Royal Australasian
College of Surgeons

Select for Rural

Rural Health Equity Strategy
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Select for Rural: SET Selection and Rural Surgical Workforce

HOW COULD SET SELECTION CONTRIBUTE TO IMPROVING HEALTH OUTCOMES FOR RURAL PEOPLE?

The Rural Surgery Section Committee provides the following information and invites the Board of Surgical Education and Training, in partnership with the Specialty Training Boards and societies, to consider how they can contribute to ensuring a future sustainable rural surgeon workforce. There are three phases of a surgical career that impact on long term rural service and where we can have an impact on increasing surgical care for rural patients: Select for Rural, Train for Rural, Retain for Rural.

This paper focuses on selecting for rural workforce. Of the three phases, selection has the longest timeframe to yield results, is the least complex to address and requires the least input of resources to achieve. It’s a good place to start.

This paper uses the term “rural” to cover rural, regional, and remote or non-metropolitan.

1 Overview

WHAT’S THE PROBLEM?

Rural people have worse health outcomes that urban people [1], including a 1.1 to 1.4 times higher mortality rate, 2.4 times higher potentially avoidable death rate and up to 13 years shorter life expectancy, compared to urban areas. Rural people have poorer access to healthcare workers, including surgeons. 29per cent of Australians are Rural (defined as MMM2-7) [2] and 15per cent of the population of New Zealand are Rural [3], but only 12per cent of surgeons live and work rurally. A further 18per cent of urban specialists provide intermittent rural outreach services. The 2018 RACS census showed that for five of the nine surgical specialties, less than 5per cent of surgeons were based outside cities [4].

The way we select and train specialists has unintended consequences for rural people. 30per cent of medical students, on entry to medical school, intend to practice in a rural or underserved area in the long term [5]. Following specialist training, only five per cent of all specialists do. Selection rules can unintentionally favour urban Trainees and urban focused training programs convert rural intention students to urban specialists. Conversely, positive rural exposure for urban origin students and Trainees is strongly associated with urban to rural conversion [6], with increased rural recruitment and long-term retention.

WHAT’S THE EVIDENCE?

Three factors are known to strongly and independently increase rural recruitment and long-term retention of rural doctors: rural origin, rural medical school experience and positive post graduate rural work exposure.[7] [8] [9] [10] [11] [12].

The Australian Government introduced the Rural Health Multidisciplinary Training Program to increase the rural health workforce. Since 2002, 25per cent of all students admitted to medical school must be of rural origin, 25per cent of medical students must complete at least one year in a rural location, a further 50per cent must complete at least four weeks rural placement and all students must be offered the opportunity to undertake a rural placement. [13] The Medical Deans of Australia and New Zealand include rurality in their policies for selecting for diversity and report rural representation within their student population. [14]The Australian Government, via the National Medical Workforce Strategy [15], is looking to the medical colleges to further the promotion of rural recruitment and retention, through their selection and training practices.

Several RACS training boards have already implemented selection policies to support rural workforce, including the boards in General Surgery and ASOHNS [16] [17] [18]. Other speciality colleges have similar policies. [19]

Unintended consequences of surgical selection and training can include requiring predominantly urban work experience to satisfy selection criteria, increased cost for rural SET applicants (travel costs, more time off work to attend interviews) and selection biases due to lack of rural representation on training boards and interview panels.

IS THIS OUR CORE BUSINESS?

The Rural Surgery Section committee's objectives[20] include:

a) to ensure the provision of quality surgical care to the populations of regional, rural, and remote areas of Australia and New Zealand
b) to advise and assist RACS with workforce issues relating to the provision of surgical services including recruitment, retention, training, and support for surgeons working in regional, rural, and remote Australia and New Zealand

The Surgical Education and Training SET program objective:

The overall objective of the SET Program is to produce competent independent specialist surgeons with the experience, knowledge, skills, and attributes necessary to provide the communities, health systems and professions they serve with the highest standard of safe, ethical, and comprehensive care and leadership.

Australian Medical Council and Medical Council of New Zealand

Rural selection initiatives satisfy the accreditation requirements of the Australian Medical Council [21] and the Medical Council of New Zealand [22]. The Australian Medical Council, Standards for Assessment and Accreditation of Primary Medical Programs 2015, Standard 7[23], requires that specialist training program selection supports recruitment and selection of Aboriginal and Torres Strait Islander and/or Maori Trainees and Trainees from rural areas.

Rural selection initiatives are consistent with the RACS Strategic Plan, Code of Conduct, Diversity and Inclusion Plan, position papers (Equity of access to surgical care, Rural surgery), terms of reference for training boards and SET selection policies.[24]

FAIRNESS

Rural selection initiatives were considered legitimate by the authors of the Brennan Report [25]: Various Colleges have already made statements in relation to gender and rurality. It would be appropriate to state these as principles particularly if an affirmative weighting is to be applied during the selection process. Some disciplines give an affirmative weighting to applicants with research experience, others have determined that a prescribed period of training in a rural setting is mandatory. These principles are perfectly legitimate. Problems only arise when certain principles that impact on selection, are not declared or are only known to a select few.

Part of fairness in selection criteria is advertising the criteria in advance, to allow aspirants to plan their preparation. Rural origin and rural medical school experience are already completed prior to an applicant commencing basic surgical training and could be implemented within 12 months. Notifying of selection points for rural training experience would disadvantage pre-SET Trainees who intend to apply within 12-24 months and so would need to be forecast to commence in 24 months.

WHAT ARE THE UPSIDES OF SELECTING FOR RURAL?

1. Increasing the rural surgical workforce, improving health outcomes for rural people.
2. High calibre SET applicants; graduates of rural medical school have equivalent or superior academic results [26] [27]. Pre-SET rural doctors have more opportunities to gain procedural skills [28], more direct consultant supervision and may enter surgical training with superior skills [29].
3. Potential efficiencies and reduced cost in administering the SET application process.
4. Equity of access to SET selection and training would be increased for remote and rural junior doctors, already living, working, and committed to rural practice[30]

2 How can we select for rural?

The Board in Surgical Education and Training, in partnership with the Speciality Training Boards, could consider the following options. All options operating at once, with a parallel Rural Selection initiative would have the greatest impact. Definitions suggested evidentiary documents and precedents for each option are included in the appendix.

SET SELECTION REQUIREMENTS AND SCORING CRITERIA

1. Award selection points for
   a. Rural origin
   b. One or more years of rural medical school experience
   c. One or more years of rural pre-SET work exposure [31] [32] [33]
   d. Noting that points for all three will be more powerful than one element only.

2. Be alert to unintended consequences of selection criteria that require predominantly urban work experience and therefore disadvantage rural origin and rural work location applicants, for example, higher degrees only obtainable from urban universities and referees exclusively from specialties only encountered in tertiary referral centres or units only accessible in urban hospitals.
   a. Reduce points for these items or balance them with equivalent points for rural origin, medical school or work exposure.
   b. Examples of equitable scoring are included in the Australian Board in Plastic and Reconstructive Surgery SET Selection guide, where virtual and physical attendance at meetings receive equivalent scores and mixed rotations are scored, pro rata, as plastics experience (mixed terms, for example plastics combined with ENT or urology or general surgery, are more common in rural settings).
   c. Counter the perception that junior doctors need to stay in urban hospitals to be successful in SET applications. Communicate to junior doctors that rural origin and rural work experience will not disadvantage their SET application and may increase their experience and skills, and ensure surgeons reinforce this message when mentoring.

3. Adopt the RACS Aboriginal and Torres Strait Islander Surgical Trainee Selection Initiative (6 of 13 training boards have already adopted the selection initiative: NZOA award selection points for fluency in Te Reo Maori) (ETA-SET-046)

4. Develop a Rural SET selection initiative, analogous to the Aboriginal and Torres Strait Islander Selection Initiative,
   a. with quarantined positions (30per cent of positions for population parity or 12per cent for RACS parity, or one position, for training programs with seven or less positions available)
   b. for applicants reaching the minimum selection standard plus being all three of rural origin, 12 months of rural medical school and 12 months of pre-SET rural experience.
   c. a Remote Central and Northern Australian Selection (RCANS) Initiative, operating within a Rural Selection Initiative, would help address rural workforce in the areas of Australia most in need. See the Collaborate for Rural paper for more information on RCANS).

RURALITY AS A DIVERSITY ELEMENT

The RACS terms of reference for training boards recommends co-option for diversity, including geographic diversity [34], to realise the "positive benefits of diverse membership". The interpretation of geographic diversity can be expanded to include all states and territories and rural representation. Including rurality as a diversity element on training boards counters the urban bias inherent in positions being occupied by state chairs of regional training committees, the majority of whom work in urban settings. Rural representation could be proportionate to national population levels (29per cent Australia, 15per cent New Zealand) or RACS Fellowship levels (12per cent) [35]. In specialties with rare rural members, a surgeon who is actively involved in rural outreach could stand in (Rural Focused Urban Specialist - RUFUS).

INTERVIEWS

1. Virtual selection interviews or interviews in every state and territory, to reduce barriers to access to SET selection activities and providing the same SET selection environment for all applicants.

2. Situational interviewing rewarding applicants who demonstrate "the ability to… respond to the health needs of the community", through interview questions pertaining to equity of access and health outcomes for rural and other underserved communities (AOA).[36]

EVALUATION OF THE 'SELECT FOR RURAL' INITIATIVE

To assess if a Select for Rural initiative were effective in increasing rural surgical workforce, the data gathering on practice location could be utilised. This would come at no extra cost as it already collected via the RACS census survey.

If the process were implemented today, it would take at least five years to assess change in recruitment of surgeons to rural practice, 10 years to assess change in midterm retention and 20 years to assess change in long term retention (defined as more than 15 years).

Appendix

Definitions

Rural

Australian definition:

Note that the Federal Department of Health is moving to use the Modified Monash Model for medical workforce, rather than the Australian Statistical Geography Standard. For now, both models are used.

1. Rural area, defined by the Australian Statistical Geography Standard – Remoteness Areas (ASGS-RA) 2 to 5
    a. *https://www.health.gov.au/health-topics/health-workforce/health-workforce-classifications/rural-remote-and-metropolitan-area*
2. Modified Monash Model, where MM1 is urban and MM7 is remote
    a. https://www.health.gov.au/health-topics/health-workforce/health-workforce-classifications/modified-monash-model

New Zealand definition:

1. Urban Rural Profile Classification (rural areas with high, moderate, or low urban influence and highly rural/remote areas)
    a. https://www.stats.govt.nz/assets/Uploads/Methods/Urban-accessibility-methodology-and-classification/Download-document/Urban-accessibility-methodology-and-classification.pdf

Australian Federal Government Rural Health Multidisciplinary Training Program

(http://www.health.gov.au/internet/main/publishing.nsf/content/rural-health-multidisciplinary-training

Core requirements:

2a. A number of Australian medical students equivalent to at least 25 per cent of the university's Commonwealth-supported medical student allocation must undertake a minimum of one year of their clinical training in a rural area, defined by the Australian Statistical Geography Standard – Remoteness Areas (ASGS-RA) 2 to 5.

2b. The university must ensure that all Commonwealth-supported medical students have an opportunity to undertake a structured rural placement (ASGS-RA 2-5). At least 50 per cent of these students must complete a rural training experience of at least 4 consecutive weeks during their degree course.

2c. A number of Australian medical students equivalent to at least 25 per cent of the University's Commonwealth-supported medical student allocation must come from a rural background, defined as residency for at least 10 years cumulatively or any five years consecutively in an ASGS-RA 2-5 area.

Documenting Evidence of Rural Origin and Rural Work Experience

1. Health workforce locator tool for assessing rurality or remoteness of Australian address https://www.health.gov.au/resources/apps-and-tools/health-workforce-locator?utm_source=doctorconnect.gov.au&utm_medium=redirect&utm_campaign=digital_transformation&utm_content=%2Finternet%2Fotd%2Fpublishing.nsf%2FContent%2Flocator

2. Rural origin
    a. University of Sydney Doctor of Medicine, Domestic Admissions Guide, rural origin facilitated entry scheme P18-21

https://www.sydney.edu.au/content/dam/corporate/documents/faculty-of-medicine-and-health/guides/md-dmd-domestic-admissions-guide.pdf

   b. ASOHNS *SET Selection Rural Origin CV Marking Criteria for the 2021 intake* https://www.surgeons.org/become-a-surgeon/how-do-i-become-a-surgeon/set-selection-requirements-process-and-application/specialty-specific-eligibility-criteria-selection-processes/otolaryngology-head-and-neck-surgery-australia rural medical school experience

3. Rural Medical School placement
   a. Letter from Dean of Medical School specifying location and duration of rural placement

4. Proof of rural work experience and acceptable rural and remote practice locations
   a. Letter, on letterhead, from the hospital Director of Medical Services or Human Resources specifying location and duration of rural placement.
   b. NZBIGS SET program in General Surgery Selection Regulations for 2020 intake 4.4.8 and 4.4.9, listing eligible hospital placements
   c. AUSBIGS SET program in General Surgery Selection Regulations for 2020 intake, appendix 2 Rural Hospitals

REFERENCES

[1] Australian Institute of Health and Welfare. Australia's health 2018 [Internet]. 2018. Available from: https://www.aihw.gov.au/getmedia/0c0bc98b-5e4d-4826-af7f-b300731fb447/aihw-aus-221-chapter-5-2.pdf.aspx

[2] Australian Bureau of Statistics. 3218.0 - Regional Population Growth, Australia, 2018-19 [Internet]. Available from: (ABS 3218.0 - Regional Population Growth, Australia, 2016-17).

[3] StatsNZ. Defining Urban and Rural New Zealand [Internet]. Available from: http://archive.stats.govt.nz/browse_for_stats/Maps_and_geography/Geographic-areas/urban-rural-profile/defining-urban-rural-nz.aspx

[4] Royal Australasian College of Surgeons. 2018 Surgical Workforce Census Summary Report [Internet]. 2019. Available from: https://www.surgeons.org/government/workforce-and-activities-reports/

[5] Medical Deans Australia and New Zealand. 2019 Medical School Outcomes Database National Data Report [Internet]. 2019. Available from: https://medicaldeans.org.au/priorities/workforce/

[6] Hughes D, Williams JAR, Brooks JV. Movers and Stayers: What Birthplaces Can Teach Us About Rural Practice Choice Among Midwestern General Surgeons. J Rural Health [Internet]. 2020; Available from: http://ezproxy.surgeons.org/login?url=http://ovidsp.ovid.com/ovidweb.cgi?T=JS&MODE=ovid&PAGE=titles&NEWS=n&D=emef&AUTOALERT=267336108per cent7c1

[7] Kumar S, Clancy B. Retention of physicians and surgeons in rural areas—what works? J Public Health. 2020 Mar 5 https://doi.org/10.1093/pubmed/fdaa0310

[8] World Health Organization. Increasing access to health workers in remote and rural areas through improved retention Global policy recommendations [Internet]. 2010. Available from: https://www.who.int/hrh/retention/guidelines/en/

[9] Grobler L MBJ, Mabunda S. Interventions for increasing the proportion of health professionals practising in rural and other underserved areas. Cochrane Database Syst Rev [Internet]. 2015;(6). https://doi.org//10.1002/14651858.CD005314.pub3

[10] Chong A, Kiroff G. Preparing surgeons for rural Australia: the RACS Rural Surgical Training Program. ANZ J Surg [Internet]. 2015;85(3):108–12. https://onlinelibrary.wiley.com/doi/abs/10.1111/ans.12880

[11] Eley DS, Synnott R, Baker PG, Chater AB. A decade of Australian Rural Clinical School graduates--where are they and why? Rural Remote Health. 2012;12:1937

[12] Playford D, Ngo H, Gupta S, Puddey I. Opting for rural practice: the influence of medical student origin, intention and immersion experience. Med J Aust. 2017;207:154–8.

[13] Australian Government Department of Health. Rural Health Multidisciplinary Training (RHMT) Program 2019 – 2020 Framework [Internet]. 2020. Available from: https://www1.health.gov.au/internet/main/publishing.nsf/Content/rural-health-multidisciplinary-training

Definition of rural origin: see 2c

[14] Medical Deans Australia and New Zealand. Selection Policy Statement [Internet]. 2016. Available from: https://medicaldeans.org.au/resources/policies-and-statements/

Medical Deans Australia and New Zealand. Policy Position on Rural/Regional Student Representation in Medical School [Internet]. 2013. Available from: https://medicaldeans.org.au/resources/policies-and-statements/

[15] Australian Government Department of Health. National Medical Workforce Strategy [Internet]. Available from: https://www1.health.gov.au/internet/main/publishing.nsf/Content/Healthper cent20Workforce-nat-med-strategy

[16] Board in General Surgery New Zealand Association of General Surgeons. Selection Regulations: 2019 New Zealand Selection to Surgical Education and Training in General Surgery for 2020 intake [Internet]. 2018. Available from:

https://www.nzags.co.nz/education-training/selection/applications/ (Section 4.4)

[17] Board of Otolaryngology Head and Neck Surgery. Selection Regulations Australia - 2021 Intake Surgical Education and Training in Otolaryngology Head and Neck Surgery [Internet]. 2019. Available from: https://www.surgeons.org/become-a-surgeon/how-do-i-become-a-surgeon/set-selection-requirements-process-and-application/specialty-specific-eligibility-criteria-selection-processes/otolaryngology-head-and-neck-surgery-australia#Ruralper cent20origin (Rural Origin)

[18] Australian Board in General Surgery. Selection Regulations: 2020 Australian Selection to Surgical Education and Training in General Surgery for 2021 Intake [Internet]. 2020. Available from: https://www.generalsurgeons.com.au/education-and-training/selection

[19] The Royal Australia and New Zealand College of Obstetricians and Gynaecologists. Trainee Selection Process Guidelines and policy for selection of FRANZCOG trainees [Internet]. 2020. Available from: https://ranzcog.edu.au/training/specialist-training/applying (Selecting for rurality and indigenous identity; Training for rurality (Provincial Integrated Rural Training Program))

The Royal Australia and New Zealand College of Obstetricians and Gynaecologists. RANZCOG Trainee Selection Process CV/Application Scoring Guidelines – 2020 [Internet]. 2019. Available from: https://ranzcog.edu.au/training/specialist-training/applying

[20] Royal Australasian College of Surgeons. Sections Terms of Reference [Internet]. 2018. Available from: https://www.surgeons.org/resources/interest-groups-sections/rural-surgery/about-the-rural-surgery-section

[21] Australian Medical Council. Standards for Assessment and Accreditation of Specialist Medical Programs and Professional Development Programs by the Australian Medical Council 2015 [Internet]. 2015. Available from: https://www.amc.org.au/accreditation-and-recognition/assessment-accreditation-specialist-medical-programs-assessment-accreditation-specialist-medical-programs/ (Standard 7, 7.1.3: The education provider supports increased recruitment and selection of Aboriginal and Torres Strait Islander and/or Maori trainees. Notes: The Education Provider should facilitate opportunities to increase recruitment and selection of rural origin trainees.)

[22] Medical Council of New Zealand. Accreditation standards for New Zealand training providers of vocational medical training and recertification programmes [Internet]. Available from: https://www.mcnz.org.nz/assets/standards/Guidelines/8cef852ad7/Accreditation-standards-for-New-Zealand-training-providers-of-vocational-medical-training-and-recertification-programmes.pdf

[23] Australian Medical Council. Standards for Assessment and Accreditation of Primary Medical Programs by the Australian Medical Council 2012 [Internet]. 2012. Available from https://www.amc.org.au/wp-content/uploads/accreditation_recognition/specialist_edu_and_training/assessment/standards_for_assessment.pdf

[24] Royal Australasian College of Surgeons. Our values & constitution [Internet]. Available from: https://www.surgeons.org/about-racs/about-the-college-of-surgeons/our-values-constitution

Royal Australasian College of Surgeons. Code of Conduct [Internet]. 2016. Available from: https://www.surgeons.org/become-a-surgeon/about-specialist-surgeons/code-of-conduct

Royal Australasian College of Surgeons. Nine RACS competencies [Internet]. 2019. Available from: https://www.surgeons.org/trainees/the-set-program/nine-racs-competencies

Royal Australasian College of Surgeons. Strategic Plan 2019-2021 [Internet]. 2019. Available from: https://www.surgeons.org/resources/reports-guidelines-publications/strategic-plans

Royal Australasian College of Surgeons. RACS Diversity and Inclusion Plan [Internet]. 2016. Available from: https://www.surgeons.org/resources/reports-guidelines-publications/action-plans

RACS position papers:

Royal Australasian College of Surgeons. Equity of access to surgical care [Internet]. 2017. Available from: https://www.surgeons.org/about-racs/position-papers

Royal Australasian College of Surgeons. Rural and Regional Surgical Services [Internet]. 2014. Available from: https://www.surgeons.org/about-racs/position-papers

Royal Australasian College of Surgeons. Outreach Surgery in Regional, Rural and Remote Areas of Australia and New Zealand [Internet]. 2015. Available from: https://www.surgeons.org/about-racs/position-papers

Royal Australasian College of Surgeons. Generalists, Generalism and Extended Scope of Practice [Internet]. 2015. Available from: https://www.surgeons.org/about-racs/position-papers

[25] Australian Commonwealth Department of Health and Family Services. Trainee Selection in Australian Medical Colleges (The Brennan Report). 1998. P95

[26] Beattie J, D'Souza K, Mc Leod J, Versace V. Rural origin students match metropolitan origin students' academic performance once admitted to Bachelor of Medicine Bachelor of Surgery course. Aust J Rural Health [Internet]. 2019;27(2):181–2. Available from: https://onlinelibrary.wiley.com/doi/abs/10.1111/ajr.12503

[27] Waters B, Hughes J, Forbes K, Wilkinson D. Comparative academic performance of medical students in rural and urban clinical settings. Med Educ [Internet]. 2006;40(2):117–20. Available from: https://onlinelibrary.wiley.com/doi/abs/10.1111/j.1365-2929.2005.02363.x

[28] Brooks KD, Acton RD, Hemesath K, Schmitz CC. Surgical Skills Acquisition: Performance of Students Trained in a Rural Longitudinal Integrated Clerkship and Those From a Traditional Block Clerkship on a Standardized Examination Using Simulated Patients. J Surg Educ [Internet]. 2014;71(2):246–53. Available from: http://www.sciencedirect.com/science/article/pii/S1931720413002171

[29] Luhoway JA, Ryan JF, Istl AC, Davidson J, Christakis N, Bütter A, et al. Perceived Barriers to the Development of Technical Skill Proficiency in Surgical Clerkship. J Surg Educ [Internet]. 2019;76(5):1267–77. Available from: http://www.sciencedirect.com/science/article/pii/S1931720418307670

[30] Flinders University. Current initiatives. Available from: https://www.flinders.edu.au/flinders-nt/postgraduates/medical/current-initiatives

[31] Board in General Surgery New Zealand Association of General Surgeons. Selection Regulations: 2019 New Zealand Selection to Surgical Education and Training in General Surgery for 2020 intake [Internet]. 2018. Available from: https://www.nzags.co.nz/education-training/selection/applications (Section 4.4 Rural Surgical Experience)

[32] Australian Board in General Surgery. Selection Regulations: 2020 Australian Selection to Surgical Education and Training in General Surgery for 2021 Intake [Internet]. 2020. Available from: https://www.generalsurgeons.com.au/education-and-training/selection (Section 4.2.2 (b) Rural surgical experience (3 points))

[33] Board in General Surgery New Zealand Association of General Surgeons. Selection Regulations: 2019 New Zealand Selection to Surgical Education and Training in General Surgery for 2020 intake [Internet]. 2018. Available from: https://www.nzags.co.nz/education-training/selection/applications/ (Section 4.4.8 Regional surgical experience (1 point), 4.4.9 Rural surgical experience (up to 2 points))

[34] Royal Australasian College of Surgeons. Australian Board in General Surgery Terms of Reference [Internet]. 2016.
Royal Australasian College of Surgeons. Australian Board of Plastic and Reconstructive Surgery and Regional Subcommittees Terms of Reference [Internet]. 2017.
Royal Australasian College of Surgeons. Board of Cardiothoracic Surgery Terms of Reference [Internet]. 2016.
Royal Australasian College of Surgeons. Board of Neurosurgery Terms of Reference [Internet]. 2017.
Royal Australasian College of Surgeons. Board of Otolaryngology Head and Neck Surgery Terms of Reference [Internet]. 2020.
Royal Australasian College of Surgeons. Board of Paediatric Surgery Terms of Reference [Internet]. 2017.
Royal Australasian College of Surgeons. Board of Urology Terms of Reference [Internet]. 2017.

Royal Australasian College of Surgeons. Board of Vascular Surgery Terms of Reference [Internet]. 2017.
Royal Australasian College of Surgeons. New Zealand Board in General Surgery Terms of Reference [Internet]. 2018.
Royal Australasian College of Surgeons. New Zealand Board of Plastic and Reconstructive Surgery Terms of Reference [Internet]. 2019.
All available from: https://www.surgeons.org/about-racs/policies

[35] Royal Australasian College of Surgeons. RACS Diversity and Inclusion Plan [Internet]. 2016. Available from: https://www.surgeons.org/resources/reports-guidelines-publications/action-plans

[36] Australian Orthopaedic Association. Regulations for Selection to the AOA 21 Training Program in Orthopaedic Surgery for 2021 [Internet]. 2020. Available from: https://www.aoa.org.au/orthopaedic-training/becoming-an-aoa-trainee (item 10.1.10)