are referred to the considerable resources of the College.

Identifying a suitable mentor and Trainees access support counselling and/or mentoring

The Urological Society of Australia and New Zealand encourages all trainees to have a mentor throughout their training. Mentors are members of the Urological Society who are not expected to be involved with a Trainee's training or assessment. They are a potential confidante who may advise the Trainee professionally should they encounter a difficulty, or an issue of a delicate or personal nature. The majority of issues should be soluble with their Supervisor, or local Section TA and E Chair. A Mentor should be consistent throughout the training period. The Society Office assists in identifying a Mentor, often by giving Trainee's a short list of potential urologists.

The Board of Urology also supports trainees with personal or other behavioural issues which affects their training and will assist in organizing appropriate support such as counselling services.

Trainee involvement in the governance structure

2 Trainee elected Trainee representatives are full members of the Board of Urology.

All regional Boards and Committees are recommended to include a Trainee representative.

Regional committees are being encouraged to include Trainee representatives.

Supervisor involvement in the governance structure

Regional TA and E Committees are composed of all Trainee Supervisors, plus a Chair, Trainee representative, and jurisdictional representative as applicable.

The Board of Urology is composed of the Chairs of the respective Section TA and E Committees, and the members listed earlier in this document.

Throughout these committees, communication of issues, concerns, directives, and changes is expected to occur in both directions.

Jurisdictional Representative involvement in the governance structure and in selection

A jurisdictional representative is a full member of the Board of Urology and is expected to attend all Board Meetings.

Jurisdictional representatives are invited to all hospital training post inspections (where applicable) and to all selection interviews.

More widespread involvement of jurisdictional representatives, or community representatives, may be considered in the future.

Feedback mechanisms in place for key stakeholders

The Board of Urology reports to the Executive of the USANZ.

The Board of Urology reports to the BSST, and is accountable to the College.

The Urology Board Chair is a member of the Urology Education Policy Board, and must remain consistent with its directives.

All stakeholders influenced by decisions of the Board of Urology (trainees, hospital posts, the USANZ, the College) are invited to provide feedback on the processes and outcomes of all decisions of that board.

Support for the on-going development of training

Staffing structure, and the expertise of the staff, involved in the training program

Mr Alex Malley, Chief Executive Officer of the Urological Society of Australia and New Zealand is involved in the negotiation and management of the Memorandum of Understanding and Service Agreement between the Royal Australasian College of Surgeons and the Society in terms of the selection and training of urologists. He also provides input to a range of educational policies and procedures relevant to the program.

Deborah Klein is the Education and Training Manager of the Urological Society of Australia and New Zealand. She has been with the Society since September 2003 and manages the Specialist Surgical training program in Urology. She supports the Board of Urology, oversees Trainee selection, administers the training program and the hospital inspection process. Deborah co-ordinates Trainee Week and organises a range of seminars and scientific meetings, both for trainees and Society members. Deborah holds a Bachelor of Business degree majoring in Employment Relations from the University of Technology, Sydney. She has a wealth of experience in human resources and professional development, particularly in the area of recruitment, training and conference organisation.

Deborah is assisted by Wendy Frazer, CPD Manager, in the co-ordination of the selection process and other adhoc training related activities.

Vascular Surgery

The Vascular Surgery training program is conducted in accordance with the College policy on Selection to Surgical Education and Training and the Board responsibilities outlined in the ANZSVS Constitution.

The Board in Vascular Surgery is governed by the College policy on Terms of Reference for Boards of Specialist Surgical Training.

Documentation:
Board of Vascular Surgery (available for reference at the College)
College Policies (Weblink)

The conditions of the Vascular Surgery training program are outlined in a formal Letter of Offer sent to successful applicants prior to the commencement of their training. Applicants are required to sign and return to the College a copy of the Letter of Offer formally accepting the offer of training in the Specialist Surgical training program in Vascular Surgery and agreeing to the conditions outlined.

Selection and training of Supervisors and Examiners

Vascular surgical supervisors are selected on their experience and standing in the relevant training hospitals.

The Board of Vascular Surgery will hold a surgical supervisors meeting during 2007 at the College ASC to prepare them for changes in the current processes and with the introduction of SET. The Board will also encourage all of its supervisors to participate in the College Supervisor training program.

Examiners are selected in accordance with the College Court procedure.

Training materials available to Supervisors and/or Examiners

The College provides surgical supervisors with an information package containing relevant information and policies pertaining to training.

When it is available, the Board of Vascular Surgery will encourage all of its supervisors to access the material relating to the College Supervisor training program.

Identifying a suitable mentor — Trainees to access support counselling and/or mentoring

A mentor program facilitated by the Board Chair is offered to Vascular Trainees who wish to have a mentor during their training. Trainees are entitled to request the mentor of their choice, or alternatively a suitable mentor can be arranged.

Supervisor involvement in the governance structure

Surgical supervisors' involvement in the governance structure is represented by the Board in Vascular Surgery and the related College Boards.

Jurisdictional Representative involvement in the governance structure and in selection

The jurisdictional representative to the Vascular Board is invited to all Board meetings. Involvement is via the Board and the related College Boards.

Support for the on-going development of training

Staffing structure, and the expertise of the staff, involved in the training program

The Board of Vascular Surgery is wholly administered within the College. Therefore all aspects of curriculum development are supported by the College EDRD, and policy development is supported by the SSTA.

The administration for the Board is carried out by an Executive Officer who attends all Board meetings and associated activities.

6. ATTACHMENTS

Attachment 1 **Glossary**

Attachment 2 **General Surgery assessment plan**

Attachment 3 **Mindmap of curriculum for surgical training**

Attachment 4 **SET1 and SET2^{+} Training requirements for each of the surgical specialties**

Attachment 5 **The Selection and Work-based Assessment of Surgical Trainees**

Attachment 6 **Proforma for Managing an Underperforming Trainee**

Attachment 7 **Governance of SET**

Attachment 8 **SET Development Time-Line**

Attachment 1 Glossary

ACCC	Australian Competition and Consumer Commission
Accredited hospitals	The College accredits hospitals for Basic Surgical Training and hospital posts for Specialist Surgical Training in Australia and New Zealand. Accredited hospitals comply with RACS accreditation criteria based around seven core educational, clinical and governance standards required to provide training in a range of clinical contexts; they provide learning environments which facilitate the training of safe and competent surgeons.
Accredited Posts	Specialist Surgical Trainees are allocated to train in accredited training posts. Posts are accredited by the College when they are recognised as being able to offer appropriate training opportunities including case load, case mix and supervision. Accredited Specialist Surgical Training Posts are generally based in principal teaching hospitals.
AHMAC	Australian Health Ministers' Advisory Council
AHSS	Australian Hand Surgery Society
AHWOC	Australia Health Workforce Officials Committee (now HWPC)
AOA	Australian Orthopaedic Association
AORA	Australian Orthopaedic Registrars Association
ANZ Journal of Surgery	Publication for surgical research in Australia and New Zealand, published ten times per year.
ANZORS	Australian and New Zealand Orthopaedic Research Society
ANZSVS	Australian and New Zealand Society for Vascular Surgery
APLS	Advanced Paediatric Life Support course
ASAPS	Australasian Society of Aesthetic Plastic Surgery
ASC	Annual Scientific Congress
ASCTS	Australasian Society for Cardio and Thoracic Surgeons
ASIC	Australian Securities and Investment Commission
ASM- Urology	Annual Scientific Meeting held by the Urological Society of Australia and New Zealand
ASPS	Australian Society of Plastic Surgeons
ASSET	Australian and New Zealand Surgical Skills Education and Training
BiGS	Board in General Surgery
Basic Sciences Examination (BSE)	Examination comprised of questions in multiple choice format relating to Anatomy, Physiology and Pathology
BBST	Board of Basic Surgical Training
BSST	Board of Specialist Surgical Training
BST	Basic Surgical Training/ Basic Surgical Trainees
CanMEDS	Canadian Medical Education Directions for Specialists
CATs	Critical Appraisal Tasks
CBD	Case-Based Discussion
CCrISP	Care of the Critically Ill Surgical Patient course
CiC	Censor-in-Chief

CLEAR	Critical Literature Evaluation and Research course
Clinical Examination	Examination assessing the application of basic science knowledge to clinical practice
Clinical rotation	Period of time during which surgical trainees work and train in a specified clinical environment, usually under supervision of a Fellow of the College
The College	The Royal Australasian College of Surgeons
CPD	Continuing Professional Development
CSAG	Clinical Skills Advisory Group
DOGS	Direct Online Group Studies
DOPS	Direct Observation of Procedural Skills
EB	Education Board
EBU	European Board of Urology examination
ED	Emergency Department
EDRD	Education, Development and Research Department (at the College)
EMSB	Early Management of Severe Burns course
EMST	Early Management of Severe Trauma course
Fellow	Qualified surgeon assessed and registered with the Royal Australasian College of Surgeons
Fellowship Examination	Summative examination at the end of specialist surgical training comprising written and clinical components; the final assessment of the RACS surgical training program.
FLS	Fundamentals of Laparoscopic Surgery
FRACS	Fellow of the Royal Australasian College of Surgeons
HDU	High Dependence Unit
HWPC	Health Workforce Principal Committee
ICU	Intensive Care Unit
IMG	International Medical Graduate
iMIS	Database of individuals and organisations having a relationship with RACS
Intern*	Junior doctor (usually PGY1) working in a public hospital for twelve months immediately prior to full medical registration.
	* this term may vary across jurisdictions
ITA	In-Training Assessment
JR	Jurisdictional Representative
Jurisdiction	Government body overseeing health in a region
MCQ	Multiple Choice Questionnaire
MFA	Multiple-source Feedback Assessment
Mini CEX	Mini Clinical Evaluation Exercise
Mini PAT	Mini Peer Assessment Tool
NSA	Neurosurgical Society of Australasia
NZOA	New Zealand Orthopaedic Association
OHNS	Otolaryngology Head and Neck Surgery

OPAR	Orthopaedic Procedure Assessment Report
OPBS	Orthopaedic Principles of Basic Science
OSCE	Objective Structured Clinical Examination
PBA	Procedural Based Assessment
PGY	Postgraduate Year
PGY1-5	Numbers indicate years after graduation, e.g PGY2 is second year after graduation
PPA in-training assessment	Professional Performance Appraisals
PPA selection	Professional Performance Appraisals
P&RS	Plastic and Reconstructive Surgery
PreSET	Period during which an interest in surgical training has been formally registered with RACS, prior to selection into SET
QAR	Quarterly in-training Assessment Report
RACS	Royal Australasian College of Surgeons
RACSD	Royal Australasian College of Dental Surgery
RATS	Registrar Annual Training Seminars
Registrar*	* this term may vary across jurisdictions
RMO (HMO)*	Resident Medical Officer (House Medical Officer). Junior doctor (usually PGY2) during the one or more years of 'pre-vocational' on-the-job training immediately following successful completion of Internship and registration by the State Medical Board. *these terms may vary across jurisdictions
RTC	Regional Training Committee
RTP	Regional Training Program
SET	Surgical Education and Training
SET1	First year of the Surgical Education and Training program
SET2+	Second and subsequent years of the Surgical Education and Training program
Specialty Board	Each of 9 surgical specialties has a Specialty Board which oversees training for that specialty
SSPE	Surgical Sciences and Principles Examination
SST	Specialist Surgical Training
SSTA	Specialist Surgical Training and Assessment
STATS	Statistics for Surgeons course
Surgical News	Monthly College publication, includes articles of interest in surgery
TA& E	Training, Accreditation and Education committees (Urology)
TRHP	Trainee Report on Hospital Posts
Trainee	Medical doctor selected to be trained in the Royal Australasian College of Surgeons' surgical training program.
TST	Transitional Surgical Trainee
UMTA	Urological Mid-Term Assessment
USANZ	Urological Society of Australia and New Zealand
VMO	Visiting Medical Officer

Attachment 2 General Surgery Assessment Plan

General Surgery Assessment Plan 2007

Competencies	Assessment Tools	
	Primary	**Other**
Medical Expertise		
★ access and apply relevant knowledge to clinical practice		
▪ maintain currency of knowledge	FE	ITA
▪ apply scientific knowledge in practice	CBD	FE
▪ recognise and solve real-life problems	CEX/CBD	FE
Technical Expertise		
★ safely and effectively perform appropriate open surgical procedures		
▪ consistently demonstrate sound surgical skills	DOPS/PBA	LB
▪ demonstrate procedural knowledge and technical skill at a level appropriate to general surgery and their level of experience	DOPS/PBA	LB
▪ demonstrate manual dexterity required to carry out procedures	DOPS/PBA	LB
▪ adapt their skills in the context of each patient — each procedure	DOPS/PBA	LB/ITA
▪ maintain skills and learn new skills	DOPS/PBA	LB
▪ approach and carry out procedures with due attention to safety of patient, self, and others	DOPS/PBA 360^0	LB
▪ analyse their own clinical performance for continuous improvement	CBD (AUDIT)	ITA
Judgement – Clinical Decision Making		
★ design and carry out effective management plans	CEX	ITA/FE
▪ recognise the symptoms of, accurately diagnose, and manage common problems	CEX/CBD	ITA/FE
▪ take a history, perform an examination and arrive at a well reasoned diagnosis	CEX/CBD	ITA/FE
▪ efficiently and effectively examine the patient	CEX	ITA/FE
▪ formulate a differential diagnosis based on investigative findings	CBD	ITA/FE
▪ manage patients in ways that demonstrate sensitivity to their physical, social, cultural, and psychological needs	CBD	ITA/FE
▪ recognise the most common disorders and differentiate those amenable to operative and non-operative treatment	CBD	ITA/FE
▪ effectively manage the care of patients with trauma including multiple system trauma	CBD	ITA/FE
▪ effectively manage complications of operative procedures and the underlying disease process	CBD	ITA/FE
▪ accurately identify the risks, benefits, and mechanisms of action of currently used drugs	CBD	ITA/FE
▪ indicate alternatives in the process of interpreting investigations and in decision making	CBD	ITA/FE
▪ manage complexity and uncertainty with sound judgement	PBA	ITA/FE
▪ consider all issues relevant to the patient	CBD	ITA/FE
▪ advocate patient health	CBD	ITA/FE
▪ identify and manages risk	PBA/CBD	ITA/FE
▪ plan, and where necessary implement, a risk management plan	CBD	ITA/FE
★ organise diagnostic testing, imaging and consultation as needed	CBD/ITA	FE
▪ select medically appropriate investigative tools and monitoring techniques in a cost-effective, and useful manner	CBD/ITA	FE
▪ appraise and interpret results of investigations against patients' needs in the planning of treatment	CBD/ITA	FE
▪ critically evaluate the advantages and disadvantages of different investigative modalities	CBD/ITA	FE

▪ evaluate the significance of data	FE	Research
Communication		
★ communicate effectively		
▪ communicate information to patients (and their family) about procedures, potentialities, and risks associated with surgery in ways that encourage their participation in informed decision making	CEX	ITA/FE
▪ communicate with the patient (and their family) the treatment options, potentials, complications, and risks associated with all treatment modalities	CEX	ITA/FE
▪ communicate with and co-ordinate surgical teams to achieve an optimal surgical environment	360^0	ITA
▪ initiate the resolution of misunderstandings or disputes	360^0	ITA
▪ appropriately adjust the way they communicate with patients to accommodate cultural and linguistic differences and emotional status	CEX	ITA/FE
▪ recognise what constitutes 'bad news' for patients (and their family) and communicate accordingly	CEX	ITA/FE
Collaboration		
★ work in collaboration with members of an interdisciplinary team where appropriate	360^0	ITA
▪ develop a care plan for a patient in collaboration with members of an interdisciplinary team	360^0	ITA
▪ collaborate with other professionals in the selection and use of various treatment modalities assessing the effectiveness of each management option	360^0	ITA
▪ employ a consultative approach with colleagues and other professionals	360^0	ITA
▪ recognise the need to refer patients to other professionals	360^0	ITA/FE
Management and Leadership		
★ balanced decision making – see also Judgement – clinical decision making		
★ promote patient advocacy – see also Health Advocacy		
★ effectively use of resources to balance patient care and systemic demands		
▪ identify and differentiate between resources of the health care delivery system and individual patient needs	CBD	ITA/FE
▪ apply a wide range of information to prioritise needs and demands	CBD	ITA/FE
▪ effectively assess and manage systemic risk factors	CBD	ITA/FE
★ manage and lead clinical teams – see also Collaboration		
▪ is respectful of the different kinds of knowledge and expertise which contribute to the effective functioning of a clinical team	360^0	ITA
▪ direct and supervise junior medical staff effectively	360^0	ITA
★ maintain accurate records		
▪ contemporaneously maintain accurate and complete clinical records	CBD	ITA/LB
Health Advocacy		
★ promote health maintenance of patients	360^0	ITA
★ promote health maintenance of colleagues	360^0	ITA
★ look after their own health	360^0	ITA
Scholar and Teacher		
★ recognise the value of knowledge and research and its application to clinical practice		

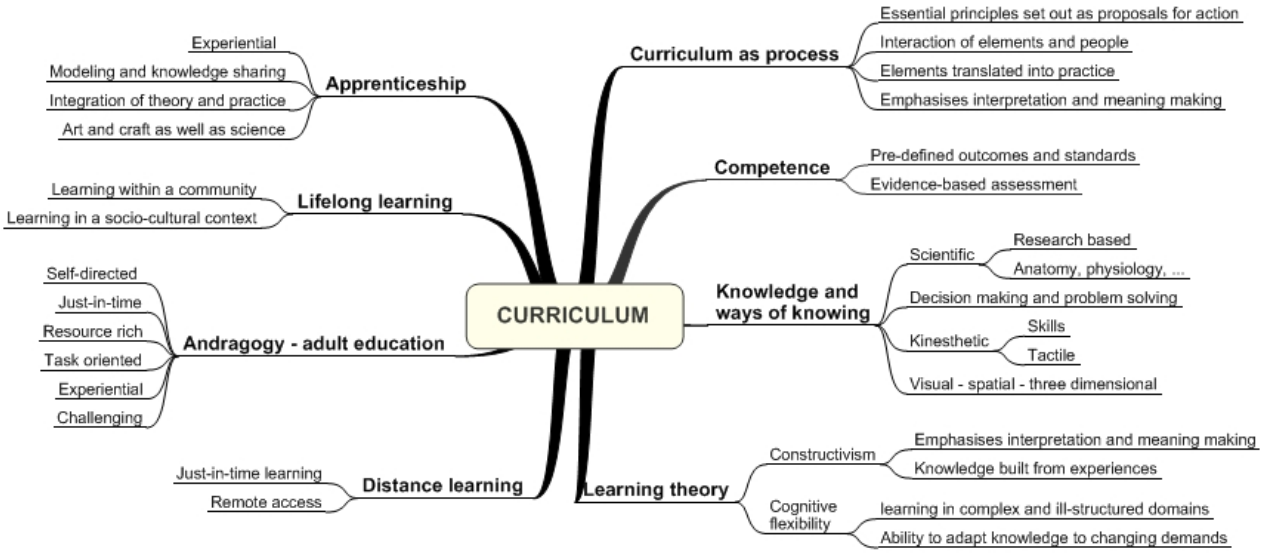
▪ assume responsibility for own on-going learning	CBD	ITA/Resch
▪ draw on different kinds of knowledge in order to weigh up patient's problems in terms of context, issues, needs, and consequences	CBD	ITA/FE
▪ critically appraise new trends in General Surgery	Research	FE
▪ facilitate the learning of others	360^0	ITA
Professionalism		
★ Appreciate the ethical issues within general surgery	360^0	ITA
▪ consistently apply ethical principles	360^0	ITA
▪ regularly participates in audit	ITA	??
▪ identify ethical expectations that impinge on the most common medico-legal issues	CBD	ITA/FE
▪ is accountable for their decisions and actions	CBD	ITA
▪ acknowledge their own limitations	360^0	ITA
▪ acknowledge and learns from mistakes	360^0	ITA
▪ act responsibly	360^0	ITA
▪ employ a critically reflective approach	360^0	ITA/LB

Key:

DOPS	Direct Observation of Procedures	Recommended minimum six times per year, early in training (multiple raters are required)
PBA	Procedure Based Assessment	Recommended minimum four times per year, later in training
CBD	Case Base Discussion	Recommended minimum four times per year, (multiple raters are required)
CEX	Clinical Evaluation	Recommended minimum six times per year, early in training
360^0	360 Degree Survey	From people other than supervisors / surgeons
ITA	In-Training Assessment Form	
FE	Fellowship Examination	
LB	Log Book	

Attachment 3 Mindmap of Curriculum for Surgical Training

A diagrammatical representation of the complex web of assumptions which underpin the curriculum for surgical training



Attachment 4 SET1 and SET2+ Training Requriements for Each of the Surgical Specialties

SET1 and SET2 Training requirements for each of the surgical specialties

SET1				
SPECIALTY	**TRAINING EXPERIENCE REQUIRED**	**COMPETENCY BASED ASSESSMENT**	**EARLY EXAMINATIONS**	**PROGRESSION BEYOND SET1**
Cardiothoracic Surgery	Four X 10-12 week terms including: • Cardiothoracic Surgery • General Surgery • ICU • Other surgical specialties Courses • CCrISP • EMST		Three components: • Generic MCQ • Specific MCQ for Cardiothoracic Surgery • An OSCE with generic stations	The BSE (generic and Cardiothoracic) must be completed by the end of SET2 before progression to SET3 is allowed
General Surgery	• A mandatory six month term in a general surgical term. Where possible this term will be in a general surgical term or acute surgical unit. There is possibility for flexibility in these rotations (i.e. combining two short rotations — General Surgery and Relief) • Terms in surgical units other than general surgery • All Trainees will be registered with the conjoint committee in endoscopy training. Although they may not get exposure in endoscopy during SET1, any experience shall be accredited for the conjoint committee. Courses: • ASSET will need to be completed during SET1 • CCrISP course Other courses may be included	The criteria for advancement are: • Satisfactory mid-and end of term reports in all terms • Pass in General Surgery BSE. This is mandatory before advancement from SET1 into SET2. The BST may be sat in November after selection into SET, prior to commencing SET1. The BSE must be attempted twice prior to the end of the first year of SET. • Trainees shall need to pass the BSE prior to advancement into SET2. The maximum time for passing is two years of SET1. Failure to pass the BSE will result in dismissal from the program. • There shall be terms that are defined as SET1 only, other terms shall be SET1 / 2 accredited. Therefore trainees may be defined as SET1 (having not passed the BSE), but they may be working in more advanced terms to continue the acquisition of clinical and technical competencies	The early examination will have three components: • Generic MCQ • Specific MCQ for General Surgery. This will have specific questions about the management of acute and elective general surgical conditions, sepsis, specific surgical anatomy, specific questions on the management of relevant co-morbidities (eg: diabetes, hepatic disease, coagulopathy etc). • An OSCE with generic stations. These would include clinical examination, history taking, obtaining consent, resuscitation and trauma. • All three components would need to be completed successfully for the Trainee would be given a pass rate	• If the Trainee has not met the criteria (Competency based assessment, and a pass in the BSE) they will stay in SET1 • The Trainee will need to achieve the clinical and operative competencies as defined in the SET1 curriculum. • There will be a two year limit for obtaining the criteria for advancement from SET1 to SET2 • Failure to meet the criteria may lead to dismissal from training

Neurosurgery	4 three month rotations in neurosurgery or 2 three month rotations in neurosurgery and 2 in another specialty as allocated by the Board. A minimum 75 major neurosurgical procedures for each 6 month neurosurgical rotation 1 core competency assessment ASSET CCrISP	There are nine (9) minimum performance standards in this category during SET1: Four satisfactory in-training assessment forms submitted on a three monthly basis. Two logbook summaries with a minimum of 75 major neurosurgical procedures submitted on a six monthly basis One satisfactory competency assessment form. Satisfactory completion of the ASSET Course Satisfactory completion of the CCrISP Course	There are two (2) minimum performance based standards in this category during SET1: Satisfactory completion of the BSE examination in Neurosurgery Satisfactory completion of the Clinical Examination	The following progression regulations apply: satisfactorily complete all minimum standards fail to complete one minimum standard (continue to next year on probation) fail to complete two or more (repeat the year on probation) fail to complete three or more (dismissal) Notwithstanding any of the above: fail a minimum standard while on probation (dismissal) fail the same minimum standard on 3 occasions during training (dismissal) can only repeat each year of SET on one occasion (dismissal)
Orthopaedic Surgery	Mandatory: If not completed in PreSET: • ASSET • CCrISP • EMST (before the end of SET2) • Remainder of time – minimum six months orthopaedics • plus three months plastic and/or vascular or neuro or general • Preferred option would be a 12 month Orthopaedic position Desirable: • CLEAR Course	• Satisfactory or better assessments from all attachments at least each three months • Satisfactory 360º Assessment from each attachment • Satisfactory Logbook from each attachment • Pass in Basic Surgical Examination	• BSE Examination: o Generic MCQ and OSCE as in current primary, but less papers o Orthopaedic MCQ as for current OPBS module • May be taken separately, but the generic component must be passed to progress to SET2	To advance to SET2, the Trainee must pass the BSE Examination and meet standards in assessment. Failure to do so will mean repeating SET1, and if still not successful, dismissal from the program

Otolaryngology Head and Neck Surgery	Three month rotations in four of the following areas: • General surgery • Cardiothoracic Surgery • Neurosurgery • Plastic surgery • Otolaryngology Head and Neck surgery • Paediatric Surgery The final mix will depend on available jobs and competition for them. It is expected that trainees will get experience across the nine competencies during these rotations. ▪ ASSET and CCrISP must be completed before progression to SET2 ▪ EMST is desirable but can be carried into SET2 and completed before SET3	During each of the four surgical rotations we require: • Satisfactory 360 degree assessments in each rotation. • Satisfactory ITA using the current OHNS assessment form • Satisfactory log book inspection for each rotation • Satisfactory DOPS or PBA for each rotation • Satisfactory CPD for each rotation • Satisfactory CE assessment for each rotation. The above assessments must be robust and frequent in order to detect unsatisfactory candidates as soon as possible.	Three components • Generic MCQ • Specific MCQ for Otolaryngology Head and Neck Surgery. This will have specific questions about the management of acute and elective Otolaryngology Head and Neck surgical conditions. • An OSCE with generic stations.	• The generic component of the BSE is required to be passed before progression to SET2 • The specialty specific component can be carried into SET2 and completed before SET3.
Paediatric Surgery	By the end of SET1 a trainee will have completed a minimum of: • six months of Surgery – the most useful specialties being General Surgery, Urology, Vascular Surgery, Plastic and Reconstructive Surgery • six months Paediatrics (preferably non-surgical) • Trainees must complete the EMST, APLS, ASSET and CCrISP courses by mid-SET2.	• Trainees must complete in-training assessments every three months during SET1 and be assessed as satisfactory in each. • assessments will take the form of DOPS, PBAs, Mini-CEX and 360^0	• Should a SET1 Trainee not pass the BSE after three attempts, they will be placed on probation but allowed to progress into SET2 and have one further attempt at the examination in April. • Should the trainee fail the examination at the extra attempt they will be automatically dismissed from SET in Paediatric surgery. • Training in the SET2 post will not be accredited until the Trainee passes the examination • SET1 Trainees must complete the OSCE	• All SET1 requirements must be successfully completed by June 30 of the second year of SET training, otherwise a Trainee will be automatically dismissed from the program

Plastic and Reconstructive Surgery	Registrar rotations in at least three disciplines (pref 3x4 months but would accept 4x3 months or 2x6 months) - Rotating through any of the nine disciplines (e.g. General Surgery /Vascular Surgery/ or Plastic Surgery/ OHNS /General) - The clinical content and work load of these positions will be approved by the Board of Plastic and Reconstructive Surgery ♦ CCrISP ♦ EMST ♦ ASSET	♦ In training Assessment performed every three months throughout training and in each rotation	SET1 ♦ Multi- Choice BSE ♦ OSCE ♦ The Specialty specific component (Surgical Science and Principles Exam) - The current rules will apply to BSTs who have successfully completed the Part 1 exams. They will sit Speciality Specific Surgical Sciences and Principles Exam in SST1 (SET2) and must pass the examination to progress beyond SST3 (SET4).	♦ Successfully pass Basic Sciences Primary (BSE and OSCE) in order to progress to SET2 ♦ May sit the Specialty Specific component in SET1 — must sit it by the end of SET2 and must pass the exam to progress beyond SET3. ♦ Current rules will apply to BSTs who have successfully completed the Part one exams.
Urology	Clinical exposure: ♦ Anaesth/ICU, ED, some Urology, and some Gen Medicine ♦ ASSET ♦ CCrISP ♦ EMST ♦ CLEAR will generally be undertaken in SET2, and remains a mandatory requirement. The circumstances under which EMST, the BSE and OSCE may be carried into SET2 are to be determined	♦ In training assessment ♦ The application of DOPS, PBA, or Mini CEX etc is yet to be determined	♦ Successfully complete the BSE and OSCE ♦ Non-specialty aligned early exam	♦ Failure would result in non-progression or exclusion from training

Vascular surgery	• Commence Level one modules • Attend annual Trainee course Rotations suitable for SET1 will include 2X10-12 week posts in: • Vascular surgery (core) • Intensive care, or • ED, or • General medicine/ cardiology, or • Radiology, or • Cardiothoracic surgery Plus • Six months in General Surgery in a hospital which is not a major tertiary teaching institution Satisfactory completion of the following by 30 June of SET2: • ASSET • CCrISP • EMST	In-training assessment every three months • Satisfactory mid and end of term reports in all terms • 360^0 assessment in all terms • DOPS and PBA in each unit (three monthly) Mini CEX every three month attachment	Satisfactory completion of the following by 30 June of SET2: • BSE examination including OSCE • Pass generic MCQ and OSCE • Pass specific MCQ for Vascular Surgery	• A rating of unsatisfactory in any two in-training assessment reports may result in automatic dismissal from the training program • Unsuccessful completion of all components of assessment will result in counselling by Board, requirement to repeat SET2 or exclusion from program

SET2 +			
SPECIALTY	**PROGRAM DURATION**	**COMPETENCY-BASED ASSESSMENT DURING TRAINING**	**FELLOWSHIP EXAMINATION**
Cardiothoracic Surgery	SET2 rotations in surgery in general, 2X26 week rotations from: o Vascular Surgery o General Surgery – Trauma o Upper GI surgery o General Surgery – rural EMST(if not done in SET1) SET3+ Four years of Cardiothoracic Surgery		Fellowship Examination to remain and will normally be taken in the final year of Cardiothoracic training (SET6)
General Surgery	There shall be no minimal duration. The assessment shall be competency based. Once all criteria for SET1 are met the trainee will advance into SET2. The later SET rotations shall be based on competencies. There is no specific duration. It is anticipated that most trainees will have a total of five years of training, although some very good trainees may complete SET in four years. Others may take more than five years to achieve the competencies.	♦ Satisfactory rating in the CLEAR course required to advance from SET2 to SET3. ** Mini CEX (must be completed successfully to gain promotion to SET3). The mini CEX will be the format of the current shot and long case clinicals. The assessment shall be for the trainees' ability to take a history, examine a patient and formulate a clinical assessment with a provisional diagnosis. This will then not be examined in the fellowship. SAGES: Once it is able to be delivered to all trainees the SAGES course a satisfactory rating will be required prior to advancement to SET3. This course represents a validated assessment of laparoscopic skills. *Satisfactory completion of EMST course will be required to move from SET2 to SET3. * All of SET will include assessment of technical competence. * The Trainee shall need to have completed 75% of the requirements of the conjoint committee in endoscopy training for gastroscopy and colonoscopy before being eligible to sit the Fellowship examination.	The Fellowship examination will be sat in the final year of training, once the Trainee has obtained all the essential competencies as defined in the curriculum. During the Fellowship, the clinical components will concentrate on the assessment of the management of clinical problems. The training shall be completed once all the essential competencies have been acquired. As this is linked with sitting the fellowship, the training will conclude at the end of the year, in which the Trainee becomes eligible to sit the Fellowship Examination. The Fellowship Examination will be an exit examination.

Neurosurgery	4 clinical years in neurosurgery (SET2, 3, 5 and 6) 1 research year (SET4)	The regulations outline the number of minimum performance standards for each year of SET. As an overall summary: satisfactory in-training assessment forms submitted on a six monthly basis (2 per year for SET2, SET3, SET5 & SET6) logbook summaries with a minimum of 100 major neurosurgical procedures submitted on a six monthly basis (2 per year for SET2, SET3, SET5 & SET6) 2 research reports submitted on a six monthly basis (SET4) EMST course (SET2) Neurosurgery Basic Exam (SET2) 1 research requirement (prior to the end of SET5) 11 core workplace assessments (3 during SET2 and 4 per year in SET3 and SET5) 2 elective workplace assessments (by end of SET6) 9 trainee seminars (2 per year in SET2 to SET5 and 1 in SET6) Fellowship Exam (SET6)	Progression regulations: satisfactorily complete all minimum standards fail to complete one minimum standard (continue to next year on probation) fail to complete two or more (repeat the year) fail to complete three or more (dismissal) **Notwithstanding any of the above:** fail a minimum standard while on probation (dismissal) fail the same minimum standard on 3 occasions during training (dismissal) can only repeat each year of SET on one occasion only (dismissal)
Orthopaedic Surgery	♦ Normally four years of orthopaedic training from SET2-5	* If competency and all other course requirements are considered passed, may sit fellowship examination in SET4 and finish at the end of SET4 year	* The candidate may sit the fellowship examination when the Regional Training Committee is satisfied that all competency and assessment requirements have been met
Otolaryngology Head and Neck Surgery	A total of five years of surgical training * SET1 specialty tailored residency, courses and exam * then four years specialty training		* Examination in final year of specialty training
Paediatric Surgery	Normally four years of training in Paediatric Surgery SET2^{+}	♦ Logbooks, Evaluation form, Overview form, Mid-term Evaluation form ♦ Critical Appraisal Tasks, Directed Online Group Studies ♦ Registrar Annual Training Seminar ♦ Procedure Based Assessments, 360°	Sat during SET5 after successful completion of Paediatric Anatomy and Paediatric Pathology Exams.
Plastic and Reconstructive Surgery	♦ Four years advanced training Normally a total of five years	♦ More details of the competency based schedule to be formalised. ♦ Mid-term and end of term assessments conducted on current Board Approved PPA form.	* Examination in final year of specialty training

		• Logbook submission	
Urology	• One year of General Surgery • Four years of Urology A total of six years	• In training assessment • The application of DOPS, PBA, or Mini CEX etc is yet to be determined • Annual clinical MCQ in November of SET2, 3 and possibly 4. Progress in training is dependant on satisfactory performance in these tests	* Urology intend to continue to conduct the Fellowship Exam in the penultimate year of the training, in future favouring the October sitting as the first attempt
Vascular surgery	By the end of SET2 • Maximum 6 months in Vascular • 12 months of surgery in general (not vascular) • ICU experience (min eight weeks) • ED (min eight weeks) Total training will be five years: • one year of General Surgery • two years of Vascular Surgery Duration of training will depend on achieving competence		• Examination in SET5

Attachment 5 The Selection and Work-based Assessment of Surgical Trainees

THE SELECTION AND WORK-BASED ASSESSMENT OF SURGICAL TRAINEES

A DISCUSSION DOCUMENT

February 2007

Foreword

Selection and work-based assessment are two of the major challenges for the new Surgical Education and Training (SET) program. Selection in particular is also a risk area for the College and its Agents, the Specialty Associations and Societies. The first draft of this document was prepared to facilitate discussion at the face-to-face meeting of the SET Working Party on 8 February 2007. It was based on extensive discussions and a review of the published literature and, the current practices of other vocational Colleges and educational institutions across the English speaking world. It also takes into account the Selection Principles document produced by the Australian Medical Council. Tables 1 and 2 were prepared to provide important background information on the current selection practices used across the nine specialties and these are attached. Examples of draft assessment proforma were also provided for discussion and can be seen in Appendices 1– 4.

The document has now been revised following the meeting of the SET Working Party. It commences with a detailed review of selection and the current methods being used and is followed by a list of recommendations. The second section looks at work-based assessment and makes recommendations on the most appropriate and practical tools to be considered for use in Australia and New Zealand. A short description of Educational or Learning Portfolios is also included.

Every effort has been made to confirm the details provided about the selection process used by each specialty to be correct but feed back on this or any other aspect is welcome

A summary is provided at the beginning of the document and includes those recommendations agreed to by the working party.

This draft document will be improved by ongoing discussions and feedback and a revised version will be produced. The final document will be linked to College policies on selection. I will be pleased to receive your comments and suggestions at john.collins@surgeons.org

John P Collins
Dean of Education
February 14 - 2007

Summary and Initial Recommendations

Summary

- The percentage of applicants who will never be able to perform surgery (can not acquire technical expertise) is very small, perhaps 2 %.
- Psychometric testing is not worthwhile at this time.
- Dexterity tests provide short-lived prediction of performance, limited mainly to the first two years of training. They can however predict the speed with which proficiency will be acquired.
- All three selection tools, e.g. referees' reports, curriculum vitae and the interview, are important, and used together can measure the RACS nine core competency domains.
- Referees' Reports – are subject to much criticism but done well provide vital information which is based on first hand observation of an applicant's performance in the workplace and which can not be ignored. Important to use multiple sources including surgeons, other health professionals and employers. Structured reports should be sought from surgeons, other health professionals and hospitals or employers. Written Reports and Professional Performance Appraisals (PPAs) are both important. It is essential to retain accurate records in case of an appeal. It is suggested that "surgeons' reports" be worth 60%, other "health professionals' reports" be worth 20% and "hospital reports" be worth 20% of the total weighting for this selection tool.
- Curriculum Vitae - important and must allow for clinical experience, academic achievements and other accomplishments. Gold medals and/or top of the class are the only medical school results which predict subsequent performance. Medical school marks are not sufficiently discriminating. It is suggested that the clinical experience component be valued at 45%, academic achievement be 35% and other accomplishments 20% of the total weighting for this tool. Flexibility must allow for the recruitment of academic surgeons.
- Interviews – use of a semi-structured format, standardised questions and multiple raters provides the best outcome. The interview should not be used to test medical knowledge, but to help select the most appropriate applicants. Questions should be aligned to the RACS nine core competency domains. Multiple raters should be considered.

Recommendations

1. **Referees' Reports: *Overall weighting should be between 35 and 45%.***
2. **Curriculum Vitae: *Overall weighting should be between 15 and 25%.***
3. **Interview: *Overall weighting should be between 35 and 45%.***

Principles of Selection into Surgery

1. The College and its Agents recognise that trainees are both postgraduate students in specialist training programs and employees of the health services, and consequently the process of selection for training and for employment are interlinked.

2. The College and its Agents, as the professional body for surgery, will take the leadership role in the ongoing development of selection criteria and will liaise with other stakeholders including the jurisdictions during this process.

3. A clear statement on the eligibility criteria required to apply for each surgical specialty program will be publicised.

4. Selection will be through open competition using a merit-based process.

5. Because there is no one agreed method for selection of the most appropriate trainees, a number of tools will be used, including referees' reports, curriculum vitae and interview.

6. The selection tools will focus on the nine RACS core competency domains.

7. Selection will be related to the objectives of each specialty's training program and the desired attributes of its graduates.

8. Selection criteria will be objective and quantifiable to the greatest possible extent.

9. Because the selection methods used are the same for all nine specialties, standardisation of procedures for selection both within specialties and between specialties is essential.

10. The College and its Agents will have formulated its expectations of the role of those on selection panels and expects them to participate in appropriate training.

11. The marking system for each selection tool and the weighting allocated (as a percentage of the total mark) will be clearly stated.

12. The marking system used must allow a candidate the opportunity to reach the maximum score.

13. Structured referees' reports and curriculum vitae, and a semi-structured interview will be used in order to achieve objectivity, comparability and quantification.

14. A standardised series of questions will be asked of all candidates during the interview without substantial deviation or additions.

15. Short-listing of applicants for interview may be necessary and will be based on a publicised minimum score in both the referees' reports and the curriculum vitae.

16. Interviews will be conducted as a face-to-face exercise.

17. In choosing members of the interview panels, care should be taken to ensure that as far as is possible, members do not know any of the candidates in order to avoid preconceived opinions entering the process.

18. Where item 17 is impossible to achieve and it is acknowledged this may be the case for many if not most specialties, the interviewer(s) concerned will disclose they know some candidates to all candidates and the basis of this knowledge, and assure all candidates that they will base their assessment solely on the interview.

19. The selection model will enable those who can demonstrate they have had a commitment to surgery to be recognised.

20. Whilst the College and its Agents may carry out pre-employment checks such as criminal record or enhanced disclosure, the ultimate responsibility for this rests with the employing organisation.

21. Candidates will be ranked for selection into a surgical program on the basis of the sum of the scores from the referees' reports, curriculum vitae and interview.

22. Feedback will be offered to candidates to help guide them in their career planning and any such feedback will provide a frank appraisal of the candidate's standing in the eyes of those conducting the selection process.

23. Accurate records will be retained by the College or its Agents relating to the process of selection into the training program and its outcomes.

Principles for Work-based Assessment

1. Work-based assessment should form part of an overall assessment program mapped to the relevant curriculum.

2. The purpose of the assessment must be explicitly stated.

3. The assessment methods used will be selected in the light of the purpose and content of that component of the assessment framework.

4. The methods used to set standards of Trainee's performance or competence must be transparent and publicised.

5. Employers (jurisdictions) must recognise the importance of work-based assessment and the need for appropriate time for surgeons to undertake this.

6. Feedback from the assessment should be provided and linked to educational planning.

7. Clinical content and assessor variability are important sources of variation in all work-based assessment.

8. Wide sampling across content and assessors is essential for all work-based assessment methods.

9. If sufficient judgments are combined, subjective judgments can achieve acceptable levels of reliability.

10. Documentation must be standardised and records of assessment retained for record purpose.

11. Work-based assessment should be subject to quality assurance.

12. Trainees are both postgraduate students and employees of the health services. Copies of all assessments completed on trainees must be sent to their employer(s).

Introduction

Over the past five years an average of 362 doctors applied each year for the approximately 220 places available in Basic Surgical Training with a success rate of 64%. During the same period an average of 433 individuals applied each year for the 250 places available in Specialist Surgical Training giving a success rate of 58%. The majority of applicants for specialist training apply to one specialty. In 2006 76% of applicants applied to one specialty, 20.4% to two specialties, 2.7% to three specialties and 0.9% for four or more specialties. In other words, 96% of applicants applied to one or two specialties. It is of interest that the four applicants who applied to four or more specialties originated from BST4 (2), IMGs (1) or TSTs (1). Concerns have been expressed that the number of medical graduates applying for surgical training has decreased in some countries but there is no evidence of this trend in Australia or New Zealand. Cohort studies of graduating UK medical students indicates that about 20% (13-26%) depending on the medical school of the graduates, list surgery as their first choice of long term career, and there is evidence that 75% of graduates have made their career decision by the end of their first postgraduate year (PGY1). A major influence on the making of a career choice, relates to the personal experience of a subject by a student and this has been found to be more important than a particular teacher or department.

The recruitment and training of tomorrow's surgeons must be based on the best selection process available and be accompanied by an objective and continuous assessment of the Trainee's progress during training through work-based assessment. In this document selection and work-based assessment will be reviewed in detail and recommendations made on possible ways to strengthen both processes.

Selection

The selection process sets out to recruit into surgery those with the most appropriate aptitudes or abilities, and personality traits capable of being trained to the required level of proficiency to practise surgery. It also attempts to select those most likely to complete the program.

With the introduction of the new seamless surgical education and training program or SET, there will be one episode of selection. Once a Trainee is selected it is extremely difficult to subsequently dismiss them from the program if they are found to be unsuitable for training. Experience has shown that the de-selection process is less rigorous than often perceived or wished and is a common source of appeals. For this reason it is crucial that the most meticulous selection process is used and that continuous work-based assessment is founded on validated and precise methodology.

Selection is based on a number of methods or tools which attempt to measure the candidate's innate ability or aptitudes, and various aspects of their personality.

Amongst the innate abilities that a candidate can bring to given tasks and determine the level of proficiency they will reach with training are visuo-spatial ability, aiming, multi-limb coordination, hand-arm steadiness and eye-hand coordination, all of which underpin manual dexterity. Visuo-spatial problem-solving ability is considered the most innate and the most crucial to superior technique. It is frequently stated in the literature that between five and 10% of trainees never reach technical proficiency because they do not possess an adequate level of innate dexterity. The evidence to support this is weak and it is now thought that less than two percent may be in that category.

Apart from these specific attributes considered important by a group of master surgeons, general cognitive abilities such as intelligence, knowledge, judgment and decision-making were thought to be equally important for the practice of surgery. Various aspects of personality are also important including insight, team work, honesty and emotional stability, ability to cope with stress, empathy, integrity and organisational ability. Some experts believe that decision-making ability is linked to a person's personality.

Eligibility Criteria for Selection into Surgery

In order to apply for selection for any one of the nine surgical specialties, an applicant must have full medical registration which will enable them to work anywhere in Australia or if necessary in New Zealand. They must also possess Australian citizenship (or where applicable New Zealand citizenship) or have permanent residency status for the full duration of the program – usually five to six years.

Surgery is a craft specialty and all applicants must have prior experience in surgical posts where their technical skills and aptitude for surgery can be observed and assessed. This exposure to surgery not only helps applicants with their long-term career planning but it also enables them to provide evidence which demonstrates they have the competencies required to enter surgical training.

Current Selection Tools

Background

Psychometric measures or standardised psychological measures are used to augment the selection process across a wide range of private and public sector managerial and professional groups and it has been suggested such measurements should be included in the selection of surgeons. The lack of precise outcome measures with which to predict the "good surgical candidate" and the difficulties of defining the ideal profile of a surgeon has precluded the use of psychometric testing at this time. Measurement of dexterity is possible and it has been suggested that this should play a more significant part in selection. However dexterity tests provide only short-lived prediction of performance – possibly for the first two years of training. On the other hand such tests can predict how quickly a Trainee will gain technical proficiency.

Those responsible for current selection in each of the nine specialties rely on the referees' reports, curriculum vitae and interviews for selection. The literature is full of opinions as to how trainees should be selected but there is a paucity of evidence to support any particular method. In an attempt to improve the validity of selection process, consideration is being given by some educational institutions to incorporate clinical management scenarios, multiple mini interviews and a small number (possible three) of OSCE-type stations. It is suggested that these OSCE stations should be matched to the core competency domains identified by an educational institution. Great care is needed to ensure that knowledge testing does not find a way back into the selection process of these very junior residents.

There is no agreement on an appropriate scoring framework and rating scale or how to separate aggregate scores or deal with the clustering of scores, and what the discriminators should be that decide which candidates will be selected from those with clustered scores. Whilst there may not be uniformity, this decision must be made and will need to be addressed.

It is generally agreed that the selection tools must focus on the core competency domains identified by each educational institution which for this College are the RACS nine core competency domains.

Appropriate records of the selection process for each candidate must be retained. One of the principles stated by the AMC relating to selection process is as follows; "The College keeps accurate records relating to the process of selection into the training program and its outcomes. The records should enable accurate reconstruction of the original detail and process. Adequate documentation also enables external scrutiny, audit and evaluation of the selection process" (Australian Medical Council 2007).

Referees' Reports

These are used to obtain information from those who know the candidates professionally - through working with them, and are either, Written Referees' Reports, Professional Performance Appraisals (PPAs), Hospital Assessment Reports including those from the administration and other health professions or a combination of all of these.

Written Referees' Reports

Referees' reports are an attempt to undertake an assessment of an applicant's personal attributes and skills and have been greatly improved through the adoption of a structured format. Six of the nine specialties use written referees' reports (Table1) but the number required, how they are scored and their overall weighting varies from specialty to specialty.

The number of reports requested varies from two to seven. Some specialties limit referees to those surgeons who have been nominated by the applicant or a selection of these, whilst others seek reports from those nominated by the specialty. Some specialties also seek reports from other health professionals such as those in emergency or intensive care departments and may use these in certain circumstances. Most specialties limit referees to those whom the applicant has worked with over the previous two years. One specialty (Cardiothoracic Surgery) requests five referees' reports but discards two e.g. those with the highest and lowest scores. The number of criteria to be rated varies, with General Surgery listing 24 headings.

A review of referees' reports in General Surgery for 2006 showed a very high reliability of 0.98 between the different attributes measured and each correlated positively with the overall score. However between 10% and 20% of referees were unable to score applicants on aptitude, whilst over 20% failed to score them on technique or teaching. Although the accompanying instructions stated that "the majority of applicants would gain a satisfactory rating (rating 4), a few applicants would be above average (rating 5) and only on occasions would an applicant be rated as outstanding (rating7)", analysis showed that 30% were given a rating of "5", and 28% were given either a rating of "4" or a "6". Discussion with the other specialties confirms a similar reluctance by referees to record lower scores for any candidate and failure to use the full scale provided remains a challenge. The introduction of more robust work-based assessment tools during the PreSET period would enable referees to provide a more valid and reliable report.

An ongoing problem exists with failure of some referees to return the completed form and in some countries trainees are requested to ensure their completed reports are returned. Failure to return completed forms may have negative consequences on an applicant's likelihood of being selected.

Weighting of reports varies from 10% to 50% of the total score for selection and in some specialties is combined with or replaced by Professional Performance Appraisals. Some specialties require a minimum score in the referees' reports for candidates to be short-listed for interview.

Recommendations

1. The RACS nine core competency domains should be the categories measure by referees' reports

2. Reports should be obtained from those with whom the applicant has worked, during the previous two years.

3. A specialty must reserve the right to contact some of those whom the applicant has worked with but has not nominated.

4. The number of written referees' reports sought should not be less than three except where Professional Performance Appraisals are used as additional measures.

5. The proforma used must have a suitable scale with equal intervals and brief descriptions given for each interval point on the scale. The use of a five point scale is recommended with anchor descriptors at the intervals one, three, and five.

6. Weighting should ensure that this assessment of an applicant makes up a significant percentage of the total score.

7. Scoring and completion of referees' reports should be covered in future Supervisors' courses.

Professional Performance Appraisal (PPAs)

This is often referred to as a "verbal reference" and involves a member of the Board or their deputy – usually a supervisor – contacting a number of persons who have worked with the applicant, in order to complete a structure PPA form. Contact is made, either via a telephone or through a face-to-face meeting, usually with a surgeon but it may be with any of a number of health professionals.

This tool is currently used by five of the nine surgical specialties (Table1) including Cardiothoracic, OHNS, Paediatrics, Plastics and Urology. Only one other Specialist College in Australia namely RACDS - Oral and Maxillofacial Surgery - uses this tool. The number of persons contacted and the method of their selection varies between the specialties. Similarly the categories evaluated vary and some specialties use five whilst other use 12. Marking practices also vary with one specialty (Paediatrics) using negative marking. Some specialties such as Plastics use PPAs as their sole measurement of performance in the workplace, while others use it in combination with other personal reports. The weighting given to this tool also varies from 25% to 50% of the total overall possible score.

Experience has shown that no record is held of the discussion which takes place during the collection of the information required to score the PPA form, and the referee being interviewed does not sight or sign the completed form. These factors may lead to difficulties with the defence of this tool in an appeal against the outcome of selection.

There is a paucity of information in the literature on the use of this tool for selection into medical programs. However the experience of those specialties which use this tool confirms that it is very helpful. For some of the large specialties it has proved very labour intensive and they have had to abandon it.

Recommendations

1. The categories to be evaluated should be standardised and it is proposed these be the same as the nine RACS core competency domains.

2. The form must have a suitable scale with equal intervals and brief descriptions given for each interval point on the scale. The use of a five point scale is recommended with anchor descriptors at the intervals one, three, and five.

3. Negative marking should not be used in the selection process.

4. The weighting allocated to this tool must allow for any other measurements of similar workplace performance (e.g. written referees' reports).

5. Avoidance of a possible Halo Effect is necessary. The person making the contact to complete the PPA form should ideally not be part of the subsequent interview panel assessing this candidate, otherwise bias may enter the process through failure to keep different selection tools independent of each other.

6. The methodology for selecting the persons to provide the information, on which the PPAs are based, must be clear and publicised.

7. The person providing the information on which the PPA is based should normally countersign the completed form.

Hospital Reports

These provide the opportunity for the employer to make an appropriate contribution to the selection process from a very important perspective. This tool has been an established part of the selection of Basic Surgical Trainees for some time and has been found to be very useful. It is used by three specialties (Table 1) which support its place in selection. It is however unclear what weighting it contributes to the overall mark in these specialties. Information may also be sought from other health professionals – the so called "360 degree" reports and these are also used by some specialties.

Recommendations

1. Reports should be requested from the employer or hospital for all candidates and allocated an appropriate weighting.

2. Consideration should also be given to the use of 360 degree reports in order to obtain information from a broad spectrum of heath professionals.

Curriculum Vitae

The purpose of the CV is to enable applicants to provide a synopsis of their qualifications, meritorious performances, appointments and experience in various areas of medical and surgical practice. Recently some countries have introduced the concept of an Educational or Learning Portfolio which provides additional detail and evidence of what is included in the CV.

All nine specialties include the CV as one of their three selection tools but the percentage weighting varies from 10% to 30%. The categories scored vary in their level of detail but the most significant variance lies in the marks allocated to the different categories. As an example it is possible in some specialties for those with a very high academic achievement to reach 75% of the total mark for the CV whereas others give more recognition to clinical experience. In one specialty it would appear to be impossible to achieve the total score.

Flexibility is required in the percentage weighting allocated to the CV and recruitment of future academic surgeons borne in mind.

Recommendations

1. The RACS 9 core competency domains should be the categories measure by CVs.

2. The marks allocated should ensure a balance between clinical experience, academic achievements and other accomplishments.

3. During the transition to SET, research undertaken at the right time and for the right reasons should remain important but in the future, research should be integrated into surgical training rather than a measurable criterion for selection.

4. Guidance should be provided to applicants on what fulfils the marks allocated to each category, otherwise applicants will continue to submit extra material for which they will not receive any extra marks.

5. The score allocated for this tool should be between 15 and 25%.

The Interview

The purpose of the interview is to elicit information from the candidates to help in establishing whether they have the desired attributes and qualifications commensurate with the training program. The interview component of the selection process "is extremely important, in part because difference between candidates or other considerations may be minimal" (AMC).

A single interview is most commonly used except for Vascular, and for General Surgery in New Zealand which have two interviews. The number of categories scored is fairly uniform but the weighting varies from 25% (Plastics) to 55% (Vascular). Vascular Surgery use one of their two interviews to assess vascular specific knowledge for which they allow 20% of the total of 55% allocated for the interview. Some specialties use a short-listing process before applicants are invited for interview and this is based on applicants reaching a defined minimum score in each of the other two selection tools (referees reports and CVs). The % weighting for the interview must be less than 50% otherwise all applicants could rightly claim they might have done well in the interview and thereby achieved an overall high score.

Of all the methods of selection the most vulnerable to a successful challenge on the grounds of perceived unfairness is the interview process. It is vulnerable in two respects, the first is in the selection of the interview panel and the second relates to the process of the interview.

Wherever possible, the interview panel should not consist of persons who know any of the candidates. As pointed out earlier, the views of those who know the candidates should be expressed in the referees' reports. To have on the interview panel, persons who know one or some of the candidates is to substitute a preconceived view for a view based solely on answers to questions which is the purpose of the interview process. For this reason, it risks successful challenge on the ground of perceived unfairness.

Whilst this is fine in theory it is acknowledged this may be impossible to achieve. Where this is the case, and it almost certainly will be so, the interviewer(s) concerned should:

a. Disclose to all candidates that he or she knows some of the candidates, stating which, and the basis of that knowledge.

b. Assure all candidates that the interviewer will put prior knowledge of any candidate out of their mind and will base their assessment solely on the interview.

In no case should a person related to a candidate or having a close personal connection with a candidate sit on an interview panel for candidates which include the candidate.

The second issue relates to the process of interview. A standardised series of questions must be produced and developed to assess the different attributes, each clearly defined with anchor descriptors provided for each of the three points (1, 3 and 5) on a five point scale. There should be no substantial deviation or addition to the standardised series of questions and these same questions must be asked of all candidates. Any substantial deviation or addition to these questions is likely to leave open a challenge on the basis of perceived unfairness.

Recommendations

1. The RACS nine core competency domains should be the categories measure by the interview.

2. Interviews must be face-to-face.

3. Short-listing of applicants based on reaching a minimum score in the other two selection tools may be necessary.

4. The interview panel should not exceed five people.

5. Interviewers must be appropriately trained.

6. Interviewers, should as far as is possible, not be aware of the scores achieved by the candidate in the other two selection tools.

7. The interview should be a minimum of 30 minutes.

8. The score allocated to the interview should be between 35 and 45%.

WORK-PLACED ASSESSMENT

Robust work-placed assessment is essential to enable the early selection of trainees and the monitoring (and feedback) of their subsequent progress through the SET program. It is acknowledged that not all trainees will progress through specialty training for a variety of reasons, including aptitude and ability, and it is important these individuals are identified early to help them plan an alternative career as well as ensuring that future surgeons have the appropriate competencies to reach proficiency. Formal examinations can demonstrate a candidate's knowledge and what they are capable of doing (can do) but work-placed assessment is necessary to assess their performance (does do) or confirm they have the appropriate ability to reach proficiency.

Several assessment tools have been studied and the most accepted are modifications of those which have been around for years. These include clinical evaluation exercises such as the mini-CEX, peer assessment or 360 degree appraisal, case-based discussion and direct observation of surgical skills.

The mini-CEX (mini-Clinical Evaluation Exercise)
The direct observation of a junior doctor obtaining a history, carrying out a physical examination and outlining a management plan on one of their patients on the ward or in outpatients has been shown to be both valid and reliable. Structured checklists (Appendix1) are used for marking. It can be performed by a trainer or a senior Trainee, takes about 20 minutes and six-eight evaluations per annum have been shown to provide one of the most reliable and valid assessment available. The Postgraduate Medical Councils support its use for all medical graduates and hopes to see its full implementation. It is also being considered by medical schools and is being piloted by the AMC for International Medical Graduates.

Peer Assessment Tool or 360 Degree Appraisal (the mini-PAT)
This appraisal is already being used successfully by some of the nine specialties. It involves a wide spectrum of raters including surgical staff, nursing staff, anaesthetists, allied health professionals and hospital administration personnel, usually selected by the Trainee. The aggregate ratings can be compared with self-assessments and used to provide feedback on behaviour and skills as well as being used as part of overall assessment. An example is provided in Appendix 2.

Case-based Discussion (CBD)
This is a focused discussion on the doctor's recent entries in a patient's notes to explore clinical judgement and decision making. The focus of the discussion is on the actual record of the case and is not a viva style assessment. Published reports recommend four such assessments per annum by different assessors and it is said that this assessment takes about twenty minutes. It is strongly supported in the published literature and an example is provided in Appendix 3.

Direct Observation of Basic Surgical Skills (DOBS)
This refers to small and basic procedures and is primarily used during PGY1 and PGY2. It is unlikely to be feasible in the current working environment of a busy hospital.

Direct Observation of Procedural Skills (DOPS)
Direct observation of surgical skills in intermediate and advanced procedures has become a major tool for assessing surgical trainees, particularly in the United Kingdom where it has been developed to a sophisticated degree by Orthopaedics in particular. It can be used to assess either a part or the whole of the procedure including obtaining informed consent and a management plan. Multiple raters and assessments are necessary. This tool has gained increasing importance as an objective assessment of a Trainee's intra-operative technical and decision-making skills. An example is provided in Appendix 4.

Recommendations

Two tools are selected for discussion on the basis of their proved validity, reliability, and practicality as well as providing the most efficient outcome given the time involved.

1. The well validated mini-CEX should be considered for implementation as soon as it is feasible and a minimum of three should be required in any six month period with the ideal being four. Surgeons should also be encouraged to use this tool in PreSET to provide them with more robust and reliable assessment on which to base their reports.

2. Direct Observation of Procedural Skills should also be implemented and will provide more objective information on this aspect of a Trainee's competence and their achievement of proficiency.

3. Performing these assessments takes time and jurisdictions must acknowledge time is allowed for this in the surgeons' contracts

Educational or Learning Portfolios

Portfolios are used to facilitate professional development and provide evidence of self- directed learning and have now become a major part of the education and training of health professionals. They enable a Trainee to keep a personal record of their learning and assessment as well as the collection of evidence that certain required competencies have been acquired. In some countries, those applying for training are required to bring their portfolio folder to interviews where they are reviewed. The literature on educational portfolios is extensive and the following is a list of the most common items included in a portfolio:

Photo-ID
Certificate of full medical registration or copy
Copies of all professional qualifications
Curriculum vitae – up to date
Evidence of courses attended
Evidence of formal examinations passed
Logbook of clinical activity
Copies of workplace assessments
Copies of posters, presentations, abstracts, and publications
Paperwork to support personal audit
Signed/verified references where available
Evidence of posts worked as on an application form
Evidence of competencies cited
Trainers' reports if available
Evidence of reflective practice

It has recently been recommended in the United Kingdom and the United States that a portfolio should contain brief details of any significant behavioural or other problems which may have occurred either in medical school or subsequently. There is now clear evidence that such issues in medical school or during subsequent training predict subsequent problems. The appropriate and legally acceptable way to do this requires further research but it is noteworthy that the British General Medical Council and some American States now support this requirement.

Recommendation

The use of learning portfolios should be further explored given the major contribution they make to a Trainee's learning.

Selection into Specialist Surgical Training (2006)

Table 1: Number of specialties using each selection tool, the number required and the % of the total score (weighting) allocated

Selection Tools	Number of Specialties using this tool	Number Required	Weighting (%) of total selection score
Referees reports	6	2-6	10-50
Employer (hospital) reports	3	1-2	?
Professional Performance Appraisals (PPAs)	4	3-5	25-50
Curriculum Vitae	9	1	10-30
Research presentation	1 (+NZ Gen Surg)	1 (+1)	10 (30)
"Section Connection Questionnaire	1	1	7.7
Interview	9	1-2	15-55

Selection into Specialist Surgical Training (2006)

Table 2: % of total score (weighting) allocated by each specialty to the different selection tools

	Candidate Report Information					
Surgical Specialty	**Written Referee's Report**	**Professional Performance Appraisal**	**Hospital Assessment Report**	**Curriculum Vitae**	**Interview**	**Research Presentation**
Cardiothoracic	20	25	-	15	40	-
General (Aus)	40	-	✓*	30	30	
General (NZ)	15	-	-	20	25	30
Neurosurgery	35	-	-	25	40	
Orthopaedics	50	-	✓#	20	30	-
OHNS	-	40	-	20	40	
Paediatrics	10	30º	-	18	32	10
Plastic RS	-	50	-	25	25	-
Urology☼	30	-	-	15.5	46	-
Vascular	-	35	-	10	55+	-
Mean	28.6	36		20	36	
Basic Surg Training	40		8	12	40	

* Contributes to minimum selection criteria but not to total weighted score.

May be combined with written referee report.

º Negative marking used.

+ Vascular specific 20%; semi-structured 35%.

☼ Urology adds 8% for "Section Questionnaire"

APPENDIX 1

RACS - Mini-Clinical Evaluation – Assessment Form

Surname ..... First name……..

Assessment date……. iMIS ID number..... (if a RACS Trainee)

Level ☐ PreSET ☐ SET1 ☐ Other

Specialty: ☐ Cardio ☐ General ☐ Neuro ☐ Ortho ☐ OHNS ☐ Paed ☐ P&RS ☐ Urol ☐ Vasc

Hospital .....

Clinical setting:
☐ ICU ☐ Emergency Department ☐ Other ……..

Type of case: ☐ New case ☐ Follow-up

Focus of clinical encounter: ☐ History ☐ Diagnosis ☐ Management ☐ Explanation

Complexity of case: ☐ Low ☐ Average ☐ High

Assessor's position: ☐ Consultant: ..... ☐ Other health care professional: .....

Please assess and mark the following areas:	Below expectations for level of training	Borderline	Meets expectations	Above expectations for level of training	Not observed / not applicable
1. History taking					
2. Physical Examination					
3. Communicates to patients (and their family) about procedures, potentialities, and risks to encourage their participation in informed decision making					
4. Adjusts the way they communicate with patients for cultural and linguistic differences and emotional status					
5. Recognises what constitutes 'bad news' for patients (and their family) and communicates accordingly					
6. Recognises the symptoms of, accurately diagnose, and manage common problems					
7. Professionalism					
8. Organisation / Efficiency					
9. Overall Clinical Care					

Suggestions for development
……
……
Other comments
……
Agreed action……

Assessor's signature: ……..... Assessor's name…….....

Signature of person being assessed ……

APPENDIX 2

RACS – 360-Degree Survey Form

Surname ..... First name……

Assessment date…… iMIS ID number..... (if a RACS Trainee)

Level ☐ PreSET ☐ SET1 ☐ Other

Specialty: ☐ Cardio ☐ General ☐ Neuro ☐ Ortho ☐ OHNS ☐ Paed ☐ P&RS ☐ Urol ☐ Vasc

Hospital.....

Clinical setting/hospital post .....

Instructions

Please rate this doctor in comparison to other doctors with whom you have worked. Circle one number per item where **1** is the lowest rating and **5** is the highest rating. If you have insufficient contact with the doctor to evaluate him/her on a particular characteristic, circle **UE** (Unable to Evaluate)

1 – Below expectations for this competence – Unsatisfactory

2 – Performance in this competence is Borderline

3 – this doctor demonstrates competence in this characteristic – satisfactory performance

4 – Above expectations for this competence – Proficient performance

5 – Performance in this competence is Outstanding

UE – unable to evaluate this characteristic

Technical Expertise

Technical Skills					
1	***2***	***3***	***4***	***5***	***UE***
Requires development of technical skills				Proficient technical skills	

Communication

Communication with patients					
1	**2**	**3**	**4**	**5**	**UE**
Communication skills require development				Communicates very well with patients	

1	***2***	***3***	***4***	***5***	***UE***
Communication skills with Peers requires development				Communicates very well with Peers	

Able to resolve misunderstandings or disagreements					
1	**2**	**3**	**4**	**5**	**UE**
Never					Always

Collaboration

Working in a multidisciplinary team					
1	***2***	***3***	***4***	***5***	***UE***
tends to work all, rarely collaborates				Always collaborates as appropriate	

Consults with other disciplines and appropriately refers					
1	***2***	***3***	***4***	***5***	***UE***
Consultation with colleagues or other professionals infrequent				Always consults and refers as appropriate	

Leadership					
1	***2***	***3***	***4***	***5***	***UE***
Rarely provides leadership				Outstanding team leader. Leads by example.	

Management and Leadership

Respectful of expertise of others					
1	***2***	***3***	***4***	***5***	***UE***
Shows less than expected respect for peers				Always respectful of others	

Directs and supervises other team members including medical students appropriately for level of expertise					
1	***2***	***3***	***4***	***5***	***UE***
Rarely manages or supervises more junior team members			Manages junior team members very effectively		

Health Advocacy

Commitment to improve health outcomes for patients					
1	***2***	***3***	***4***	***5***	***UE***
	Rarely		**Consistently**		

Scholar and Teacher

Recognises value of learning and research and it's application to clinical practice					
1	***2***	***3***	***4***	***5***	***UE***
	Rarely		Consistently		

Professionalism

Consistently applies ethical principles					
1	***2***	***3***	***4***	***5***	***UE***
Inconsistent					Always ethical

Integrity and reliability					
1	***2***	***3***	***4***	***5***	***UE***
Does not meet commitments, may be late, not always reliable				Always h1st and trus2rthy Always reliable	

Acknowledge own limitations					
1	***2***	***3***	***4***	***5***	***UE***
Rarely acknowledges own limitations Does not admit mistakes				Always acknowledges limitations Always learns from mistakes	
Responsibility					
1	***2***	***3***	***4***	***5***	***UE***
Rarely accepts responsibility for own actions and decisions			Fully accepts responsibility for own actions and decisions. Never blames others.		

Critically reflective of own knowledge and skills					
1	***2***	***3***	***4***	***5***	***UE***
Reflective approach needs development				Appropriately aware and self critical	

Collation of 360 reports

Name (of Trainee/Surgeon being appraised)…….

Responses from the Survey are collated and compared with the individual's own appraisal prior to the meeting between the individual and their Supervisor. Indicators of potential issues arise if there is more than one respondent who rates the individual four or lower on an item, or where there is two or more points difference between the individual's own rating and that of the majority of the responses.

The following example of a tally sheet shows that the Trainee consistently rates themselves higher than the other assessors and that there are several areas of concern.

Example showing sections of a Summary Sheet 10 respondents plus the individual (T)

	1	**2**	**3**	**4**	**5**	**UE**
Technical Expertise		6	4	T		
Communication with patients		2	3	3	T	2
Collaboration – working in a multidisciplinary team	5	5		T		
Management and Leadership	4	3	3		T	
Professionalism – Integrity and reliability		5	4	1 / T		

APPENDIX 3

RACS – Case-Based Discussion (CBD) Assessment Form

Surname ..... First name……

Assessment date…… iMIS ID number..... (if a RACS Trainee)

Level ☐ PreSET ☐ SET1 ☐ Other

Specialty: ☐ Cardio ☐ General ☐ Neuro ☐ Ortho ☐ OHNS ☐ Paed ☐ P&RS ☐ Urol ☐ Vasc

Hospital.....

Clinical setting described: ……

Type of case /problem: ……..……..

Complexity of case: ☐ Low ☐ Average ☐ High

Assessor's position: ☐ Consultant ☐ Other health care professional……..

Please assess and mark the following areas:		Below expectations for level of training	Borderline	Meets expectations	Above expectations for level of training	Not observed / not applicable
1.	Diagnostic skills					
2.	Communication with patients demonstrates sensitivity to their physical, social, cultural, and psychological needs					
3.	Recognises the most common disorders and differentiate those amenable to operative and non-operative treatment					
4.	Manages the care of patients with trauma including multiple system trauma					
5.	Identifies and manages complications of operative procedures and the underlying disease process					
6.	Identifies and manages risks including planning for risk management					
7.	Indicates alternatives in the process of interpreting investigations and in decision making					
8.	Considers all issues relevant to the patient and differentiates between health care delivery resource and individual patient needs to prioritise needs and demands					
9.	Selects appropriate investigative tools and monitoring techniques in a cost-effective, and useful manner					
10.	Critically evaluates the advantages and disadvantages of different investigative modalities					
11.	Appraises and interprets results of investigations against patients' needs					
12.	Maintains accurate and complete clinical records					
13.	Identifies ethical expectations that impinge on medico-legal issues					
14.	Assumes responsibility for own on-going learning					
15.	Is accountable for their decisions and actions					
16.	Overall clinical judgement					

Suggestions for development

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……

……

……

Other comments
……
……

Agreed action:
……
……

Assessor's signature: …… Assessor's name……...

Signature of person being assessed .....……

APPENDIX 4

RACS – Direct Observation of Procedural Skills (SURGICAL DOPS) Assessment Form

Surname ..... First name……..

Assessment date…… iMIS ID number..... (if a RACS Trainee)

Level ☐ PreSET ☐ SET1 ☐ Other

Specialty: ☐ Cardio ☐ General ☐ Neuro ☐ Ortho ☐ OHNS ☐ Paed ☐ P&RS ☐ Urol ☐ Vasc

Hospital.....

Clinical setting:
☐ Theatre ☐ ICU ☐ Emergency Department ☐ Other .....

Name of procedure: …….....

Difficulty of procedure: ☐ Easier than usual ☐ Average ☐ More difficult than usual

Number of times this procedure has been performed by this Trainee prior to this occasion ……

Assessor's position: ☐ Consultant ..... ☐ Other health care professional……

Please assess and mark the following areas:		Below expectations for level of training	Borderline	Meets expectations	Above expectations for level of training	Not observed / not applicable
1.	Explains the procedure and complications to the patient and obtains patient's informed consent					
2.	Prepares for procedure according to an agreed protocol					
3.	Demonstrates good asepsis and safe use of instruments/ sharps					
4.	Performs technical aspects competently					
5.	Demonstrates manual dexterity required to carry out procedure					
6.	Adapts procedure to accommodate patient and/or unexpected events					
7.	Is aware of own limitations and seeks help when appropriate					
8.	Completes required documentation (written or dictated)					
9.	Analyses their own clinical performance for continuous improvement					
10.	Overall ability to perform whole procedure					

Suggestions for development
……
……
Other comments
……
……
……

Agreed action:

……

Assessor's signature: ……..... Assessor's name…….....

Signature of person being assessed .....

Attachment 6 Proforma for Managing an Underperforming Trainee

PERFORMANCE MANAGEMENT OF SPECIALIST … SURGICAL TRAINEE

Timely remediation of deficiencies in performance is more likely to result in improved training outcomes for the Trainee. The purpose of the "Performance Management" form is to assist a Trainee in improving his/her performance, where one or more significant deficiencies in performance have been identified. The form may be regarded as a performance contract. Details entered into the form must be discussed between the Trainee and the Supervisor and the performance management process should be mutually agreed to by the signatories. There must be regular evaluation of the Trainee's performance, referenced to this form, thereby allowing a measured assessment of progress made by the Trainee. The performance management process and its outcome must remain strictly confidential.

GUIDING NOTES

Objectives

- List the specific performance objective that the Trainee is required to meet.
- Do not combine objectives – list them separately if required.
- Objectives must be consistent with the training requirements and expectations of the Specialist --- Surgical Training Program, and must be referenced accordingly.

Strategies to Meet Objectives

- It is useful to list as many strategies as is appropriate to guide the Trainee in meeting an objective.
- Describe all appropriate methods by which the objective can be met.
- Specifically, describe how the Trainee should be expected to behave / perform.
- Specifically, describe what reasonable supports will be provided to assist the Trainee.
- Ensure strategies are appropriate to the objective and to the work and training conditions.

Performance Indicators

- An indicator should be considered as an outcome that measures whether a performance objective is being met.
- Indicators must therefore be consistent with the specified objective and defined strategies.
- List as many indicators as is appropriate to guide the Trainee in meeting an objective.
- Performance indicators should include reasonable time frames.
- Performance indicators may be used to verify to what extent a Trainee has met an objective.

PERFORMANCE MANAGEMENT OF SPECIALIST ---- SURGICAL TRAINEE

Outcomes

Note these must correspond with competency requirements as defined in the In-training Assessment Form

- A performance management period covered by this form must be specified and should be sufficient to allow performance objectives to be met.
- The overall performance of a Trainee will be formally assessed at the completion of the review period – this date is to be set prior to commencing the performance management process.
- The overall performance of a Trainee for each performance objective will be rated according to the criteria tabled below.
- It is imperative that both the Trainee and the Supervisor are familiar with the criteria.
- Taking into account the outcome of performance management, continuation of a remediation process will be determined by the Board in …. Surgery

Outcome Rating	Criteria
NOT MET	**Requires repeated prompting or guidance to achieve objective or meet performance indicators. -Significant omissions or errors in achieving objective or in meeting performance indicators.**
MET	- Independently achieves objective and meets all performance indicators. - Minor or no omissions or errors in achieving objective or in meeting performance indicators.
EXCEEDED	- Independently exceeds objective and performance indicators. - No omissions or errors in achieving objective or in meeting performance indicators.

PERFORMANCE MANAGEMENT OF SPECIALIST …. SURGICAL TRAINEE

The example below addresses a significant problem of time management (specifically about appropriate task organization and prioritisation.).

The strategies describe various approaches to ensure the Trainee participates in those activities central to the Trainee's role as a junior registrar, and ensuring that adequate support is provided.

The performance indicators reflect whether the Trainee is meeting the primary performance objective by defining specific activities that assist in time management. This may be prescriptive if required. If the Trainee is able to achieve all or most of the performance indicators with minimal prompting, guidance, omissions or errors, the Trainee may be assessed as having "Met" the performance objective at the completion of the review period.

OBJECTIVE	STRATEGIES TO MEET OBJECTIVE	PERFORMANCE INDICATORS	OUTCOME
Effective time management (task organisation and prioritisation)	• Be familiar with unit weekly timetable and schedule of outpatients, elective operating lists, ward rounds, unit meetings. • Punctual arrival at morning ward rounds. • Attend entire ward round with resident staff. • Liaise with senior registrar in determining daily patient management plan – prioritise where required. • Delegate ward administrative tasks to resident and clerical staff. • Divide attendance at operating lists with senior registrar. • Maintain elective operation booking diary – liaise with booking clerk to review up to date waiting list. • Punctual attendance at operating sessions. • Liaise with consultant about patient progress. • Maintain surgical unit audit database. • Share medical student tutorial sessions with senior registrar – coincide tutoring with when not allocated to attend elective operating session.	• Obtain, read and be familiar with surgical unit policy manual by 22-07-05. • Meet senior registrar at 0730 for daily ward round in HDU. • Confirm priority of patient care tasks with senior registrar after each ward round. • Communicate task requirements to resident staff after each ward round. • Assign elective operating sessions to either junior or senior registrar every Monday (must note in operating diary). • Meet with booking clerk each Wednesday to schedule elective operations one month in advance. • Discuss elective operation bookings at Monday morning unit meeting. • Meet with consultant surgeon 10 minutes prior to commencement of each operating session – discuss patient progress. • Complete all audit database entries within 24 hours of each operation (unit head to verify at weekly unit meeting). • Submit and discuss six month unit surgical audit at unit meeting on 12-09-05. • Present six month audit at divisional meeting on 19-09-05. • Conduct medical student tutorials every fortnight – submit tutorial topic to unit head one week in advance.	

PERFORMANCE MANAGEMENT OF SPECIALIST … SURGICAL TRAINEE

- The performance objective(s), related strategies and performance indicators in this form have been discussed between the Trainee and the Supervisor.
- The performance objective(s), related strategies and performance indicators reflect the expected and required responsibilities and performance of the Trainee, consistent with the Specialist … Surgical Training Program.
- The performance objectives are achievable under the conditions of the work and training environment.
- The Trainee and supervisor will regularly meet to review the Trainee's progress with the performance objectives.
- The Trainee and supervisor are required at all times to openly and actively engage in the performance management process.
- At the completion of the performance management period, the performance of the Trainee will be rated according to the defined outcome criteria.
- All performance indicators for each performance objective are to be completed in order to meet the performance objective.

Performance management start date	
Performance management end date	
Frequency of review meetings	
Next formal performance review date	
Name of Trainee	
Signature of Trainee	
Date	
Name of Supervisor	
Signature of Supervisor	
Date	

Attachment 7 Governance of SET

Draft discussion document by Ian Gough. 11/12.06.

We need to consider governance in the transition phase while BST exists and in the future when BST has been completed (2010).

BBST will continue while BSTs need governance and this is likely to be until the end of 2010.
BBST will supervise BST training and examinations as is done currently.
BBST will have an important role in collaborating with Specialty Boards in the development of the content of nine new Basic Science Examinations and it is suggested that the BBST administers and assesses (marks) all nine BSEs. BBST will administer and assess the OSCE that all specialties have indicated will continue in its current generic form.

BBST will administer the courses that are currently provided (ASSET, CCrISP, EMST, CLEAR) and will work with the ASSET committee to develop the new Basic ASSET course. The expansion of Skills courses for other purposes e.g. technical and non-technical competencies will be an area of significant demand and growth.

The role of the College and Specialty Boards in regard to communication with PreSETs (this does not mean governance) requires further discussion. It is suggested that BBST might be the first point of contact for enquiry and counselling and more specific enquiry would be referred to the relevant Specialty Board. Another function is the development of Personal SET Portfolios for trainees and BBST may have expertise in this area that might lead to a common portfolio format for all specialties.

In summary BBST will govern BSTs, BSEs, OSCEs, existing courses and the development of new skills courses.
BBST will collaborate with Specialty Boards in administration of PreSET enquiries and Personal SET Portfolios.

SET1 is part of SET and therefore will be governed by Specialty Boards reporting to BSST. This relates specifically to the selection, supervision and assessment of trainees. As noted above BBST will provide courses and examinations.

In the future the role of BBST will probably evolve into provision of SET1 Examinations and courses for the acquisition of skills and competencies and we will think of a new name.
BSST will probably continue with new name of BSET and its role will be governance of all of SET1-5+ and IMGs.

The roles of the Fellowship Examination, IMG assessment, EDRD and Education Board will continue with no need for significant revision at this stage.

Attachment 8 SET Development Time-Line

	Key Tasks and Activities
2006	
June	Education Board established the SET Working Party
	First meeting of SET Working Party
	Each Specialty Board to define what they mean as competent and how the period of time they require for training, justified in terms of both education and training.
July	Develop a model of the transition process incorporating the numbers of current BST and SST trainees
	Two meetings of SET Working Party
	All Board Chairs review their proposed SET program in light of the revised schema
	The Executive Committee of Council recommended that the SET program will commence registration for PreSET and selection into SET in 2007 and that SET1 will therefore commence in 2008.
August	Meeting of SET Working Party
September	Meeting of SET Working Party
	Consultation with the Health Workforce Principle Committee
October	Consultation with the Directors of Medical Services and Health Administrators
	Meeting of SET Working Party
	Begin regional consultation meetings
November	Finalise 20 page Overview of SET in light of feedback from Regional Consultation
	Meeting of SET Working Party
December	Approval of revised draft of 20 page Overview for Council
	Meeting of SET Working Party
	Prepare a discussion paper on governance of SET
	Prepare a discussion paper on Selection for SET
2007	
January	Opening of PreSET with on-line registration
	Opening of on-line Registration for Selection into SET
	Invite expressions of interest from accredited hospitals for SET1 positions
February	To prepare further documentation on reliable approaches to selection, consistent with the BSST selection policy
	Meeting of SET Working Party
	Define the process for paper accreditation of SET1 positions
March	Finalisation SET Accreditation Document for AMC
	Define what trainees would be expected to include in their Personal SET Portfolio
	Clear definition of SET1 positions
	Meeting of SET Working Party
	Discussion on the defining of minimum criteria for progress to interview
	Second round of regional meetings
April	SET applications with on-line application capacity
	Meeting of SET Working Party
May	Supervisor Training program to be launched at the ASC in Christchurch
June	Meeting of SET Working Party

July	Selection to SET completed
August and beyond	SET Working Party Meetings arranged as required
	College staff work on developing standardised selection tools for 2008
2008	
January	Trainees selected into SET1 & SET2 commence training
	Opening of on-line registration for selection for 2009
	Continuing SST trainees are re-named SET trainees
	BST trainees continue
October	First specialty specific SET1 examinations