ROYAL AUSTRALASIAN COLLEGE OF SURGEONS

AMC PROGRESS REPORT 2012

COLLEGE DETAILS

Name: Royal Australasian College of Surgeons

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

Date of last AMC assessment: 2011 Comprehensive report

Periodic reports since last AMC assessment:

Reaccreditation due: 2017

Officer to contact concerning the report: Dr. David Hillis

Telephone number: +61 3 9249 1205

Email: david.hillis@surgeons.org

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

1.1 Governance

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

Challenges and Changes

As reported in the 2011 Comprehensive Report, the issue of some surgical specialist societies wishing to evolve separately was discussed with representatives of the AMC (Jill Sewell, Chair, AMC Education Accreditation Committee (SEAC) and Robin Mortimer, Deputy President AMC (by teleconference) at a meeting at RACS on February 4, 2011.

Currently the College is renegotiating the Memorandum of Understanding and Service Agreements that supported the arrangements of delivering the nine Surgical Education and Training programs over the past five years. With the increased autonomy and capability of the Specialty Societies these are being reconfigured as Partnering Agreements. These agreements include more detail and clearer understanding of the support required for the training programs and also the requirements for compliance. In particular the latter are focused on the accreditation requirements and standards of the AMC.

Following several months during which working parties looking at Governance and Educational Relationship issues, there has been wide consultation with each of the specialty societies. Most specialties are expected to have signed the new agreements before the end of September when the previous agreements expire. If Societies need longer to consider them, then an Extension Agreement has also been prepared which will enable continuity of training under the existing MOU and Service Agreement.

Given that the trainees of the College require certainty about ongoing arrangements to achieve their FRACS, the agreements provide a multi-year commitment by the Societies to the specialty training program. So, if the Partnering Agreements cannot be completed by the end of September then the Extension agreement will ensure the stability and certainty required by our trainees.

- If the AMC wishes to review these documents, the most up-to-date version can be made available.
- There has been no change in the Governance structure of the College. A map depicting the Governance structure and the relationship of all of the Education and Professional Development Committees to Council is depicted at: http://www.surgeons.org/media/307051/governance_may_2011.pdf
- The terms of reference for each committee are available on-line at: http://www.surgeons.org/about/governance-committees/committees/#eb

1.2 Program Management

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

- *setting and implementing policy on continuing professional development and reviewing the effectiveness of continuing professional development activities.*

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

Challenges and Changes

There has been no change in the committees responsible for management of the training program; the assessment of International Medical Graduates (IMGs); or Professional Development.

1.3 Educational Expertise and Exchange

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

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

- The College continues to be involved in the annual Tripartite meetings between RACS; the Royal Australasian College of Physicians (RACP); and the Royal College of Physicians and Surgeons of Canada (RCPSC) (2011-2013).
- RACS education staff are actively involved in the Network of Medical College Educators (NMCE) which meets four times per year and reports to the Education Subcommittee of the Committee of Presidents of Medical Colleges (CPMC).
- In the past 12 months RACS Fellows and senior staff have presented papers at Surgical Education conferences in Canada and Sweden.

Recommendation 2:
Report to the AMC on the schedule of planned changes in its educational programs and the proposed time of implementation. Please include an update on changes to the assessment of generic and specialty specific basic sciences, and potential changes to the Fellowship examination.

Challenges and Changes

A. Curriculum Changes

College - generic

- The College and the Specialty Training Boards continue to address the planned changes to a 'competency based' Training Program. See the attached Table in Appendix 2.
- The College is currently piloting two new courses for IMGs, which, it is anticipated will also become available for Supervisors and Trainees.
    - Training Standards – Interpretation and Application' (TSIA), will introduce participants to the training standards, as defined in the booklet: "*Becoming a competent and proficient surgeon: Training standard for the nine RACS Competencies*" http://www.surgeons.org/media/18726523/mnl_2012-02-24_training_standards_final_1.pdf
    - 'Surgical Decision Making – a complex competency' (SDM), will provide participants with training in the underlying principles and processes required to effective adapt and apply Judgement – Clinical Decision Making in complex surgical situations.
- The SAT SET (Supervisors and Trainers for Surgical Education and Training) course that was introduced in 2008 has been re-developed as an on-line module. It is now available free to College members both on-line and face-to-face.
- A Trainee version of the SAT SET course is currently being developed to be published on-line.

Cardiothoracic Surgery

Cardiothoracic Surgery is moving to competency based assessment of training and this may affect the length of training (i.e. not everybody will take the same amount of time to complete their training). The Training Board is also reviewing their selection process.

General Surgery

- New regulations have been introduced that make it compulsory for trainees to attend four GSA or NZAGS Trainees' Days over the course of their training program before Fellowship is awarded.
- The GSA MOSES (Management of Surgical Emergencies) has also been introduced but is not compulsory.
- The Board is reviewing the selection processes for General Surgery and therefore the duration may be shortened to four years.

Neurosurgery

- The SET Board of Neurosurgery and Neurosurgical Society of Australasia have made modifications to the SET Program in Neurosurgery to deliver greater flexibly and an increased focus on competency based training within a time based framework. As part of this process the SET Program will be divided into three stages as follows:
    - SET1 and SET2 will be combined to form Basic Neurosurgical Training known as Level 1. It will be possible for the very competent trainee to complete Level 1 in one year, although the expectation is that most trainees will take two years, which is the maximum time allowed.
    - SET3 to SET5 will be combined to form Intermediate Neurosurgical Training known as Level 2. It will be possible to complete Level 2 in three years, with a maximum of four years allowed.
    - SET6 will become Advanced Neurosurgical Training known as Level 3. We hope that most trainees will complete Level 3 in one year, with a maximum of three years allowed.
- The new SET Program structure introduces flexibility so that the very competent trainee can complete the SET Program in five years, although it is expected that the majority of trainees will still take six years which is the previous standard duration.
- The previous structure SET Program (still applicable to trainees who commenced prior to 2013) has a six year structure which includes one year of compulsory full-time research. The new SET Program replaces the compulsory full-time research year with additional clinical training and a formal research requirement to be completed while undertaking clinical training.
- New trainees in 2012 had the option of enrolling in the current SET Program or the new SET Program. Existing trainees at that time remained enrolled in the previous SET Program structure. New trainees in 2013 will be automatically enrolled in the new SET Program structure.

Otolaryngology Head and Neck Surgery

No change

Orthopaedic Surgery

- Following the roll out of the new AOA/NZOA curriculum in 2011, a review of curriculum has been identified as a task for commencement in the next 12 months. This review will incorporate stakeholder feedback from the first two years, lessons learned through experience of Fellows and staff in managing the implementation of the curriculum and changes in medical education best practice.
- Changes to assessment tools will be informed by the curriculum review outlined at item A. A number of optional tools are often mandated as part of a remedial plan for under-performing trainees as appropriate, according to areas of weakness (mini-CEX, MSF, CBD)

Paediatric Surgery

- RACS Paediatric Surgery SET is a competency-based training program which has already had several trainees complete training in shorter time periods than the gazetted length of training due

to demonstration of competency. Similarly there are trainees who are undertaking increased duration of training due to slower but continued satisfactory acquisition of competency.

- In 2012 a new SET 1/probationary year was introduced (making it a gazetted 7 year program for these new trainees- previously six years). In this year they are assigned to an accredited post in a tertiary Paediatric Unit where they follow a comprehensive program which will has been designed for the trainee to be trained and assessed in their progression in the basic surgical technical, medical knowledge and clinical management competencies of the training program. This is being achieved through a specific curriculum and series of mandatory formative assessments utilising presentations, mini-CEX, DOPS, MOUSE and 360^0s. This will standardise trainee's competencies to enable them to get the maximum benefits from their general surgical training in SET 2 and 3 and allow early identification of trainees who are unsuitable for progression in Paediatric Surgery.

- <u>Plastic and Reconstructive Surgery</u>
  - The Board of Plastic and Reconstructive Surgery is investigating online learning modules to cover aspects of the curriculum.
  - New online e-learning courses offered on the College website e.g. goal setting and self-assessment are used.
  - The Board has enrolled trainees to the American Society of Plastic Surgeons' Plastic Surgery Education Network, an e-learning portal for plastic surgery, on a two year trial basis. The portal could be a significant e-learning resource for pre-fellowship training and the Board will have the ability to post content, after review by the section editorial boards.
  - The Board plans to standardise regional tutorial programmes by mandating fortnightly clinical didactic tutorials in each region. These tutorials will cover the syllabus over a two year period. Trainees will be required to attend 80% of these tutorials each six month rotation. Regional tutorial programmes are being developed.

<u>Urology</u>

- In late 2011, the Board of Urology established a Curriculum Review Committee, co-chaired by the Senior Examiner and the Chair, Board of Urology. This committee undertook an extensive review of the available curriculum from a range of urological associations including those from USANZ, the Canadian Urology Association, BAUS, AUA and EAU. The committee noted that there was a distinct difference between the terms "curriculum" and "syllabus". The latter term defines the knowledge required of our trainees at various levels of training through to completion and achievement of their fellowship. It was felt that there was a need to define the core and specialist knowledge required throughout the breadth of Urology as well as a recommended reading list of key text books, guidelines and journals.
- The committee felt that a review of the external resources by the appropriate Special Advisory Group (SAG) in their area of interest would be useful in compiling an up to date and relevant syllabus for all SET Urology trainees. The curriculum review committee and SAG leaders met in early 2012 and progress is being made to develop the new syllabus.
- The Board has determined that SET2 trainees will now attend the USANZ Trainee Week together with trainees in SET3-SET5. This is a one week intensive and interactive clinical programme focussing on up to date, relevant and possibly controversial issues in urological surgery and practice.
- The Board of Urology has developed specific in-training assessment reports for trainees in SET1, SET2 and SET3-SET6. These reports are aligned to the College competencies.
- All trainees from SET1 – SET6 are required to submit 3 monthly in-training assessment reports and logbook summaries.

<u>Vascular Surgery</u>

The Board of Vascular Surgery is currently revising their on-line modules and the associated on-line MCQs.

B. Changes to Examination processes

College - generic

- In consideration of the demands and workload on Trainees in the first two years of training when they are currently required to pass the Generic Surgical Sciences Examination (SSE); the Generic Clinical Examination, and (in some specialties) the specialty specific SSE - in 2014 the Generic SSE will become available for medical graduates prior to being selected into SET.
- A modified closed marking system was trialled at the September 2011, and May and September 2012 Fellowship Examinations. This new process is designed to increase the reliability and validity of the examination. Ongoing review and modification of this system is planned.
- In February 2012 RACS Council approved the document '*Becoming a competent and proficient surgeon: Training Standards for the nine RACS Competencies'*.
  http://www.surgeons.org/media/18726523/mnl_2012-02-24_training_standards_final_1.pdf
- This document identifies key patterns of behaviour and behaviour markers for five levels — 'Prevocational'; 'Novice'; Intermediate'; 'Competent'; and 'Proficient', for each competency. Some specialties are using this document to identify Trainees who are not ready to sit their Fellowship Examination.

  In an ideal world this could lead to competency based training replacing the time-frame of current training. Conflicting such an approach is the reduction in pre-SET and SET training hours due to safe-hours approaches and the increased number of medical graduates. It is also recognised that exceptional ('brilliant') trainees are rare.

Cardiothoracic Surgery

A specific curriculum is currently being developed for the new Cardiothoracic Specialty Specific Surgical Science Exam – to be completed by end of 2012 and introduced in 2014.

General Surgery

A series of on-line learning modules SEAM (Surgical Education and Assessment Modules) will be introduced in 2014 which will replace the current SSE – General Surgery Specialty Specific exam.

Neurosurgery

No change

Otolaryngology Head and Neck Surgery

No change

Orthopaedic Surgery

No change

Paediatric Surgery

No change

Plastic and Reconstructive Surgery

The question bank for the Plastic and Reconstructive Surgical Science and Principles Examination (PRSSPE) was expanded over a 12 month period beginning in July 2011.

Urology

- The Board of Urology has determined that the Surgical Sciences Examination (Generic) will be undertaken in early SET (SET 1-2) and the Surgical Sciences Examination (Urology Specific) undertaken in mid SET (SET3-4). The Fellowship examination will be then undertaken in SET5/SET6.
- Under the SET programme, trainees are subjected to a more defined and structured training program. The College and each Specialty Board has acknowledged the need for rapid acquisition of basic knowledge in the surgical sciences (Anatomy, Pathology and Physiology) and the need to ascertain an acceptable level of basic understanding. This is assessed by MCQ examination in early SET (SET1 & SET2). During these years, Urology trainees are expected to gain skills in

assessment and treatment of acute surgical emergencies and attain skills in general surgery which they can utilise in their SET3-SET6 posts. As the urology attachments at a more senior level commence in SET3, the attainment of more urology specific Anatomy, Pathology and Physiology is important and expected to be rapidly attained during the SET 3-4 years. This is reinforced by the day to day learning environment. Assessment of knowledge in these areas of urology is essential before progression to more advanced aspects of clinical decision making and management which are expected of trainees in their later SET 5-6 years and prior to undertaking the fellowship examination. This allows trainees to progress through the training, acquiring knowledge and skills on an incremental basis. The distribution of exams allows trainees to demonstrate the attainment of knowledge sufficient for them to progress to the next level and complexity of training. It is anticipated that the final fellowship examination will focus on the assessment of complex, higher clinical decision making and as such the assessment of surgical science knowledge specific to urology is best assessed in SET 3-4.

- A committee of USANZ members has been established to review the curriculum and develop the examination methodology and content and the first SSE (Urology Specific) examination will be undertaken in 2014. It has been agreed that the exam will be in MCQ format and will be offered twice a year, in February and June, at the same time as the Generic and other SSE papers are being undertaken.
- The examination will be 2.5 hours with 120 MCQs. The mix will be the same as the current combined General Surgery/Urology SSE with about 30% Type A and B questions and 70% Type X questions. Of the 120 MCQs, 40 will be Anatomy (including embryology and imaging), 40 will be Physiology (including laser, diathermy, radiation and physics) and 40 will be Pathology (including pharmacology, microbiology, infection, immunology and statistics). The questions will be based on the basic sciences but have a clear relationship to urologic practice.
- Trainees will be required to pass this examination before being approved to sit the Fellowship examination. The Board is yet to determine the number of attempts permitted and in what time frame.
- Since the introduction of the SET programme, the experience and knowledge base of trainees presenting for the Fellowship Examination has altered and at times has been inadequate. The Board of Urology together with the Senior Examiner has developed comprehensive criteria to assist surgical trainers in determining exam readiness.

Vascular Surgery

No change

Recommendation 4:
Report, as part of its College Activity Report, numbers of entrants into SET1 and SET2+ and the origin of these entrants (by PGY year, whether or not BST, IMG) by jurisdiction and specialty.

Activity Reports are available for public assess on the RACS website at:
http://www.surgeons.org/government/workforce-and-activities-reports/

1.4 Interaction with the Health Sector

1.4.1. The training organisation seeks to maintain constructive working relationships with relevant health departments and government, non-government and community agencies to promote the education, training and ongoing professional development of medical specialists.
1.4.2. The training organisation works with healthcare institutions to enable clinicians employed by them to contribute to high quality teaching and supervision, and to foster peer review and professional development.

Recommendation 5:
Agree with jurisdictions on mechanisms to facilitate resolution of issues of concern, including workforce numbers. These could include (a) a high-level consultative forum, possibly along the lines outlined in

this report, to meet at least twice a year, and (b) consultative arrangements at the jurisdictional level with the relevant Regional Committee (and representatives of the regional sub-committees of specialty boards) to identify appropriate posts for accreditation and to facilitate resolution of issues of concern including issues of workforce availability.

Challenges and Changes

- The College, the Specialty Training Boards and the Specialty Societies continue to interact with the Health Sector at all levels of government across two nations being National, Commonwealth, and State based. For example:
    - Senior surgeons (College Counsellors; Specialty Society members) and representatives of the health sector continue to discuss issues of mutual concern at the College Leaders' Forums.
        - The Surgical Leaders' Forum at the October Council meeting will have a major section on recent Health Workforce Australia (HWA) reports and initiatives towards developing national networks for training.
    - Senior surgeons serve as members on regional medical education committees such as iMET; and SA IMET;
    - The Board of Regional Chairs (BoRC) and their regional committees have a very strong role in advocacy within each of the regions
    - P&RS have consulted with, and provided input to, the workforce projection planning of HWA and Health Workforce New Zealand
    - Where possible specialties continue to have JRs as members of their Training Board
    - JR's involvement is actively sought in the accreditation inspection of training posts in Australia. It has been difficult to arrange these in New Zealand due to issues around Ministry of Health funding.
    - JR's involvement is actively sought in the selection of trainees
    - Interactions with health services undertaken at a local (hospital) level between training supervisors and administration to ensure effective service-based training.

<u>Paediatric surgery</u>

1. The Board of Paediatric Surgery (BoPS) works collaboratively with information provided by executive council and membership of ANZAPS and had therefore identified significant workforce issues in Australia and New Zealand related to funding for salaries and onerous on call hours in major tertiary paediatric institutions and also from decreased support from non-tertiary hospitals for non-paediatric specific pathologies in adolescents; all of which has resulted in critical problems with consultant appointments, retention and recruitment. This workforce crisis is also affecting training as there are inadequate consultants to provide teaching and supervision, and decreased access to elective workload. BoPS has brought these problems to the RACS Council and a combined working party is to be formulated to examine these issues.
2. The BoPS has identified safety and training issues with rostering in the 38-40 hour weeks for surgical registrars and has asked RACS to convene working party with jurisdictional representatives to recommend introduction of safely rostered minimum 55 – 60 hour working week for training registrars.
3. BoPS has increased training numbers to address future workforce needs based on population but remains unable to identify or access surgery in general posts; the lack of which is the main restrictive factor in increasing training numbers.
4. There have been seven new SET One posts and two SET 2/3 posts accredited in last two years. Lack of STP funding and competition by Board of General Surgery has limited ability to accredit further SET 2/3 posts.

Urology

- A Jurisdictional Representative is a member of the Board of Urology and attends a small number of Board meetings. Due to financial constraints the JR is unable to attend some meetings as they are held interstate.
- Members of the Board and USANZ personnel have also consulted jurisdictional representatives to assist with the identification and accreditation of appropriate training posts. USANZ has also participated in the College workforce analysis study to assist in identifying current and future workforce needs.

1.5 Continuous Renewal

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

Challenges and Changes

- Given the proposed changes from the Memorandum of Understanding and Service Agreements to Partnering Agreements, the College has begun to change the policies relation to Surgical Education and Training (SET) from their existing format to 'principle-based' policies.
  http://www.surgeons.org/policies-publications/policies/surgical-education-and-training/
- Currently only one of these new policies — the selection policy — has been approved.
  http://www.surgeons.org/media/348041/pol_2012-02-25_selection_to_surgical_education_and_training_v5.pdf

STANDARD 2: THE OUTCOMES OF THE TRAINING PROGRAM

2.1 Purpose of the Training Organisation

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

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

Challenges and Changes

No change in the purpose of the training organisation

2.2 Graduate Outcomes

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

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

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

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

Challenges and Changes

- There has been no change to the defined graduate outcomes which, since publication in 2003 of the RACS statement of graduate outcomes, the *Definition of Surgical Competence,* has become the curriculum framework all of the surgical specialties. This framework is publically accessible on the RACS website at: http://www.surgeons.org/becoming-a-surgeon/surgical-education-training/competencies/
- Now that the first cohort of SET trainees is completing their training, the College is developing a plan to evaluate the outcomes of the SET training program in 2013-14.
- The number of Trainees completing their Fellowship examination (by specialty; region and gender) are publically accessible on the RACS website at: http://www.surgeons.org/government/workforce-and-activities-reports/
- The has been no change in the way that the College, or the specialties address cultural competence

Recommendation 7:
Recognising the different needs of the specialty groups, aim to increase the uniformity between presentation of the aims and goals of training for nine surgical specialties particularly on the website, taking account of feedback from the trainee and supervisor groups.

- The new RACS website provides Fellows and Trainees with the facility (via their password) to directly access their own 'My page'. On this page they can prioritise the items according to their usage.
- Given the changes in the relationships between the College and the Specialty Societies and the increased autonomy and capability of the Specialty Societies (as outlined in Section 1.1) the appearance of the specialty websites will continue to evolve and change. This is in-line with the desires of the members of those societies.

  However the new Partnering Agreement clearly defines the documents (policies, regulations, and training requirements) that need to be published on the public section of their websites.

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

There are no plans to change the goals and objectives of surgical training – therefore no consultation.

STANDARD 3: CURRICULUM CONTENT

3.1 Curriculum Framework

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

Since publication in 2003, the RACS statement of graduate outcomes, the *Definition of Surgical Competence* has become the curriculum framework all of the surgical specialties.

Documents are available for public assess on the RACS website
http://www.surgeons.org/becoming-a-surgeon/surgical-education-training/competencies/

3.2 Curriculum Structure, Composition and Duration

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

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

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

- See Appendix 2
- See detailed response to Standard 1.3, Recommendation 2, on page 5-9.

3.3 Research in the Training Program

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

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

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

Challenges and Changes

College - generic

The Working Party that was established in the latter half of 2012 is expected to make a report at the October meeting of the Boards of Surgical Education and Training (BSET). Prior to receiving the recommendations from that Working Party no changes have been made to the College objectives of the research component of training and the associated requirements.

Cardiothoracic Surgery

No change

General Surgery

No change

Neurosurgery

- The SET Board of Neurosurgery approved changes to the research requirement as part of the new SET Program structure. It is important to note that these changes do not apply to existing trainees already enrolled in the SET Program.
- The new SET Program replaces the compulsory full-time research year with additional clinical training and a formal research requirement to be completed while undertaking clinical training. The formal requirement includes:
  - The RACS Critical Literature Evaluation and Research (CLEAR) workshop
  - A supervised research project relevant to neurosurgery during SET
  - An oral presentation of the research at a suitable scientific meeting
  - One neurosurgical publication in a peer reviewed scientific journal (not a case report)
- The proposal for the research project must be submitted and approved by the SET Board of Neurosurgery prior to the completion of Basic Neurosurgical Training and the research requirement must be successfully completed prior to the end of Intermediate Neurosurgical Training.
- Trainees in the new SET Program who wish to undertake a period of full-time research may still apply to the Board for interruption of training for that period (as is currently the case for trainees in the current SET Program who wish to spend more than one year in research).

Otolaryngology Head and Neck Surgery

No change

Orthopaedic Surgery

No change

Paediatric Surgery

- The Board of Paediatric Surgery (BoPS) has recently mandated trainees attendance at Paediatric Annual Scientific meetings at least 3 times throughout their training (early, mid and late SET) and has strongly recommended attendance at the Annual Developing a Career in Academic Surgery Course. This enables trainees to undertake research and present to their Paediatric Surgery peers.
- BoPS has identified the objectives of research components in training:
  - to encourage the consideration of an academic surgical career
  - to learn the basic skill sets of good clinical research (i.e. design of clinical study and basic statistical knowledge)
  - to enable the surgeon to critically analyse results of research and clinical studies to determine the applicability and reliability of published research to changes in surgical knowledge.
- BoPS is examining appropriate courses and requirements to achieve these aims, including mandating appropriate courses (e.g. CLEAR and DCAS) but will need to do this in the overall context of the number of mandatory competency courses, availability of new e-modules, and the training experiences possible in overall program. BoPS is reviewing the potential benefit of all current compulsory training courses.

Plastic and Reconstructive Surgery

The Board of Plastic and Reconstructive Surgery are planning to develop a schedule listing the points categories of published articles including an impact factor for scoring articles.

Urology

There is now a USANZ Supplement in the British Journal of Urology. The Board of Urology has discussed the role of the Supplement as an educational tool for trainees. It has been agreed that trainees could take a more active role in working on a systematic review of a topic which could then be published in the Journal. This would then comply with the research requirements as part of the SET

Programme in Urology. The Board of Urology is working on identifying topics that would be suitable to be reviewed.

Vascular Surgery

No change

3.4 Flexible Training

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

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

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

Challenges and Changes

- Flexible training has been identified as one of the issues that will be addressed under the umbrella of 'Advocacy' in the most recent Strategic Plan. At the August teleconference of the Education Board Executive it was agreed to establish a working party to investigate the issues. The Terms of Reference, membership and guidelines will be developed prior to Council in October. In the meantime no changes have been made to the policies or processes.
- Training boards recognise the need of flexible training opportunities and recognise that these training opportunities:
  - may take a number of different forms - Full time flexible – Stand-alone part time– or Job share
  - require the support from employers. As the trainees are employed by different jurisdictions, this means that arrangements for other than standard hours/rosters are complex.
- Some training boards have requested members to attempt to identify suitable training sites.
- Some specialties, whilst supporting the concept of flexible training, are concerned that this may put more pressure on training resources, given the pressure to fill all possible training posts.

3.5 The Continuum of Learning

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

Challenges and Changes

In response to increasing pressure to provide information across the spectrum of education and training RACS has implemented the following strategies:

- In the new version of the College website that is a public-access link from the homepage to necessary information for a person who wants to understand the pathway to becoming a surgeon. http://www.surgeons.org/becoming-a-surgeon/surgery-as-a-career.aspx
- The 'essential surgical skills' document has been published on the RACS website as well as being more broadly publicised. This document identifies skills that a person needs to be able to perform before applying for selection. Whilst most of the information is generic, some of the surgical specialties have identified additional skills that they expect of a prevocational doctor. http://www.surgeons.org/media/473135/gdl_2011-10-10_essential_surgical_skills_document.pdf
- The booklet '*Becoming a competent and proficient surgeon: Training Standards for the nine RACS Competencies'* key patterns of behaviour and behaviour markers for five levels —

‘Prevocational’; ‘Novice’; Intermediate’; ‘Competent’; and ‘Proficient’, for each competency. Pre-vocational is the standard required of people prior to selection into any specialty.

http://www.surgeons.org/media/18726523/mnl_2012-02-24_training_standards_final_1.pdf

- In 2012 the College has contributed to the following consultations:
  - CPMEC — Revision of the Australian Curriculum Framework for Junior Doctors (ACF)
  - AMC — Changes to Primary Qualifications for Admission to Practise Medicine in Australia - implications for AMC accreditation
  - AMC — Review of the approved Accreditation Standards for medical schools and their program of study
- See Section 5.1 for changes to the Generic Surgical Sciences Examination.

STANDARD 4: TEACHING AND LEARNING METHODS

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

Challenges and Changes

No change

STANDARD 5: ASSESSMENT

5.1 Assessment Approach

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

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

Challenges and Changes

See detailed response to Section 1.3, Recommendation 2, pages 8&9

College - generic

- In consideration of the demands and workload on Trainees in the first two years of training, in 2014 the Generic SSE will become available for medical graduates prior to being selected into SET.
- Changes in specialty specific surgical sciences examinations are being introduced for a number of reasons:
  - Changes in timing to:
    - spread the workload on the trainees more evenly across the training program
    - provide increased opportunities to monitor progress
  - Changes of content to make the examination more specific to the requirements of the specialty
  - Introduction of assessments from other countries (e.g. P&RS) to ensure internationally comparable standards
- Specialty training boards frequently assist each other by sharing their assessment tools

Recommendation 16:
~~Research thoroughly the strengths, weaknesses, practicalities and generalisability of the Mini-Clinical Evaluation Exercise and Direct Observation of Procedural Skills as assessment tools in the local hospital setting and make public its findings.~~ The AMC notes that since the 2007 assessment, considerable literature has been written on these tools. The AMC considers that this recommendation is no longer appropriate. It asks that in future reports the College advise the AMC on it is using the available research findings in making decisions about the assessment tools it employs.

College - generic

- As outlined in Section 1.3 (Recommendation 2) the specialty training boards are at varying stages in their curriculum reviews. In conducting their review they are consulting internationally to ascertain current trends in work-based assessment in their specialty.
- RACS is considering the evidence supporting the use of P-MEX as a way to assess Professionalism.

Cardiothoracic Surgery

2012 is the first year of implementing DOPS for their Trainees. It will be evaluated in 2013.

General Surgery

No change in work-based assessment tools

Neurosurgery

- These tools are not used by the SET Program in Neurosurgery because they workplace competency assessments in place prior to the development of the RACS Mini-CEX and DOPS.
- For all new trainees commencing in 2012 and beyond the in-training assessment and workplace competency assessments were replaced by two new assessment tools.
- The in-training assessment was replaced by a Professional Performance Assessment (PPA) Report which must be submitted quarterly during SET1 and SET2 (Level 1). The PPA report is focused on minimum standards of behaviour and attitudes (this assessment tool does not focus specifically on clinical skills, technical skills and knowledge). The standards in the PPA Report are the minimum standards we would expect trainees to have prior to entering SET, and therefore this assessment is not expected to be onerous for the vast majority of trainees. These minimum standards must be maintained or exceeded at all times during SET by all trainees.
- The workplace competency assessment requirements for SET1 and SET2 (Level 1) will be replaced with a single Basic Neurosurgical Competency Assessment (the Basic Assessment) which must be submitted half yearly during SET1 and SET2 (Level 1). This Basic Assessment includes core procedural competencies and components of the current in-training assessment form relating to clinical and technical skills. Trainees will be assessed as either 'competent' or 'not yet competent' for each area within the form and as such there is no unsatisfactory, just a failure to have attained competence at that time. Attainment of competence in all areas of the Assessment will be required prior to the end of the SET2 training year (Level 1) in order to be eligible to progress to SET3.

Otolaryngology Head and Neck Surgery

No change in work-based assessment tools

Orthopaedic Surgery

Changes to assessment tools will be informed by the curriculum review outlined in section 1.3. A number of optional tools are often mandated as part of a remedial plan for under-performing trainees as appropriate, according to areas of weakness (mini-CEX, MSF, CBD)

Paediatric Surgery

- The Board of Paediatric Surgery continues to use Mini-CEX and DOPS for all trainees. Assessment forms have recently been redeveloped to increase paediatric surgical applicability. DOPS (DOPS in paediatric surgery is called Measure of Understanding of Surgical Expertise MOUSE) is performed monthly in years SET One and SET 4,5,6 and 7.
- BoPS continually reviews program, curriculum and assessments via a formal yearly timetable and is currently looking at proposals to further customise MOUSE/DOPS assessment forms for level of training so that technical competencies appropriate to seniority of training are considered.
- The reliability and amount of information available from use of the paediatric surgery assessment tools including the trainee evaluation form has informed the decision of BoPS to use all these tools for IMGs under clinical supervision.

Plastic and Reconstructive Surgery

No change in work-based assessment tools

Urology

No change in work-based assessment tools

Vascular Surgery

No change in work-based assessment tools

Statistical data:

a) Data from the Summative Examinations is published in the Activity Reports which are available for public assess on the RACS website at:
http://www.surgeons.org/government/workforce-and-activities-reports/

b) Data from the 2012 May examinations is in Appendix 3

5.2 Feedback and Performance

5.2.1. The training organisation has processes for early identification of trainees who are under performing and for determining programs of remedial work for them.
5.2.2. The training organisation facilitates regular feedback to trainees on performance to guide learning.
5.2.3. The training organisation provides feedback to supervisors of training on trainee performance, where appropriate

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

Challenges and Changes

Underperforming Trainee

College - generic

- The document '*Becoming a competent and proficient surgeon: Training Standards for the nine RACS Competencies'* has been developed to provide Supervisors with clearer guidelines about expected Trainee performance at different levels/ stages of training. This document identifies key patterns of behaviour and behaviour markers for five levels — 'Prevocational'; 'Novice'; Intermediate'; 'Competent'; and 'Proficient', for each competency. Whilst being adopted differently within the different specialties, some specialties are using this document to identify and assist Trainees who are progressing through the training program more slowly than expected.
  http://www.surgeons.org/media/18726523/mnl_2012-02-24_training_standards_final_1.pdf
- The College has developed and published two new e-learning modules to assist all Trainees. These modules are 'Goal setting' and Self assessment'. Whilst these modules have been designed to assist all Trainees, these two adult learning skills are particularly important for underperforming Trainees.
- 'Competent but not Confident' is an issue that has been identified by the Trainees' Association (RACSTA) and the Younger Fellows' Committee (YF) as a concern for senior Trainees. This group of trainees have successfully completed all of the training requirements, however they do not feel confident enough to take up independent practice. This issue will be addressed by the College under the umbrella of 'Advocacy'. At the August teleconference of the Education Board Executive it was agreed that a working party involving representatives of RACSTA and YF, will be established with the support of Education Board and the Board of SET.
- Some of the specialty training boards (particularly General Surgery and Paediatric Surgery) have very well developed procedures and template documents for managing a trainee once they have been put onto probation.
  - Those two specialties have been very generous in sharing these resources with other specialties (Plastic and Reconstructive Surgery; Otolaryngology Head and Neck Surgery; Vascular Surgery)
- The College has conducted an extensive literature review and consulted other Australasian post-graduate medical colleges to identify information and resources relating to:
  - early identification of trainees in difficulty
  - remediation
  - identifying trainees who may 'lack insight'
- The College is currently developing an on-line resource for Supervisors and Trainees that will provide ready access to both generic and specialty specific materials to address all stages of identification, remediation and management of underperforming trainees.

Cardiothoracic Surgery

No change

General Surgery

No change. Trainees on Management Programs receive feedback monthly.

Neurosurgery

No change

Otolaryngology Head and Neck Surgery

The OHNS training board have introduced new guidelines for management of trainees in trouble including improved feedback (based on the GS and PS resources)

Orthopaedic Surgery

Process documents for assessment, probation and remediation are currently being re-drafted for clarity and ease of use.

Paediatric Surgery

The Board of Paediatric Surgery continues to improve in dealing with under-performing trainees, by following College processes and using uniform templates to ensure transparency and document remedial processes. BoPS has been encouraged by success in early feedback, identification and remediation in underperforming trainees where the trainees have gone on to complete training. Additionally BoPS has been able to identify early those unsuitable trainees who cannot progress despite remediation, enabling these people to transition to other careers much sooner than previously possible.

Plastic and Reconstructive Surgery

The P&RS training board have introduced new guidelines for management of trainees in difficulty including improved feedback (based on the GS and PS resources)

Urology

- The in training assessment report for SET3-SET6 trainees includes a section devoted to the identification of poor or unsatisfactory performance. Supervisors are provided with guidance as to the process and documentation required in this regard.
- The Board of Urology plans to trial the templates provided by the College in the management of under-performing trainees. It is believed these templates will assist supervisors in documenting performance issues and remedial interventions.

Vascular Surgery

The Board of Vascular Surgery has recently adopted the template of performance management plans of General Surgery. These plans will be introduced for any Vascular borderline or probation trainees.

Feedback to Trainees

See response to Section 7.3

Feedback to Supervisors

No change

5.3 Assessment Quality

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

Challenges and Changes

In 2012 the Fellowship Examination Court continued trialling the proposed Expanded Close Marking System at both the May and September sittings. Policies to support the continued use of this process will be tabled at the October meeting of Education Board.

5.4 Assessment of Specialist Trained Overseas

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

Challenges and Changes

- No change to the processes of assessing IMGs
- The forms are accessible on the College website at http://www.surgeons.org/becoming-a-surgeon/international-medical-graduates.aspx

Monitoring of IMGs

College - generic

- A Clinical Assessment of an IMG is carried out every three months
- IMGS under supervision are also assessed on DOPS and Mini-CEX
- The forms are accessible on the College website at: http://www.surgeons.org/becoming-a-surgeon/international-medical-graduates.aspx
- To streamline the clinical assessment processes the College IMG Department is considering changing the submission requirements so that all IMGs will submit their forms at the same time (rather than according to their commencement date).
- The College IMG Department is considering introducing 360^0 evaluation for all IMGs.
- IMGs are required to complete CME requirements (previously MOPS) and these are verified annually.

Orthopaedic Surgery

Assessment tools for IMGs are currently being adapted

Plastic and Reconstructive Surgery

IMGs are also given access to the online Trainee Management Program (TMP) and their performance can be assessed and monitored by their supervisors using PPAs, mini-CEX and DOPS. NZ IMGs use paper PPAs, mini-CEX and DOPS.

Urology

No change although the Board is planning on implementing an IMG liaison/mentoring program. The plan would be to appoint a urologist who has gone through the IMG process as a liaison to help guide new/current IMGs working through the system. This would be a peer rather than a Supervisor or Mentor.

STANDARD 6: MONITORING AND EVALUATION

6.1 Ongoing Monitoring

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

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

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

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

Challenges and Changes

College - generic

- All specialty training boards receive feedback from hospital administrators as an integral part of post inspections.
- Under the new Partnering Agreements specialties will be required to provide more information about
    - any consultancies conducted
    - the manner in which they collect feedback from external stakeholders such as health care administrators and other health care professionals, and
    - the results of those consultations / feedback

Orthopaedic Surgery

Orthopaedic Surgery is the only specialty that is currently undergoing an extensive curriculum review. As stated in Section 1: Recommendation 2.

Following the roll out of the new AOA/NZOA curriculum in 2011, a review of curriculum has been identified as a task for commencement in the next 12 months. This review will incorporate stakeholder feedback from the first two years, lessons learned through experience of Fellows and staff in managing the implementation of the curriculum and changes in medical education best practice.

Urology

In carrying out their curriculum review the Urology training board consulted widely amongst a range of international urological associations (see Section 1: Recommendation 2)

Recommendation 23:
Report in annual reports to the AMC on plans for trainee and supervisor evaluation of SET. Please include the results of this in the next report.

Challenges and Changes

College - generic

- Many of the specialty groups continue to conduct their end-of-term evaluations with their own Trainees. The results of these evaluations are used within the specialty to inform on-going development.

- The College continues to monitor the end-of-term survey of all trainees designed and conducted under the auspices of the Trainee Association (RACSTA).
- Trainees who participate in these surveys are assured of confidentiality, and because they have not been advised that the information would be provided to the AMC, the College is reluctant to release it.

Cardiothoracic Surgery

No change

General Surgery

No change to the Trainees six monthly Training Post Evaluations

Neurosurgery

- No change to Trainee evaluations
- The SET Board of Neurosurgery, with funding from the Neurosurgical Society of Australasia, hosted its first supervisors face to face workshop over two days in June 2012. This was an opportunity for supervisors to get together to discuss issues and developments within the SET Program in Neurosurgery and will become an annual event.

Orthopaedic Surgery

- As above
- No change to the Trainees six monthly Training Post Evaluations

Otolaryngology Head and Neck Surgery

No change to the Trainees six monthly Training Post Evaluations

Paediatric Surgery

- No change to the yearly meeting with trainees at which areas of concern or updates to the program are communicated bi-laterally between Board and Trainee.
- The Trainee Representative attends the Board meetings and concerns or feedback are provided and noted in the Board minutes.
- No change to the yearly meeting with supervisors to provide updates and supervisors can also voice any concerns.
- The BoPS is developing a secure e-forum for supervisors as a place they can discuss the training program with the Board.

Plastic and Reconstructive Surgery

No change to the Trainees six monthly Training Post Evaluations on the on-line Trainee Management Program (TMP). These evaluations include assessment of the following components: clinical training, operative teaching, research, career advice, clinical management and feedback.

Urology

The Board of Urology receives ongoing feedback from trainees regarding the teaching, learning activities and training posts via the formal post assessment process that occurs each year. Additionally, the Board of Urology has established a Urology Training Forum comprising trainee representatives from each Section and SET level. One of the roles of the UTF is to provide regular feedback to the Board. The UTF has recently completed a survey of trainees regarding supervision during training and the results will be provided shortly.

Vascular Surgery

No change

6.2 Outcome Evaluation

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

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

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

Challenges and Changes

- Now that the first cohort of SET trainees are completing their training, the College is developing a plan to evaluate the outcomes of the SET training program in 2013-14.
- See the response in Section 1.5 – Recommendation 5 in regards to on-going communication with health care administrators and the jurisdictions
- Quantitative date on the outputs of the training program are available in the Activity Reports for public assess on the RACS website at:
  http://www.surgeons.org/government/workforce-and-activities-reports/

Brief summary of any completed training program evaluations

- Each year the Education Development and Research Department evaluates the selection process for most surgical specialties (some do their own) providing feedback on the effectiveness of the various selection tools and suggestions for improvements.
- A staff member in the Education Development and Research Department is currently undertaking her PhD, researching to find the level of congruence between the different selection tools and trainees' performance on examinations and workbased assessment during training.
- No evaluation of course outcomes or outputs have been completed in the last 12 months
- In the new Partnering Agreements the specialty training boards will be required to pay continued attention to monitoring their programs and reporting on the outcomes of those evaluations

STANDARD 7: ISSUES RELATING TO TRAINEES

7.1 Admission Policy and Selection

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

7.1.2. The processes for selection into the training program:

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

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

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

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

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

Challenges and Changes

College - generic

As part of the new Partnering Agreement the policy on selection has been modified to articulate the principles on which selection must be based whilst giving the specialty training boards more flexibility in the way in which they implement their selection processes.

http://www.surgeons.org/media/348041/pol_2012-02-25_selection_to_surgical_education_and_training_v5.pdf

Cardiothoracic Surgery

Based on applicant and stakeholder feedback the Cardiothoracic training board are in the process of changing the SET Selection Regulations and requirements for 2013 Selection process.

- Extension of the validity period of mandatory rotations from 2 to 5 years.

General Surgery

Selection will change in the future but the three selection tools of Interview, CV and Referee Report will remain, only the structure and format will change. This is still in development - further details cannot be provided until approved by the Board in General Surgery and BSET.

Neurosurgery

The SET Board of Neurosurgery continues to evaluate its selection process on an annual basis and collects evaluations from applicants who present for the interview as part of the selection process.

Otolaryngology Head and Neck Surgery

Each year the OHNS training board conducts on-line surveys with their interviewers and all interviewer candidates. Based on that feedback their interview processes have been modified to allow applicants more time to pre-read the interview questions prior to meeting the panel.

Orthopaedic Surgery

- Feedback from stakeholders has been incorporated where possible, including:

- Moving to a fully online application form
- Flexible submission processes facilitating dialogue between AOA and applicants
- Greater communication at all stages of the process to promote clarity of requirements and ease anxiety amongst applicants
- Streamlining of Interviews
- Provision of practical, effective feedback to unsuitable/unsuccessful applicants
- More stringent eligibility pre-requisite requirements
- A trial of competency-based eligibility requirements (as opposed to purely time-based)
- CV point weighting for research and anatomy

- Informal positive feedback from all parties has been received in response to these changes, following the most recent selection round.
- A further selection review workshop is scheduled for September

Paediatric Surgery

No change, although the Board wishes to undertake a study on trainees and selection results from the last 10 years to improve the selection process this has been difficult to progress due to perceived privacy issues in accessing training records of completed and failed trainees.

Plastic and Reconstructive Surgery

No change

Urology

- The Board of Urology undertakes a review of the selection process each year. Comprehensive feedback is obtained from applicants, interviewers and SET supervisors. Amendments are made (where appropriate) with the aim of selecting the most appropriate candidates within a robust, objective and transparent process.
- A review of the process undertaken in 2012 is currently underway. The Board is also taking into account the revised principles based policy regarding selection and there may be some amendments to the process for 2013.

Vascular Surgery

Based on concerns expressed by interviewers and board members about the high proportion of candidates interviewed compared to the number of available posts, the Vascular Surgery training board is collecting data and reviewing the impact of revising their 'eligibility for interview' cut-point.

Statistical data:

Data from the selection processes as well as on Trainee progression is published in the Activity Reports which are available for public assess on the RACS website at:
http://www.surgeons.org/government/workforce-and-activities-reports/

7.2 Trainee Participation in Training Organisation Governance

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

Summary of interactions with Trainee Associations

- The College Trainee Association, RACSTA has matured into an organisation that has wide representation across all specialties and regions.
- There are robust reporting systems within RACSTA that enable communication with College Boards (including Council), specialty training boards and trainees
- RACSTA is supported well by administrative staff at the College.
- RACSTA continue to run a very successful induction course for new Trainees

- RACSTA and the trainee opinion it represents is highly valued and often approached to give its opinion on training matters and governance structures within the College (for examples see below).
- All of the specialties are represented in RACSTA
- These specialty Trainee representatives also participate in and contribute to the specialty training board meetings
- Some of the larger specialty training boards also have their own Trainee associations
- All specialties arrange trainee meetings as part of their Annual Scientific Meetings

Significant issues raised

- Three of the issues that Trainee representatives have brought to the attention of College Education committees are:
  - 'Safe working hours' and
  - 'Competent but not Confident'
  - Mentoring and Coaching
- In each instance the Education Board Executive have agreed to set up working parties which will involve members of RACSTA (and Younger Fellows)
- See also Section 5.2 Recommendation 17, page 21

7.3 Communication with Trainees

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

Challenges and Changes

College - generic

- The new College public website provides clearer access to information for potential trainees
- The Member (password protected) website is designed to provide Trainees with quicker access to the information they are likely to need.
- All College members (Trainee and Fellows) receive the weekly College e-journal – Fax Mentis.
- All College members (Trainee and Fellows) receive monthly e-news of Council Highlights from the College President
- As part of the new Partnering Agreements the specialties will be required to publish clearly defines documents (policies, regulations, and training requirements) that need to be published on the public section of their websites.

Cardiothoracic Surgery

No change

General Surgery

a) mechanisms to inform trainees of activities of decision making committees

Trainees are communicated with regularly through a trainee newsletter and also through email when changes to regulations occur. The Board and regional subcommittee each have a trainee

representative as a committee member who liaise with RACSTA if and when required. The Board is also looking at having trainees on hospital inspection teams.

b) capacity to provide training status information to trainees

Trainees have access to their online portfolio through the GSA Database – TMS (Trainee Management System). Trainees have access to their status, start date, end and max dates, assessments, logbooks, requirements completed and requests including periods of interruption.

Neurosurgery

No change

Otolaryngology Head and Neck Surgery

No change

Orthopaedic Surgery

a) mechanisms to inform trainees of activities of decision making committees

- Formal terms of reference for Trainee Committee developed and approved by the AOA Board, committee support provided by AOA head office
- Trainee representation on major Boards and Committees, additional input sought routinely for projects/activities managed by AOA staff
- Direct support of AORA conference

b) capacity to provide training status information to trainees

Information currently provided on request, individual live progression data to be available to trainees following eLC system upgrade

Paediatric Surgery

- The Board of Paediatric Surgery has a yearly meeting with trainees: areas of concern or updates to the program are communicated bi-laterally between Board and trainee.
- The Trainee Representative attends the Board meetings and concerns or feedback are provided and noted in the Board minutes.

Plastic and Reconstructive Surgery

No change

Urology

a) mechanisms to inform trainees of activities of decision making committees

The Board has established a Urology Trainee Forum which meets regularly. This forum provides an opportunity for the Board to disseminate information to trainees on activities and new developments. Additionally, the Board holds two meetings a year (one at the ASM, one at Trainee Week) with all trainees. At these meetings, the Board provides an update to trainees on activities and changes in policies or regulations. There is also regular contact (via email) to all trainees and supervisors regarding new processes or changes to current procedures

b) capacity to provide training status information to trainees

This information is currently provided by the College and provided the information is accurate, the Board does not feel there is a need to duplicate the work in this area

Vascular Surgery

No change

7.4 Resolution of Training Problems and Disputes

7.4.1. The training organisation has processes to address confidentially problems with training supervision and requirements.

7.4.2. The training organisation has clear impartial pathways for timely resolution of training related disputes between trainees and supervisors or trainees and the organisation.

7.4.3. The training organisation has reconsideration, review and appeals processes that allow trainees to seek impartial review of training-related decisions, and makes its appeals policies publicly available.

7.4.4. The training organisation has a process for evaluating de-identified appeals and complaints to determine if there is a systems problem.

Challenges and Changes

- The College policies and process have not changed
- See response to Recommendation 17: Section 5.2 in relation to underperforming trainees
- The College has recently appointed a part-time **'**In-house Counsel' to provide advice on training issues
- The relevant policy is available for public access on the College website at: http://www.surgeons.org/policies-publications/policies/appeals/

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

8.1 Supervisors, Assessors, Trainers and Mentors

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

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

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

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

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

Recommendation 27:
Report in annual reports to the AMC on:

- *changes in the workload of supervisors after the introduction of SET*
- *the introduction of training for supervisors and trainers in the new work-based assessment methods*
- *progress in developing a process for trainee evaluation of their supervision.*

Challenges and changes

College - generic

- The policies outlining the process for the selection of Supervisors and assessors and requirements and responsibility for surgical Supervisors and Trainers have not changed. These are available on the College website for public access at: http://www.surgeons.org/policies-publications/policies/surgical-education-and-training/
- The College continues to provide training for Supervisors, Trainers and assessors in the SAT SET and KTOT courses which are free for members of the College.
- See information about the two new courses being piloted in Section 1.3, Recommendation 2: page 5

Progress in developing a process for trainee evaluation of their supervision –

See the information about Trainee evaluation in Section 6.1, Recommendation 23, pp. 20-21.

Cardiothoracic Surgery

- Introduction of electronic logbooks and DOPS in 2012 have increased input of supervisors, assessors and trainers. The impact of this will be evaluated in 2013
- A newsletter is sent to supervisors after each Board meeting outlining any training updates and any current relevant training information or reminders.

General Surgery

- The process of appointing supervisors occurs at the hospital level, then approved by regional subcommittee, Board and reported to BSET

- The roles of supervisors, assessors and trainers are defined in the Supervisor handbook specific to General Surgery has been developed and supervisors also have access to the online portfolio through the TMS for trainees under their supervision for any given term.

Neurosurgery

- As reported above, the SET Board of Neurosurgery with funding from the Neurosurgical Society of Australasia hosted a supervisors face to face workshop over two days in June 2012. This was an opportunity for supervisors to get together to discuss issues and developments within the SET Program in Neurosurgery and will become an annual event.
- This also included training on the new competency assessment methods and the RACS training course Keeping Trainees on Track

Otolaryngology Head and Neck Surgery

The RACS version of the NOTSS (Non-Technical Skills for Surgeons) course was run in association with the 2012 ASM.

Orthopaedic Surgery

Methods to better support supervisors have been identified for progressive implementation including:

- A supervisor workshop is scheduled for the ASM in October
- Better definition of the role of Supervisors is to be documented
- Handbook type materials are to be developed

Paediatric Surgery

The Board of Paediatric Surgery acknowledges the increase to the workload of supervisors especially those that are supervising underperforming trainees.

Plastic and Reconstructive Surgery

- The Board provides supervisors and trainers with a supervisors' edition of the Plastic and Reconstructive Surgery Training Handbook. This handbook includes comprehensive information about the training programme and related policies.
- They also receive a manual to facilitate their use of the online Trainee Management Program (TMP) to enter PPAs, mini-CEX and DOPS.
- The College courses - Supervisors and Trainers for Surgical Education and Training (SAT SET) and Keeping Trainees on Track (KTOT) provide training.
- The Board considers that the influx of junior registrars and their associated lower skill levels since the introduction of SET has placed more strain on the Consultant's time.
- The Board resolved that new supervisors be strongly advised to attend the SAT/SET course within six months of beginning their tenure as supervisor.

Urology

- No change to current process of appointing supervisors
- No change to current process in relation to the roles of supervisors, assessors, trainers and mentors.
- Activities to support supervisors etc. currently provided via College courses and initiatives and the Board of Urology actively encourages supervisors and trainers to participate in these initiatives.

Vascular Surgery

No change

Summary of activities to support supervisors, assessors, trainers and mentors

College - generic

- The College has developed and published the document '*Becoming a competent and proficient surgeon: Training Standards for the nine RACS Competencies'*.
- The College provides a range of free training courses that are available for all Fellows (including Supervisors, Assessors, Trainers, and Mentors). Currently these include:
  - SAT SET; KTOT; and NOTSS
- The College also encourages Fellows and IMGs to attend the 'Process Communication Model' course

Information about these courses is available at: http://www.surgeons.org/for-health-professionals/register-courses-events/professional-development/

- As outlined in 1.3, Recommendation 2, the College is in the process of piloting two new courses that will be appropriate for Fellows, Trainees, and IMGs.
- The College is redeveloping its Academy of Surgical Educators to provide better supports for, and educational development opportunities for, its surgical educators – who include the supervisors and trainers.

Specialty specific

- Many of the specialties have arranged for the above courses to be run in association with their Annual Scientific Meetings (ASMs).
- During their ASMs (and at other times) specialties have designated meetings for their Supervisors, Assessors, Trainers, and Mentors.
- The larger specialties have regional training boards comprised of the Supervisors in that region (state)
- The training boards of all specialties comprise Supervisors from all regions
- Many of the specialties have manuals for supervisors on their websites
- Some of the specialties have regular news bulletins that are sent out to all of their Supervisors
- Orthopaedic Surgery is reviewing their material for supervisors. Their plans include:
  - A supervisor workshop scheduled for the ASM in October
  - Better definition of the role of Supervisors is to be documented
  - Handbook type materials are to be developed

8.2 Clinical and Other Educational Resources

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

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

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

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

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

Challenges and changes

College - generic

- The College Hospital Accreditation requirements have not changed
- See information in response to Section 1.4 Interactions with the health sector, pages 9-10

Supplementary question:
How does the college ensure that trainees receive appropriate experience in ambulatory and consultative surgery in NSW in the absence of outpatient clinics?

College - generic

This issue was discussed at the August teleconference of Education Board Executive where it was proposed that the College reinvestigate training access in private hospitals.

Cardiothoracic Surgery

Access to outpatient and ambulatory experiences are regarded as important criteria and are assessed when accrediting posts for training

General Surgery

Interactions with health services to ensure effective service-based training and to ensure that trainees can experience the breadth of the discipline are undertaken during inspections when we meet with the hospital administration

Neurosurgery

No change

Otolaryngology Head and Neck Surgery

No change

Orthopaedic Surgery

A JR continues to sit on the Training Board. Improved definition of the role of JRs in AOA activities is to be documented.

Paediatric Surgery

The Board of Paediatric Surgery has discussed the issues in NSW and seen the effects to trainees who have less exposure to consultants and ambulatory clinics however the specific problems of underfunding of paediatric surgery in Australia and New South Wales makes this difficult to address solely through the training board as it is an industrial and governmental health funding issue. The BoPS will however be scrutinising compliance with compulsory ambulatory and elective caseload access in NSW during the hospital post accreditation cycle in 2013.

Plastic and Reconstructive Surgery

Hospital accreditation procedure has been revised to more specifically define the training requirements for Standard 5: clinical load and theatre sessions.

Urology

- Appropriate supervision of SET urology trainees creates an environment of safety for patients with enhanced opportunities for mastering the competencies outlined by the College. The Urology Trainee Forum has conducted an anonymous survey of all SET Urology Trainees to determine the levels of supervision currently being provided. The results will shortly be presented to the Board of Urology.

- Trainees in NSW receive appropriate experience in ambulatory and consultative surgery in NSW either in formal outpatient clinics or clinics that are arranged within the private rooms of urologists. This gives the trainees a greater understanding of consultative surgery. Clinics may comprise new and follow up consultations and are supervised by an urologist.

Vascular Surgery

No change

Supplementary question:
Please provide an up-date on the progress of the attempts to charge jurisdictions for the accreditation of training posts.

Because of continued resistance from the hospitals and jurisdictions to paying the cost of the accreditation and reaccreditation of hospital posts this charge has reverted to being taken from fees paid by the Trainee.

Summary of Post accreditation activities

See Appendix 4

STANDARD 9: CONTINUING PROFESSIONAL DEVELOPMENT

9.1 Continuing Professional Development Programs

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

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

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

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

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

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

Statistical data:

Data for CPD participation is published in the Activity Reports which are available for public assess on the RACS website at:

http://www.surgeons.org/government/workforce-and-activities-reports/

Summary of activities aimed at improving participation in CPD programs

All active Fellows of the College (engaged in medicine, surgery and medico-legal services) are required to participate in the CPD Program. The program aims to:

- advance the individual surgeon's surgical knowledge and skills for the benefit of patients
- provide surgeons with tangible evidence of participation in and compliance with the program by the award of a certificate.

For those surgeons who are vocationally registered in Australia and New Zealand, and who are not Fellows of the College, the Department of Professional Standards also offers the Maintenance of Professional Standards (MOPS) Program.

As of August 2012, 90% of Fellows were compliant in 2010 (the last full annual cycle) and 84% in 2011. The Professional Development and Standards Board continue to deliberate on incentives and sanctions to increase participation and compliance in the CPD Program (please see below).

Challenges and changes

The review of the College's CPD program ahead of the conclusion to the 2010-2012 triennia has included an in-depth analysis of program requirements and incentives/penalties for Fellows participation. The review involved consultation with Fellows, Specialty Societies, Regional Committees and other interest groups within the College. The Professional Development and Standards Board are currently developing a framework for CPD with key aims including:

- From 2013, there is an annual program, which will enable refinement of the CPD program to collect and review CPD data on annual basis and align with AHPRA/NZMC requirements;
- Simplification of CPD Categories and Practice Types to reduce complexity to participants;
- In addition to a continued focus on audit, clinical governance and learning activities, there will be the introduction of a 'Performance Assessment' category to encourage Fellows to seek feedback on their performance

- Following statistical advice to the relevant Councillor, In 2013 there will be a review of the number of participants selected to verify their CPD participation annually with view to increase this percentage
- An increase in Fellows submitting their CPD online with a view to mandating this in the next 2-3 years

Achieving full participation and compliance in the CPD program remains an on-going challenge. The Council have supported in principle a move to addressing persistent failure to comply with CPD requirements as a breach of the College's Code of Conduct with the ultimate penalty for persistent breaches being loss of Fellowship.

At present the College sends up to four reminder letters annually to Fellows who have not participated or who are not compliant with their CPD requirements. In addition all specialty societies are provided with a list of all non-participating and non-compliant Fellows. This is provided to societies in June and again in October. The College also offers a variety of information services to Fellows through the College website, email and in print, with CPD participation and reminders featuring regularly in each medium.

The College is also undertaking a significant review and upgrade of its online system to ensure CPD participation is effective and time efficient for surgeons participating in the program. The system will provide functionality that allows Fellows to easily upload verification documents against their CPD record.

9.2 Retraining

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

- The College has a process of retraining and reskilling surgeons. However as noted in the 2011 report the two terms are not synonymous.
    - Retraining applies to surgeons who previously possessed the skills in the areas where there are now deficiencies. These deficiencies may be technical or non-technical skills.
    - Reskilling requires the attainment of skills not previously possessed which may pertain to a new procedure or an alteration in devices used. This is particularly relevant to surgeons returning to practice after an absence, or those who have not kept up with surgical developments. This pertains mainly to technical skills and less commonly to non-technical areas.

  In both these areas RACS maintains a policy which is managed through the Offices of the Executive Directors for Surgical Affairs. The policy was reviewed in 2012 and is available via the College website:
  http://www.surgeons.org/media/312190/pol_2012_06_19_re-skilling_and_re-entry_program_guidelines.pdf

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

Challenges and Changes

- As RACS has no regulatory powers regarding registration or credentialing for practice within hospitals and other institutions we are limited in activity to requests from the Medical Board of Australia (MBA) or the Medical **C**ouncil of New Zealand (MCNZ) for re-training, or re-skilling; or in

response to issues that arise out of review of the practice of individual surgeons which is often performed at the request of individual hospitals or District Health Boards (DHBs).

- On many occasions the difficulty that RACS as well as the jurisdiction(s) face relates to insight of the surgeon undertaking this process.
- It is difficult to find a position that is possible to achieve either re-skilling or re-training, with a willing supervisor, whilst at the same time not interfering with the training program of registrars in the SET program.
- It is also difficult if the surgeon is required to move from their place of employment.
    - The best situations are where surgeon supervisors are familiar with supervising Trainees and methods of assessment commonly used. Then the surgeon undergoing re-training or re-skilling is able to be assessed and benchmarked with the same rigor and with the same endpoint of a Trainee/ surgeon who is equipped for independent surgical practice.

9.3 Remediation

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

Challenges and Changes

- RACS regards remediation as one of the collegial obligations to our Fellows/Trainees/IMGs on a pathway to Fellowship.
- Remediation more often refers to failure to perform appropriately or departure from acceptable practice involving the non -technical skills and behaviours of surgeons. Again there are difficulties, but courses and programs are available through the RACS Professional Development Department, concerning communication skills, dealing with the difficult patient, surgical audit and cultural awareness. In addition surgeons are directed to appropriate courses run by outside providers relating to anger management, bullying and harassment.
- See Section 9.2. Similar difficulties are experienced in this area and it presents RACS with the challenge of sourcing such re-training whilst providing appropriate supervision, an income stream, and at the same time not interfering with the experience gained in training programs for surgical Trainees who are aspiring to gain appropriate training and experience to serve the community.
- RACS has developed an assessment tool for measuring Surgical Competence and Performance based on behavioural markers. This is aimed for use by surgeons and also by Trainees aspiring to be surgeons. The Surgical Competence and Performance Guide can be accessed via the College website:

http://www.surgeons.org/media/348281/pos_2011-06-23_surgical_competence_and_performance_guide__2nd_edition_.pdf

APPENDICES:

Appendix 1 List of Acronyms

AHPRA	Australian Health Practitioner Regulation Agency
AMC	Australian Medical Council
ACF	Australian Curriculum Framework (Junior doctors)
ANZAPS	Australian and New Zealand Association of Paediatric Surgeons
AOA	Australian Orthopaedic Association
AORA	Australian Orthopaedic Registrars Conference
ASC	Annual Scientific Congress (College)
ASM	Annual Scientific Meeting (Specialties)
AUA	American Urological Association
BAUS	British Association of Urological Surgeons
BoPS	Board of Paediatric Surgery
BoRC	Board of Regional Chairs
BSET	Board of Surgical Education and Training
CBD	Case-Based Discussion
CBT	Competency-based training
CE	Clinical Examination
CETI (IMET)	Clinical Education and Training Institute (NSW)
CLEAR	Critical Literature Evaluation and Research (course)
CPD	Continuing Professional Development
CPMC	Council of Presidents of Medical Colleges
CPMEC	Confederation of Postgraduate Medical Councils
CV	Curriculum Vitae
DCAS	Developing a Career in Academic Surgery (course)
DHA	Department of Health and Aging
DHBs	District Health Boards
DOPS	Direct Observation of Procedures
EAU	European Association of Urology
EB	Education Board
EDRD	Education Development and Research Department
FEX	Fellowship Examination
FRACS	Fellow of the Royal Australasian College of Surgeons
GSA	General Surgeons Australia
HWA	Health Workforce Australia
IMG	International Medical Graduate
ITA	In-Training Assessment
JRs	Jurisdictional representatives
KTOT	Keeping Trainees on Track
MBA	Medical Board of Australia
MCQ	Multi-choice Question

MCNZ	Medical Council of New Zealand
Mini-CEX	Mini-Clinical Examinations
MOPS	Maintenance of Professional Standards
MOSES	Management of Surgical Emergencies
MOU	Memorandum of Understanding
MOUSE	Measurement of Understanding of Surgical Expertise
MSF	Multi-Source Feedback – also know as 360^0
KTOT	Keeping Trainees on Track
NMCE	Network of Medical College Educators
NOTSS	Non-technical Skills for Surgeons (course)
NZAGS	New Zealand Association of General Surgeons
NZOA	New Zealand Orthopaedic Association
NZMC	New Zealand Medical Council
PBA	Procedure Based Assessment
PD	Professional Development
P-MEX	Professionalism Assessment Form
PPA	Professional Performance Assessment
PSA	Provincial Surgeons of Australia
PRSSPE	Plastic and Reconstructive Surgical Science and Principles Examination
RACP	Royal Australasian College of Physicians
RACS	Royal Australasian College of Surgeons
RACSTA	Royal Australasian College of Surgeons Trainees' Association
RCPSC	Royal College of Physicians and Surgeons of Canada
RCS	Royal College of Surgeons
SAG	Special Advisory Group
SA IMET	South Australian Institute of Medical Education and Training
SAT SET	Supervisors and Trainers for SET (course)
SDM	Surgical Decision Making (Course)
SEAC	Special Education Advisory Committee
SEAM	Surgical Education and Assessment Modules
SET	Surgical Education and Training
SSE	Surgical Sciences Examination
STP	Specialist Training Program
TMP	Trainee Management Program
TMS	Trainee Management system
TSIA	Training Standards – Interpretation and Application (course)
USANZ	Urological Society of Australia and New Zealand
UTF	Urology Training forum
WPB	Work-place-based
YF	Younger Fellows

360^0	360 degree evaluation – also known as MSF

Surgical Specialties

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

Appendix 2 Timetable for the planned move to competency-based training

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

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

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

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

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

As commented earlier, safe-hours guidelines and increased numbers of medical graduates have reduced typical working hours in PGY1-4. Hospitals, in order to accommodate service workload as well as the governmental ‘directives’ to increase the number of training positions, have often then employed more registrars, who in turn have shorter working weeks. Less opportunity for clinical experiential learning will limit the influence of CBT in terms of shortened time of training programs such as the College’s SET system. However, utilising CBT concepts and mapping progress such as described by TSIA documents, within the SET system should aid efficiency by identifying any issues across the RACS Nine Competencies early.

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

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

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

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

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

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

Appendix 3 Data from the Fellowship Examination May 2012

Candidates who passed the Exam by Location

	ACT	NSW	NT	QLD	SA	TAS	VIC	WA	NZ	OS	Total
Total Sitting	1	64	3	35	13	4	61	12	29	1	223
Pass	1	36	2	29	7	2	43	6	26	1	153
	100%	56.3 %	66.7 %	82.9 %	53.8 %	50%	70.5 %	50%	89.7 %	100%	68.6 %

Candidates who passed the Exam by Specialty and Location

		ACT	NSW	NT	QLD	SA	TAS	VIC	WA	NZ	O/S	Total
CAR	Sat	0	1	0	0	0	0	3	0	2	0	6
	Pass	0	1	0	0	0	0	3	0	2	0	6
GEN	Sat	1	25	2	14	8	0	23	6	12	0	91
	Pass	1	13	1	10	4	0	14	1	11	0	55
NEU	Sat	0	3	0	3	0	0	5	0	0	0	11
	Pass	0	3	0	3	0	0	5	0	0	0	11
ORT	Sat	0	14	1	9	5	1	13	6	11	1	61
	Pass	0	9	1	7	3	1	8	5	9	1	44
OTO	Sat	0	4	0	4	0	1	9	0	2	0	20
	Pass	0	3	0	4	0	0	6	0	2	0	15
PAE	Sat	0	2	0	0	0	0	0	0	0	0	2
	Pass	0	0	0	0	0	0	0	0	0	0	2
PLA	Sat	0	9	0	0	0	2	3	0	0	0	14
	Pass	0	5	0	0	0	1	3	0	0	0	9
URO	Sat	0	2	0	4	0	0	4	0	1	0	11
	Pass	0	1	0	4	0	0	3	0	1	0	9
VAS	Sat	0	4	0	1	0	0	1	0	1	0	7
	Pass	0	1	0	1	0	0	1	0	1	0	4
Total		1	64	3	35	13	4	61	12	29	1	223

Appendix 4 List of hospital posts accredited / reaccredited in 2011

Hospital Name	Specialty	Region	Country
Prince Charles Hospital	CAR	QLD	AUSTRALIA
Princess Alexandra Hospital & Health Service District	CAR	QLD	AUSTRALIA
Royal Perth Hospital	CAR	WA	AUSTRALIA
Sir Charles Gairdner Hospital	CAR	WA	AUSTRALIA
Waikato Hospital	CAR	NZ	NEW ZEALAND
Wellington Hospital	CAR	NZ	NEW ZEALAND
Broome District Hospital	GEN	WA	AUSTRALIA
Bunbury Regional Hospital - Renamed South West Health Campus	GEN	WA	AUSTRALIA
Bundaberg Base Hospital	GEN	QLD	AUSTRALIA
Casey Hospital	GEN	VIC	AUSTRALIA
Dandenong Hospital	GEN	VIC	AUSTRALIA
Epworth Hospital	GEN	VIC	AUSTRALIA
Frankston Hospital	GEN	VIC	AUSTRALIA
Frimley Park Hospital (SW Thames)	GEN	Overseas	
Goulburn Valley Health	GEN	VIC	AUSTRALIA
John Hunter Hospital	GEN	NSW	AUSTRALIA
Joondalup Health Campus	GEN	WA	AUSTRALIA
Liverpool Hospital	GEN	NSW	AUSTRALIA
Maitland Hospital	GEN	NSW	AUSTRALIA
Mackay Health Service District	GEN	QLD	AUSTRALIA
Monash Medical Centre	GEN	VIC	AUSTRALIA
Moorabbin Campus Southern Health	GEN	VIC	AUSTRALIA
Mt Druitt Hospital	GEN	NSW	AUSTRALIA
Osborne Park Hospital	GEN	WA	AUSTRALIA
Princess Alexandra Hospital & Health Service District	GEN	QLD	AUSTRALIA
Queen Elizabeth Hospital & Health Service	GEN	SA	AUSTRALIA
Rockhampton Hospital	GEN	QLD	AUSTRALIA
Rockingham Kwinana District Hospital	GEN	WA	AUSTRALIA
Sandringham & District Memorial Hospital	GEN	VIC	AUSTRALIA
Sir Charles Gairdner Hospital	GEN	WA	AUSTRALIA
St George Hospital	GEN	NSW	AUSTRALIA
St John of God (Bunbury)	GEN	WA	AUSTRALIA
St John of God (Subiaco)	GEN	WA	AUSTRALIA
Sunshine Hospital	GEN	VIC	AUSTRALIA
Tweed Hospital	GEN	NSW	AUSTRALIA
Whangarei Hospital	GEN	NZ	NEW ZEALAND
Whanganui District Health Board	GEN	NZ	NEW ZEALAND
Werribee Mercy Hospital	GEN	VIC	AUSTRALIA
West Gippsland Healthcare Group	GEN	VIC	AUSTRALIA
Western Hospital Footscray	GEN	VIC	AUSTRALIA
Westmead Hospital	GEN	NSW	AUSTRALIA
Austin Health	NEU	VIC	AUSTRALIA
Canberra Hospital	NEU	ACT	AUSTRALIA
Christchurch Hospital	NEU	NZ	NEW ZEALAND
Macquarie University Private Hospital	NEU	NSW	AUSTRALIA
Prince of Wales Hospital	NEU	NSW	AUSTRALIA
Royal Brisbane and Women's Hospital	NEU	QLD	AUSTRALIA
Royal Children's Hospital (VIC)	NEU	VIC	AUSTRALIA
St George Hospital	NEU	NSW	AUSTRALIA

St Vincent's Hospital Sydney	NEU	NSW	AUSTRALIA
The Children's Hospital At Westmead	NEU	NSW	AUSTRALIA
Townsville Health Service District	NEU	QLD	AUSTRALIA
Westmead Hospital	NEU	NSW	AUSTRALIA
Wollongong Hospital	NEU	NSW	AUSTRALIA
Adelaide Women's and Children's Hospital	OHN	SA	AUSTRALIA
Alfred Hospital	OHN	VIC	AUSTRALIA
Flinders Medical Centre	OHN	SA	AUSTRALIA
Royal Melbourne Hospital	OHN	VIC	AUSTRALIA
St Vincent's Hospital Sydney	OHN	NSW	AUSTRALIA
Sydney Hospital / Sydney Eye Hospital	OHN	NSW	AUSTRALIA
Westmead Hospital	OHN	NSW	AUSTRALIA
Concord Repatriation General Hospital	ORT	NSW	AUSTRALIA
Fairfield Health Service	ORT	NSW	AUSTRALIA
Hawkesbury District Health Service Ltd	ORT	NSW	AUSTRALIA
Hornsby Ku-ring-gai Hospital	ORT	NSW	AUSTRALIA
Hutt Hospital	ORT	NZ	NEW ZEALAND
Joondalup Health Campus	ORT	WA	AUSTRALIA
Lismore Base Hospital	ORT	NSW	AUSTRALIA
Liverpool Hospital	ORT	NSW	AUSTRALIA
Logan Hospital	ORT	QLD	AUSTRALIA
Mater Private Hospital Brisbane	ORT	QLD	AUSTRALIA
Mater Misericordiae Hospital (NSW)	ORT	NSW	AUSTRALIA
Middlemore Hospital (NZ)	ORT	NZ	NEW ZEALAND
North Shore Hospital (NZ)	ORT	NZ	NEW ZEALAND
Northern Hospital	ORT	VIC	AUSTRALIA
Norwest Private Hospital	ORT	NSW	AUSTRALIA
Palmerston North Hospital	ORT	NZ	NEW ZEALAND
Prince of Wales Hospital	ORT	NSW	AUSTRALIA
Princess Margaret Hospital	ORT	WA	AUSTRALIA
Rotorua Hospital	ORT	NZ	NEW ZEALAND
Royal Darwin Hospital	ORT	NT	AUSTRALIA
Royal North Shore Hospital	ORT	NSW	AUSTRALIA
Royal Prince Alfred Hospital	ORT	NSW	AUSTRALIA
Sir Charles Gairdner Hospital	ORT	WA	AUSTRALIA
St George Hospital	ORT	NSW	AUSTRALIA
St George Private Kogarah	ORT	NSW	AUSTRALIA
St Vincent's Hospital Sydney	ORT	NSW	AUSTRALIA
Sutherland Hospital Caringbah & Community Health Service	ORT	NSW	AUSTRALIA
Sydney Adventist Hospital	ORT	NSW	AUSTRALIA
Sydney Hospital / Sydney Eye Hospital	ORT	NSW	AUSTRALIA
The Children's Hospital at Westmead	ORT	NSW	AUSTRALIA
Tweed Hospital	ORT	NSW	AUSTRALIA
Wanganui Hospital	ORT	NZ	NEW ZEALAND
Royal Darwin Hospital	PAE	NT	AUSTRALIA
Wellington Hospital	PAE	NZ	NEW ZEALAND
Christchurch Hospital	PLA	NZ	NEW ZEALAND
Concord Repatriation General Hospital	PLA	NSW	AUSTRALIA
Frankston Hospital	PLA	VIC	AUSTRALIA
Hutt Hospital	PLA	NZ	NEW ZEALAND

Liverpool Hospital	PLA	NSW	AUSTRALIA
Middlemore Hospital (NZ)	PLA	NZ	NEW ZEALAND
Mount Hospital	PLA	WA	AUSTRALIA
Nepean Hospital	PLA	NSW	AUSTRALIA
Prince of Wales Hospital	PLA	NSW	AUSTRALIA
Princess Margaret Hospital	PLA	WA	AUSTRALIA
Royal Perth Hospital	PLA	WA	AUSTRALIA
Royal Prince Alfred Hospital	PLA	NSW	AUSTRALIA
Sir Charles Gairdner Hospital	PLA	WA	AUSTRALIA
St George Hospital	PLA	NSW	AUSTRALIA
St Vincent's Hospital Sydney	PLA	NSW	AUSTRALIA
Sydney Hospital / Sydney Eye Hospital	PLA	NSW	AUSTRALIA
Bega District Hospital	URO	NSW	AUSTRALIA
Box Hill Hospital	URO	VIC	AUSTRALIA
Canberra Hospital	URO	ACT	AUSTRALIA
Concord Repatriation General Hospital	URO	NSW	AUSTRALIA
Fremantle Hospital & Health Service	URO	WA	AUSTRALIA
Geelong Hospital	URO	VIC	AUSTRALIA
Hornsby Ku-ring-gai Hospital	URO	NSW	AUSTRALIA
Mater Private Hospital Brisbane	URO	QLD	AUSTRALIA
Monash Medical Centre	URO	VIC	AUSTRALIA
Nepean Hospital	URO	NSW	AUSTRALIA
Queen Elizabeth Hospital & Health Service	URO	SA	AUSTRALIA
Royal Brisbane and Women's Hospital	URO	QLD	AUSTRALIA
Royal Perth Hospital	URO	WA	AUSTRALIA
Royal Prince Alfred Hospital	URO	NSW	AUSTRALIA
St Vincent's Private Hospital Lismore	URO	NSW	AUSTRALIA
Sydney Children's Hospital	URO	NSW	AUSTRALIA
Western Hospital Footscray	URO	VIC	AUSTRALIA
Canberra Hospital	VAS	ACT	AUSTRALIA
Christchurch Hospital	VAS	NZ	NEW ZEALAND
Flinders Medical Centre	VAS	SA	AUSTRALIA
Frankston Hospital	VAS	VIC	AUSTRALIA
Gosford Hospital	VAS	NSW	AUSTRALIA
Liverpool Hospital	VAS	NSW	AUSTRALIA
Middlemore Hospital (NZ)	VAS	NZ	NEW ZEALAND
Prince Charles Hospital	VAS	QLD	AUSTRALIA
Queen Elizabeth Hospital & Health Service	VAS	SA	AUSTRALIA
Royal Brisbane and Women's Hospital	VAS	QLD	AUSTRALIA
Royal Melbourne Hospital	VAS	VIC	AUSTRALIA
St Vincent's Hospital Sydney	VAS	NSW	AUSTRALIA
Townsville Health Service District	VAS	QLD	AUSTRALIA
Westmead Hospital	VAS	NSW	AUSTRALIA
Wollongong Hospital	VAS	NSW	AUSTRALIA