ROYAL AUSTRALASIAN COLLEGE OF SURGEONS

RACS response to AMC assessment team request for additional information

March 2017

Contents

Standard 1 3
Standard 2 5
Standard 3 6
Standard 4 8
Standard 5 8
Standard 6 10
Standard 7 11
Standard 8 13
Standard 9 15
Standard 10 17

Standard 1

The context of education and training (governance; program management; reconsideration, review and appeal processes; educational expertise and exchange; educational resources; interaction with the health sector; continuous renewal)

Additional information:

Please provide the following:

AMC requirement	RACS response
• Up-to-date membership lists for Council and the College's principal education and training committees. Please indicate which committees have external members and trainee representation.	Attached (AI001): • Council (Office holders and councillors 2016-2017) • Education Board • BSET • PDSB • Professional Development Committee • Professional Standards Committee
• Details regarding how the College recruits and appoints external members to its committees.	Attached (AI002): • Procedure: External Co-opted Members on Committees and Boards • Policy: External Co-opted Members of Committees and Boards • Policy: Nomination Committee Terms of Reference
• A copy of the College's diversity plan as detailed on page 29 of the College's accreditation submission.	Attached: (AI003) Diversity plan
• A copy of the 2016 RACS Activities Report.	Attached: (AI004) 2016RACS Activities Report
• A copy of the Building Respect, Improving Patient Safety Action Plan for the next 12 months.	Attached: (AI005) Plan, (AI006)2016 Progress Report
• A list of the staff of the Academy of Surgical Educators, which includes specialty (where relevant) and all qualifications (e.g. medical, educational).	Attached: (AI007) list of Academy of Surgical Educators members Background Surgical educators are critical to the success of RACS education, training and professional development programs at multiple levels. They are involved in the governance, design and development, implementation and assessment of a range of surgical education activities. The quality of RACS education programs is dependent on the broadest skills of these educators. The Academy of Surgical Educators includes Fellows, Trainees and others who are educators at various levels who have a keen interest in facilitating learning and teaching and a commitment to surgical education. Objectives • To advise on the strategic direction needed to sustain a strong culture of professional development of surgical educators in the competence of Scholar and Teacher.

AMC requirement	RACS response
	• To raise the standard of educational support provided by supervisors and trainers of Trainees and International Medical Graduates. • To encourage innovation and scholarship in professional development to enhance the effectiveness and competence of surgical educators. • To recognise, reward and sustain RACS surgical educators. • To foster links with external organisations/groups and engage their expertise to achieve the objectives of the Academy. *Note that surgical educators include supervisors, trainers, IMG Clinical Assessors, workshop facilitators, interviewers, course instructors and examiners, including both FRACS and non-FRACS educators*
• A report on how the College is addressing AMC recommendation 2: Report to the AMC on the schedule of planned changes in its educational programs and the proposed time of implementation. Include an update on changes to the assessment of generic and specialty specific basic sciences, and potential changes to the Fellowship examination.	Each specialty program continues to progress at its own pace, guided by RACS principle-based policies and training agreements. See *(AI008) Additional information provided by specialty training boards* attached, p. 2-4. RACS Generic Surgical Science Examination (GSSE), delivered online only, became a prerequisite for application to SET in most specialties in 2016. It is a prerequisite for application to SET in all specialties from 2017. Delivery numbers have increased to approximately 300 per implementation (3 times per year). This exam continues to be held at venues throughout Australia and New Zealand. The specialty specific SSE is also delivered online only, at venues as per the GSSE. Specialties continue to refine the content of the specialty specific SSE and methods of standard setting were reviewed in 2015-2016. RACS is transitioning to electronic delivery of the written component of the FEX. Five specialties (cardiothoracic surgery, neurosurgery, paediatric surgery, urology and vascular surgery) to date give candidates the option to take this as paper-based or electronic format. Orthopaedic surgery delivers their MCQ component only electronically. (Note: no other specialty has an MCQ component). Vascular Surgery replaced one of the written components of their FEX with a viva. Tablet marking of the Viva components of the FEX is planned. This is likely to be piloted in 2018. No changes to the content are planned

Standard 2

The outcomes of specialist training and education (educational purpose; program outcomes; graduate outcomes)

Additional information:

Please provide the following:

AMC requirement	RACS response
• A collated summary document showing program outcomes for every surgical specialty.	See *(AI008) Additional information provided by specialty training boards* attached, p. 5
• A collated summary document showing the graduate outcomes for every surgical specialty, and how each aligns with the RACS graduate outcomes.	See *(AI008) Additional information provided by specialty training boards* attached, p. 6
• A report on how the College is addressing AMC 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.	RACS communicated guidelines for presentation of key components of program information to specialty training boards via BSET in 2015. All specialties present web-based information regarding curriculum, assessment and training regulations. In keeping with agreements between specialty societies and RACS, specialties are at liberty to adapt the information that they present. Specialty information, from the RACS website, is attached (AI009).
• A report on how the College is addressing AMC recommendation 10: Involve health consumers and patients in any future consultation about the goals and objectives of surgical training.	RACS has introduced into all terms of reference for all specialty training boards inclusion of a community representative and a process for sourcing and selecting representatives.

Standard 3

The specialist medical training and education framework (curriculum framework; content; continuum of training, education and practice; structure of the curriculum)

Additional information:

Please provide the following:

AMC requirement	RACS response
• A definition of the College's underlying pedagogy for its curriculum framework including what is meant by 'competency-based'.	See *(AI008) Additional information provided by specialty training boards* attached p. 7.
• A report on how the College is addressing AMC recommendation 11: Present to the AMC its timetable for the planned move to competency-based training.	See *(AI008) Additional information provided by specialty training boards* attached, p. 8
• A collated summary document showing curriculum content across the nine surgical specialties. Please provide separate summaries covering standards 3.2.2 to 3.2.10.	Collated summary of curricula attached (AI027)
• A report on how the surgical specialties are addressing the additional Medical Council of New Zealand criteria on cultural competence in New Zealand. The team notes that Attachment 81 OHNS Aboriginal – Torres Strait Islander – Māori cultural awareness, does not refer to the Treaty of Waitangi and appears to mostly cover Aboriginal and Torres Strait Islander health.	See *(AI008) Additional information provided by specialty training boards* attached, p. 10-11
• What is the minimum number of rotations to be completed by trainees across all surgical specialties?	See *(AI008) Additional information provided by specialty training boards* attached, p. 12-14
• On page 45 of the accreditation submission, the table shows the maximum time available for trainees to complete all requirements. Can the College provide a breakdown of the numbers of trainees moving from the standard expected time into extended time and approaching maximum time in each of the specialties? In addition, please provide information on the number of trainees dismissed for having reached maximum time?	See *(AI008) Additional information provided by specialty training boards* attached, p. 12-14

AMC requirement	RACS response
• On page 56 of the accreditation submission, the College provides data on the number of trainees in part-time and interrupted training. Please provide data for 2016.	See *(AI008) Additional information provided by specialty training boards* attached, p. 12-14
• A report on how the College is addressing AMC recommendation 14: Report to the AMC on the impact of SET on the availability of flexible training opportunities.	All specialties are supportive of flexible training and address this in their regulations; however, uptake continues to be limited. Currently, five general surgery trainees are part-time. See *(AI008) Additional information provided by specialty training boards* attached, p. 12-14.
• The Team notes that the Critical Literature Evaluation and Research (Clear) course is mandatory for some of the surgical specialties. Do the other surgical specialties plan to make this course mandatory.	See *(AI008) Additional information provided by specialty training boards* attached, p.9.

Standard 4

Teaching and learning (teaching and learning approach; teaching and learning methods)

Additional information:

Nil

Standard 5

Assessment of learning (assessment approach; assessment methods; performance feedback; assessment quality)

Additional information:

Please provide the following:

AMC requirement	RACS response
• Copies of supervisor reports or in-training assessments for each of the surgical specialties.	See *(AI008) Additional information provided by specialty training boards* attached, summary p. 15. Assessment documents attached (AI010 – AI020).
• Please provide the 2016 fellowship examination pass rates for all surgical specialties, for Australia and New Zealand, and by gender.	See Table 1 2016 Fellowship Exam pass rates for SET trainees and IMGs by specialty and Table 2 2016 Fellowship Exam pass rates for SET trainees and IMGs by gender below.

Table 1 2016 Fellowship Exam pass rates for SET trainees and IMGs by specialty

	Sat	Passed	%
CAR	8	6	75%
GEN	117	102	87%
NEU	14	11	79%
ORT	83	70	84%
OTO	21	17	81%
PAE	5	4	80%
PLA	28	22	79%
URO	25	18	72%
VAS	11	11	100%

(source: 2016 Activities Report pg. 213)

Table 2 2016 Fellowship Exam pass rates for SET trainees and IMGs by gender

		CAR	GEN	NEU	ORT	OTO	PAE	PLA	URO	VAS
Female	Sat	0	32	4	9	11	3	13	5	0
	Passed	0	24	2	6	5	2	7	3	0
	%	0%	75%	50%	67%	45%	67%	54%	60%	0%
Male	Sat	8	113	11	93	15	2	23	22	14
	Passed	6	78	9	64	12	2	15	15	11
	%	75%	69%	82%	69%	80%	100%	65%	68%	79%

(source: 2016 Activities Report pg. 215)

AMC requirement	RACS response
• The team notes on page 83 of the accreditation submission that there are a large number of trainees dismissed from general surgery. Please provide the number of dismissals versus the total number of trainees as a percentage for each surgical specialty.	See Table 3 Percentage of trainees dismissed from SET 2008-2016 below.

Table 3 Percentage of trainees dismissed from SET 2008-2016

Specialty	% Dismissed
Cardiothoracic surgery	5.88%
General surgery	12.45%
Neurosurgery	7.28%
Orthopaedic surgery	1.43%
Otolaryngology head and neck surgery	1.52%
Paediatric surgery	7.89%
Plastic and reconstructive surgery	3.46%
Urology	2.18%
Vascular surgery	6.61%

Note 1: Dismissals determined if terminated by 1) Misconduct 2) Non-financial 3) Maximum exam attempts 4) Time expired and 5) Unsatisfactory performance.

Note 2: percentage dismissed is calculated from a dataset of former trainees who are now fellows and current trainees (2008-2016)

Standard 6

Monitoring and Evaluation (monitoring; evaluation; feedback, reporting and action)

Additional information:

Please provide the following:

AMC requirement	RACS response
• A copy of feedback from the last RACSTA six-monthly survey of trainees.	RACSTA survey report attached (AI021 & AI 022)
• Does the College have an overarching framework for monitoring, evaluation and feedback? If so, please provide a copy.	RACS does not have a framework document for monitoring evaluation and feedback.
• A report on how the College is addressing AMC recommendation 22: Introduce procedures to collect feedback on the training program from external stakeholders such as health administrators and health consumer groups.	There is variability in the specialty approaches to external feedback. See *(AI008) Additional information provided by specialty training boards* attached, p.16. Feedback is incorporated into RACS' evaluation activities. However, there is no formal process for seeking routine feedback from external stakeholders.

Standard 7

Trainees (admission policy and selection; trainee participation in education provider governance; communication with trainees, trainee wellbeing; resolution of training problems and disputes)

Additional information:

Please provide the following:

AMC requirement	RACS response
• Please provide information on how selection panels are appointed.	See *(AI008) Additional information provided by specialty training boards* attached, p.18-19.
• Please provide data on the number of withdrawals by specialty and by gender for 2016.	See Table 4 Withdrawals per specialty, 2016 below.

Table 4 Withdrawals per specialty, 2016

Specialty	Males	Females	Total
Cardiothoracic Surgery	0	1	1
General Surgery	1	3	4
Neurosurgery	0	0	0
Otolaryngology Head and Neck Surgery	1	0	1
Orthopaedic Surgery Au	0	0	0
Orthopaedic Surgery NZ	0	0	0
Paediatric Surgery	0	1	1
Plastic and Reconstructive Surgery Au	0	1	1
Plastic and Reconstructive Surgery NZ	0	0	0
Urology	0	0	0
Vascular Surgery	0	0	0
TOTAL	2	6	8

Source: RACS database iMIS

AMC requirement	RACS response
• Please provide data on the number of Indigenous applicants entering the program and how many of these applicants have been admitted to fellowship.	The data in Table 5 Indigenous trainees and fellows per specialty (below) is not comprehensive. RACS did not collect information from applicants to SET regarding their indigeneity until 2015. From 2015 this has been a voluntary component of registration to apply to SET. Some trainees and Fellows have recently informed RACS of their indigeneity.

Table 5 Indigenous trainees and fellows per specialty, 2017

Specialty	SET trainees	Fellows
Cardiothoracic surgery	0	0
General surgery	1	7
Neurosurgery	0	0
Otolaryngology head and neck surgery	2	3
Orthopaedic surgery Au	1	0
Orthopaedic surgery NZ	4	1
Paediatric surgery	0	1
Plastic and reconstructive surgery Au	0	1
Plastic and reconstructive surgery NZ	0	0
Urology	1	0
Vascular surgery	0	0

Source: RACS database iMIS

AMC requirement	RACS response
• How does the College support and train its trainee representatives for their roles on College committees?	See *(AI008) Additional information provided by specialty training boards* attached, p.20-21

Standard 8

Implementing the program – delivery of educational and accreditation of training sites (supervisory and educational roles; training sites and posts)

8.1 Supervisory and educational roles

Additional information:

Please provide the following:

AMC requirement	RACS response
• What is the ratio of trainees to supervisors across the surgical specialties?	See *(AI008) Additional information provided by specialty training boards* attached; p.22. Most specialties do not specify trainee to supervisor ratios. Table 6 Ratio of trainees to supervisors per specialty, 2017, provides ratios per specialty sourced from data in RACS database.

Table 6 Ratio of trainees to supervisors per specialty, 2017

Specialty	Supervisors	Trainees
Cardiothoracic Surgery	35	/36
General Surgery	179	/435
Neurosurgery	31	/46
Otolaryngology Head and Neck Surgery	62	/84
Orthopaedic Surgery Au	-	/233
Orthopaedic Surgery NZ	-	/48
Paediatric Surgery	21	/30
Plastic and Reconstructive Surgery Au	36	/81
Plastic and Reconstructive Surgery NZ	5	/15
Urology	47	/98
Vascular Surgery	58	/43

Note 1: The RACS database, iMIS, does not retain supervisor numbers for Orthopaedic Surgery.
Source: RACS database iMIS

AMC requirement	RACS response
• Does the College award CPD points for supervision?	Yes, CPD points are accrued for supervision, to a maximum of 15 points per annum.
• Please provide some commentary on which courses are mandatory and for which types of supervisors.	The Foundation Skills for Surgical Educators (FSSE) course, the Operate with Respect (OWR) online module and the OWR face to face course are mandatory for all SET supervisors, trainers and clinical assessors.
• Please provide data on the percentage of supervisors who have attended the courses.	See Table 7 Supervisors and Clinical Assessors Overall* March 14, 2017 , below.

Table 7 Supervisors and Clinical Assessors Overall* March 14, 2017

	OWR module			OWR course				FSSE course				
	Completed	Not Completed	Total	Completed	Not Completed		Total	Completed		Not Completed		Total
	Completed	Not Completed		Completed	Enrolled	Not Completed		Completed	Exempt	Enrolled	Not Completed	
SET Supervisor	247	170	**417**	5	16	396	**417**	119	23	80	195	**417**
Clinical Assessor	62	49	**111**	1	19	91	**111**	26	3	32	50	**111**
Dual Role	14	4	**18**	1	3	14	**18**	10	0	5	3	**18**
Trainer	1537	1469	**3006**	18	42	2946	**3006**	446	6	333	2221	**3006**

***Clinical Assessor and SET Supervisor: current in iMIS.*

Trainer: Not a current Clinical Assessor or Supervisor and is identified currently in MALT as a Supervisor at any point in time.

8.2 Training sites and posts

Additional information:

Please provide the following:

AMC requirement	RACS response
• A copy of the February 2017 *Accreditation of Hospitals and Posts for Surgical Education and Training booklet.*	*Accreditation of Hospitals and Posts for Surgical Education and Training* booklet is available on the RACS website.
• Please provide data on how many posts have lost accreditation as a result of an unsatisfactory hospital visit and failure of the hospital to correct the issue in a timely manner.	120 hospital posts have been disaccredited, 2011-2017. See attached table. (AI0023)
• Please provide an additional report on how the College is addressing the new additional Medical Council of New Zealand criteria regarding training sites and posts. The education provider is required to inform the Medical Council of New Zealand with reasonable notice of any intention to limit or withdraw the accreditation of any training site.	The RACS Training Post Accreditation and Administration policy has been updated to address MCNZ criteria: The outcome of new accreditation requests and the reaccreditation and/or review of existing posts will be reported by the relevant Specialty Training Board to the Board of Surgical Education and Training for noting. When required, the CIC will notify the MCNZ of any decision to limit or withdraw the accreditation of any training post reported to BSET.

Standard 9

Continuing professional development, further training and remediation (continuing professional development; further training of individual specialists; remediation)

Additional information:

Please provide the following:

AMC requirement	RACS response
• Can non-FRACS vocationally registered and non-vocationally registered surgeons join the RACS CPD program in New Zealand?	Vocationally registered surgeons can register to participate in the RACS Program (Maintenance of Professional Standards Program (MOPS)). As the RACS program has been developed for independent specialist practitioners, non-vocationally registered surgeons are not able to join the RACS program.
• Has the College notified the Medical Council of New Zealand of surgeons who are non-compliant in CPD?	To date all New Zealand RACS Fellows have complied with the RACS CPD Program. After exhausting all avenues of reminders, if a Fellow did not comply with the program, RACS would inform the MCNZ. (Note: RACS has informed the MBA of Fellows who have failed to comply with CPD or who have had their Fellowship terminated for persistent failure to comply). RACS has been working to improve its monitoring of those non-FRACS surgeons participating in the MOPS program. There is now robust reporting and monitoring functionality built into the RACS systems that will support reporting to the MCNZ for failure to comply from 2016.
• Please provide an additional report on how the College addresses the additional Medical Council of New Zealand criteria on continuing professional development in New Zealand. For example, is respect for cultural competence and formal components of the recertification programme that contributes to the cultural competence of fellows and affiliates addressed in the RACS CPD documentation?	RACS has no formal requirements; however, NZ fellows are encouraged to undertake PD relevant to improving cultural awareness, e.g. communication courses. The Maori Health Advisory Group is investigating how to encourage NZ surgeons to include ethnicity data in their audit as an action arising from the Maori health plan.
• How does the College deal with remediation of technical skills?	To ensure thorough oversight and centralisation of requests for remediation, RACS has introduced a complaints management process. Requests may be received directly from a regulatory authority, hospital or health service, specialty society or individual surgeon, or, may arise as part of the remediation process following a complaint or enquiry concerning the performance of a RACS Fellow Remediation of technical skills is detailed in the RACS Re-skilling and Re-Entry Program Guidelines. The process is overseen by the Executive Director for Surgical Affairs (EDSA) in Australia or New Zealand in consultation with the relevant specialty society of the

AMC requirement	RACS response
	surgeon concerned. If a surgeon is unsuccessful in remediation of technical skills after a period of oversight and supervision, RACS may communicate these findings to the relevant regulatory authority. *Complaints management guide (AI025)* and *Re-skilling and re-entry program guidelines (AI024) attached.*
• Please provide an additional report on how the College addresses the additional Medical Council of New Zealand criteria on remediation in New Zealand.	A process for reporting to the MCNZ, for the purposes of the MCNZ's audit of recertification, those who are participating in the recertification programme and whether they are complying or not. Requests regarding CPD compliance (and training status) for named individuals are received by the NZ Office from the MCNZ. The CPD status of the person is checked and the MCNZ advised of their status within the timeframe set by the MCNZ. A system for identifying and managing compliance with recertification programmes, and where appropriate to refer the doctor to the MCNZ. RACS has a process for managing surgeons who do not comply with the CPD Program as outlined in the RACS CPD – Participation and Compliance Policy and the RACS Sanctions Policy A system for informing the MCNZ if the provider becomes aware of performance / competence concerns on the part of the practitioner. Remediation of technical skills is detailed in the RACS Re-skilling and Re-Entry Program Guidelines. The process is overseen by the Executive Director for Surgical Affairs (EDSA) in Australia or New Zealand in consultation with the relevant specialty society of the surgeon concerned. There is no differentiation between how these cases are managed in Australia and New Zealand. HDC reports directly to MCNZ on any doctors found to have breached the Code of Patient and Disability Consumers' Rights. Therefore, RACS does not advise MCNZ when notified of this information. Although New Zealand statutes do not require reporting of competence concerns (unless related to physical or mental health), RACS is very conscious of issues of public safety. If such concerns arose e through a complaint process or a re-skilling /re-entry program RACS is aware of the processes to report these. As an education provider for the prescribed qualifications for several scopes of practice, RACS is aware of its statutory reporting obligations should it become aware that a trainee had a mental or physical condition resulting in her / him not performing the functions required of a medical practitioner.

Standard 10

Assessment of specialist international medical graduates (assessment framework, assessment methods; assessment decision; communication with specialist international medical graduate applicants)

Additional information:

Please provide the following:

AMC requirement	RACS response
• In reference to the *Specialist Assessment of International Medical Graduates in Australia Policy*, the team notes that the objectives have not been completed. Is this policy still a work in progress, or can the College provide a final version?	Specialist Assessment Policy attached.
• Please provide an additional report on how the College addresses the additional Medical Council of New Zealand criteria in the assessment of specialist international medical graduates in New Zealand.	IMGS in New Zealand are assessed by RACS for the MCNZ. This is done through the NZ Censor and not through Education. The assessment team uses MCNZ criteria and documentation. RACS has a Memorandum of Understanding with the MCNZ and adheres to the requirements within that for the assessment of International Medical Graduates applying for registration in any of the nine surgical vocational scopes of practice relevant to this College. RACS does not advise the MCNZ that any IMG must obtain FRACS in order to gain vocational registration. Some IMGs do seek that qualification but that is not via the MCNZ's vocational registration process
• A copy of the report on the outcomes of the College's international medical graduate assessment process, including information on timelines and broken down by specialty and outcome (SC, PC, NC for Australia, or recommended for supervision pathway, assessment pathway or not equivalent for New Zealand).	In the 2016 Activities Report, see section two p. 8. Specifically IMG tables 3, 5, 7, 9-13 and IMG tables 18-21 (AI004) Attached
• A copy of the results of the trial of the process for an independent review for an international medical graduate in difficulty.	The trial is still in progress. A pilot review for one IMG has been conducted. This has indicated a need to clarify reporting lines and to create an environment of support for IMGs and Trainees. Additional pilot reviews will be conducted during 2017.

ADDITIONAL INFORMATION PROVIDED BY SPECIALTY TRAINING BOARDS

ADDITIONAL INFORMATION REGARDING SPECIALTY TRAINING PROGRAMS

Does the board plan any changes to your specialty programs? If Yes, what is the proposed timeline for implementation?		
	Yes/No	**Comments**
Cardiothoracic	No	
General Surgery	Yes	Details not provided by the board
Neurosurgery		Board has approved the introduction of an Intermediate Examination Module. The Module will provide an opportunity for feedback to supervisors and trainees regarding performance and preparedness for the Fellowship Examination. The first Intermediate Examination Module will be held during October 2017.
Otolaryngology Head and Neck Surgery	Yes	Revised Curriculum under development. Anticipated launch February 2018
Orthopaedic Surgery Au	Yes	Progressive implementation of revised curriculum has commenced
Orthopaedic Surgery NZ	No	
Paediatric Surgery		
Plastic and Reconstructive Surgery Au	Yes	Review of Curriculum: Review completed with drafts distributed to the Specialty groups and external stakeholders for feedback (Australia and NZ) by end of 2017. Final documents published in 2018 for approval by RACS. Implementation in 2019. Implement competency-based training: Timeline to be determined.
Paediatric Surgery	Yes	Pathophysiology Exam revamp to be introduced next year.
Urology	Yes	There are multiple avenues where the SET Program in Urology is being examined for change. These changes are due to the work being undertaken by the new sub-committees of the Board of Urology. **Selection**: • Recognition that the training occurring within urological units can only reflect the workload performed within those units. It would be unproductive to devote large amounts of time to basic surgical competencies such as the assessment of the sick patient, and organisational skills. Formalisation of these prerequisite skills prior to entry to the training program will be made. • There is also recognition that many candidates who wish to be trained in urology will have gathered some background skills in urology itself. There will be some moves towards assessing this as part of the selection process. **Education:** • Revision of the syllabus/curriculum is underway. In terms of the non-technical competencies, negotiations have commenced with other subspecialty groups (Orthopaedics) with a view to sharing a common curriculum. • The development by NSW Health of a 'Scope of Practice' for Urologists is the focus for a common set of procedures which will be the aim of our training program. To date, surgical competency was not so strictly defined. There is now a need

Does the board plan any changes to your specialty programs? If Yes, what is the proposed timeline for implementation?		
		to ensure all trainees achieve a standard of competence. This does not limit delivery of training outside the core surgical procedures. • Formal assessment of trainees has always been a challenge. The Education subcommittee is exploring the implementation of workplace based assessment in the form of "Entrustable Professional Activities". Significant change in educational theory and principles will need to be carefully implemented amongst the supervisors and trainers. The Board will need to combat the perception of change for changes sake, and to streamline and minimise the burden on supervisors. The potential payoff will be a very explicit logbook of training experiences and competencies that trainees will have achieved by the completion of their training. It is anticipated that the stage of competence in each area will also be clear to trainees and trainers. • Better processes to facilitate support to trainees and supervisors when underperformance is identified. • Timeframes of these changes is unclear. Discussion is only its infancy. Working parties will provide recommended initiatives and changes to the Education subcommittee, and subsequently the Board for comment and implementation. **Post Accreditation** • There has been a recognition that the involvement of General Surgery posts in the training of urologists is challenging. In the future, we are likely to concentrate on providing education and training in urology skills only. This may have repercussions on the selection process as documented above, requiring certain baseline skills to be a prerequisite for entrance to the training program. • There are also continuing challenges matching the numbers of trainees each year, with the educational qualities of posts. There are fluctuations in the capabilities and seniority of the trainee cohort which do not exactly match the attributes of posts. Managing the expectation of posts and further standardising the educational requirements is a work in progress. **International Medical Graduates:** • The creation of the IMGC which comprises representation from all surgical specialties' is a forward step. **Structural Assistance:** • USANZ has recognised the need for improvement in its information technology services to members. As part of this, the Training and Education function plans to incorporate components including guidance to supervisors, regular feedback to trainees (in a more contemporaneous manner than quarterly reports), and online access to trainee records for supervisors, regional training chairs and Board Chair. These changes are dependent upon funding.
Vascular Surgery	Yes	Recently introduced regulations for flexible training – timeline is introducing now, an accrediting post for training in 2018

ADDITIONAL INFORMATION REGARDING SPECIALTY TRAINING PROGRAMS

Does the board plan any changes to the Specialty SSE examination?		
	Yes/No	**Comments**
Cardiothoracic Surgery	No	
General Surgery	N/A	GS does not have this Examination
Neurosurgery		The Neurosurgical Surgical Science Examination was removed as a training requirement for trainees commenced from 2016 onwards. This was replaced with a Neurosurgery Anatomy Examination sat as part of the selection process.
Otolaryngology Head and Neck Surgery	No	
Orthopaedic Surgery Au	Yes	Blueprinting of OPBS to revised curriculum
Orthopaedic Surgery NZ	No	
Paediatric Surgery	No	
Plastic and Reconstructive Surgery Au	No	The curriculum dictates what is assessed. As part of the curriculum review, learning outcomes in relation to plastic and reconstructive surgical sciences and principles are also being reviewed, however we do not envisage significant change.
Plastic and Reconstructive Surgery NZ		
Urology	No	
Vascular Surgery	No	

ADDITIONAL INFORMATION REGARDING SPECIALTY TRAINING PROGRAMS

Do you have a statement of program outcomes for your specialty? If Yes, please provide.		
	Yes/No	**Comments**
Cardiothoracic Surgery	Yes	Curriculum http://www.surgeons.org/surgical-specialties/cardiothoracic/modules/
General Surgery		Details not provided by the board
Neurosurgery	Yes	Neurosurgical Statement of Competence attached
Otolaryngology Head and Neck Surgery	No	Will be included in revised curriculum. Anticipated release February 2018
Orthopaedic Surgery Au	Yes	The Orthopaedic Surgical Education and Training (SET) Program is designed to ensure an AOA graduate has achieved competency in the domains of: • Communication • Teamwork and Conflict Management • Professionalism • Leadership and Organisational Skills • Advocacy • Education and Research • Medical and Surgical Expertise
Orthopaedic Surgery NZ	Yes	Once a trainee has completed their training and it is expected that they will be able to work unsupervised as an independent orthopaedic surgeon. They will be aware of the importance of lifelong learning and participate in an approved recertification programme relevant to the vocational scope of Orthopaedic Surgery. Trainees will be aware of their duty to their colleagues, peers, patients and act in accordance with the RACS and NZOA Code of Conduct.
Paediatric Surgery	Yes	Guide to Paediatric Surgical Training
Plastic and Reconstructive Surgery Au	No	This is being developed concurrently with the curriculum review.
Plastic and Reconstructive Surgery NZ		
Urology		The Board of Urology has no current explicit statement of program outcomes. The definition of a urologist and the skills necessary to graduate has been in some flux. Moving forward, development of a scope of practice set of procedures is underway to at least define minimum outcomes of our program. Holistically however there are many other areas of expertise within the urological umbrella. These are expected areas for our trainees to be trained in, observe, and to be familiar with, and contained within our curriculum document. These are also examined formally. There is also an expectation to continue to comply with the nine RACS surgical competencies throughout training and later career.
Vascular Surgery		

ADDITIONAL INFORMATION REGARDING SPECIALTY TRAINING PROGRAMS

Do you have a statement of graduate outcomes for your specialty? If Yes, please provide.		
	Yes/No	**Comments**
Cardiothoracic Surgery		See 1.1 of Cardiothoracic Training Regulations *At the conclusion of the SET Program it is expected that trainees will have a detailed knowledge of surgery and of those conditions recognised as belonging to the specialty of cardiothoracic surgery. This should include knowledge of anatomy, physiology and pathology related to the discipline.* Cardiothoracic Regulations link
General Surgery		Each curriculum module has objectives and states what each trainee should be able to do and know
Neurosurgery		The curriculum outlines the expected learning outcomes for each level of the SET Program including those when Advanced Neurosurgical Training is complete. Document attached.
Otolaryngology Head and Neck Surgery	No	Will be included in revised curriculum. Anticipated release February 2018
Orthopaedic Surgery Au	Yes	The AOA Curriculum defines graduate outcomes across Foundation Competencies and Key Medical and Surgical Expertise Learning Areas of: • Trauma and Injury • Shoulder • Elbow • Hand & Wrist • Hip • Knee • Foot & Ankle • Spine • Tumour & Tumour-like Conditions • Paediatrics • Systemic Medical Conditions
Orthopaedic Surgery NZ	Yes	A graduate of the NZOA training program will have achieved the skills and competencies as outlined in the Curriculum.
Paediatric Surgery	Yes	Guide to Paediatric Surgical Training and curriculum modules
Plastic and Reconstructive Surgery Au	No	This is being developed concurrently with the curriculum review.
Plastic and Reconstructive Surgery NZ		
Urology		The Board of Urology has no current explicit statement of graduate outcomes. The outcomes however are encompassed within the modular learning curriculum, and the nine RACS surgical competencies.
Vascular Surgery		

ADDITIONAL INFORMATION REGARDING SPECIALTY TRAINING PROGRAMS

Does the board have a definition of 'competency-based' training? If Yes, please provide.		
	Yes/No	**Comments**
Cardiothoracic Surgery		While the Board of Cardiothoracic Training doesn't have an explicit statement regarding competency based training, trainees have been signed off as program complete prior to their expected 6 year completion time or accelerated in the program as they have demonstrated all required competencies. Competency-based is being assessed by the trainee's supervisors. In addition the trainees must acquire the nine competencies as outlined by the College.
General Surgery		In progress. Part of the strategic plan is to move to competency based training
Neurosurgery	No	There is no specific definition however the Regulations state the SET Program is structured on a three-level sequential curriculum to facilitate the cumulative acquisition of the experience, knowledge, skills and attributes aligned with the overall objective. The SET Program can be completed in a minimum of five years and a maximum of nine years' subject to satisfactory progression through the levels in the timeframes outlined in the Regulations. As such there is flexibility and progression is based on achievement of the competencies and requirements at each level.
Otolaryngology Head and Neck Surgery	No	
Orthopaedic Surgery Au	No	
Orthopaedic Surgery NZ	No	However this issues is on the agenda for the upcoming NZOA Education Committee meeting.
Paediatric Surgery	Yes	Guide to Paediatric Surgical Training and Paediatric Surgery Training Regulations
Plastic and Reconstructive Surgery Au	No	This is in development concurrently along with the curriculum that is being reviewed.
Plastic and Reconstructive Surgery NZ		
Urology	No	
Vascular Surgery		As per the attached in-training assessment form, trainees are assessed against the nine RACS competencies for surgery. The terminology used had been adapted to conform to the NOTSS terminology in describing cognitive and behavioural aspects of performance and aligned with performance descriptors from the RACS Competency Standards. Trainees are assessed against the performance descriptors appropriate to their level in the SET program. Trainees applying for the Fellowship Examination are assessed against the SET5+ level.

ADDITIONAL INFORMATION REGARDING SPECIALTY TRAINING PROGRAMS

Does the board have a timetable to move to competency-based training? If Yes, please provide.		
	Yes/No	**Comments**
Cardiothoracic Surgery	Yes	The Board supports competency-based training. The Board will be reviewing the curriculum in the coming 24 months and this will assist with the development of clearer guidelines for competency based training. The Board will continue to assess each trainee individually and provide early completion pathways if required. For example one trainee was granted FRACS (2017) after his fifth year training (instead of 6). A second trainee was promoted to SET 5 from SET 3 this year based on her competency and acknowledgement of her prior learning
General Surgery	Yes	12-18 months
Neurosurgery		The Board has already introduced competency based training. It introduced three levels of training with maximum time frames set at each level but flexibility to allow trainees to progress at different speeds.
Otolaryngology Head and Neck Surgery	No	
Orthopaedic Surgery Au	Yes	Competency-based training begins in 2018
Orthopaedic Surgery NZ	No	
Paediatric Surgery	Yes	Almost complete. We think there is still a segment of trainers not fully understanding of this change, the Board continues to try and engage them.
Plastic and Reconstructive Surgery Au	No	Implementation of the revised curriculum (2019) with associated workplace based assessments will be closely linked to a transition to competency-based training.
Plastic and Reconstructive Surgery NZ		
Urology	No	No timetable but we are moving towards it via the Education Sub-Committee and development of the EPAs.
Vascular Surgery		

ADDITIONAL INFORMATION REGARDING SPECIALTY TRAINING PROGRAMS

Is the Critical Literature Evaluation and Research (CLEAR) course compulsory in your specialty? If No, are you considering making this course mandatory?		
	Yes/No	**Comments**
Cardiothoracic Surgery	No	CLEAR contributes 1 point towards the scoring system in the selection process. All trainees are required to submit a thesis at the end of their 4th year of training and 2 publications by the end of their training. This provides opportunity to appraise surgical literature and develop clinical trials. CLEAR is therefore not compulsory as the research component of cardiothoracic training adequately covers the CLEAR course. Board meeting discussion Item 2.1 14th Feb 2015.
General Surgery	Yes	
Neurosurgery	Yes	Compulsory during Intermediate Neurosurgical Training.
Otolaryngology Head and Neck Surgery	No	No, but is scored in the CV which effectively means all applicants do the course
Orthopaedic Surgery Au	No	
Orthopaedic Surgery NZ	Yes	
Paediatric Surgery	Yes	
Plastic and Reconstructive Surgery Au	No	No. This is typically completed by selection applicants (prevocational doctors). Regional teaching activities include structured teaching of research principles (frequency of teaching varies from region to region) and also annually at a mandatory research presentation day. CLEAR is recommended and actively encouraged, but not compulsory.
Plastic and Reconstructive Surgery NZ		
Urology	Yes	
Vascular Surgery	No	No plans to

How does your board address this additional Medical Council of New Zealand criterion on cultural competence in New Zealand?

4.2 Cultural competence

Accreditation standard

4.2 The training programme ensures that trainees, fellows and affiliates have access to significant training experiences in cultural competence and that evaluation of cultural competence is a specific component of the training programme.

	Comments
Cardiothoracic Surgery	The Board at present has no cultural competency in the curriculum. The Board has had consultation from Aboriginal and Torres Strait Islander (ATSI) Trainee and is aware of the significance of cultural competence issues. The Board is awaiting advice from the Board of SET and the Censor in Chief.
General Surgery	Cultural awareness is included in the Board in General Surgery non-technical curriculum within the communication module. All trainees are also required to complete the online "operating with respect" module which covers discrimination. Although the Board does not provide its own training in this area, supervisors are able to assess trainees on this attribute in the quarterly performance assessments.
Neurosurgery	This has not been addressed at this stage.
Otolaryngology Head and Neck Surgery	Will be included in revised curriculum. Anticipated release February 2018
Orthopaedic Surgery Au	The AOA Curriculum incorporates cultural competence - this includes respecting patient diversity and difference (including gender, age, religion and culture)
Orthopaedic Surgery NZ	NZOA is very aware of the issues around Cultural Competency and Health Disparities in New Zealand. There is a wide variety of training opportunities in New Zealand and trainees are expected to move around a number of centres which allows them to experience a wide variety of patients/training experiences. The End of Term assessment form does have 'Health Advocacy' and 'Empathy' as essential skills for a trainee to demonstrate. The NZOA Presidential Line is currently looking at ways to ensure that all members are aware of the issues around Cultural Competency in New Zealand. The DHBs in New Zealand also provide training opportunities for all medical staff around Cultural Competency.
Paediatric Surgery	Rely on training post trainers/hospitals to address this.
Plastic and Reconstructive Surgery Au	The MCNZ criterion is a matter for consideration of the NZ Board of Plastic and Reconstructive Surgery. The current curriculum review is also addressing the 'intrinsic roles' in addition to medical and surgical expertise. Learning outcomes in relation to cultural competency have been included in the draft, and teaching and assessment activities to address these learning outcomes will be determined in due course. As a binational curriculum, training experiences to meet learning outcomes of the curriculum will need to address both AMC and MCNZ standards. The NZ Training Board representative will provide input in this regard.
Plastic and Reconstructive Surgery NZ	

How does your board address this additional Medical Council of New Zealand criterion on cultural competence in New Zealand? 4.2 Cultural competence Accreditation standard 4.2 The training programme ensures that trainees, fellows and affiliates have access to significant training experiences in cultural competence and that evaluation of cultural competence is a specific component of the training programme.	
Urology	The SET Program in Urology recognises the importance of cultural safety with specific reference to Treaty of Waitangi principles. All New Zealand Doctors receive cultural competence training every year of their medical school education. Trainees must also comply with specific requirements of the hospitals they are employed in. In 2015, cultural competence was incorporated into the selection process for doctors applying for selection to New Zealand. As of 2017, cultural competence will be an integral part of the biannual training weekends for trainees in New Zealand. Board of Urology have recognised the importance of these initiatives. In 2017, cultural competence will be incorporated into the selection process for applicants applying for selection in Australia.
Vascular Surgery	

ADDITIONAL INFORMATION REGARDING SPECIALTY TRAINING PROGRAMS

	What is the minimum number of rotations to be completed by trainees in your specialty?	**What is the current number of trainees moving from standard, expected length of training into extended time?**	**What is the current number of trainees approaching maximum time of training?**	**What is the number of trainees dismissed for having reached maximum time of training 2012 - 2016?**	**What is the current number of trainees in part-time training?**	**What is the current number of trainees on interruption?**
Cardiothoracic Surgery	The trainee can only stay in one institution for maximum of 2 years. Minimal rotation 12	3 trainees have been put on probation and they will be expected to have extended time in their training	1 (end of 2018)	1	0	2
General Surgery	8	7 (Aus) 0 (NZ)	3 (Aus) 0 (NZ)	5 (Aus) 0 (NZ)	5 (Aus) 0 (NZ)	27 (Aus) 6 (NZ)
Neurosurgery	Trainees must be rotated through a minimum of four training units during their SET Program to ensure they receive a wide exposure to systems, supervisors and case mixes. This will	The SET Program can be completed in a minimum of five years and a maximum of nine years' subject to satisfactory progression through the levels in the timeframes outlined in the Regulations. For the 2016	Each level of the SET Program has training requirements which must be satisfied and a maximum duration in which to achieve them. There are currently 4 trainees approaching the maximum in their	All trainees dismissed to date were in Basic Neurosurgical Training (max 2 years). The dismissals were for not passing the examinations in the timeframe. This has been addressed by moving the examination to be part of	0	4

	often include two different jurisdictions.	training year the projections were: 5 years – 5 6 years – 32 7 years – 9 8 years – 5 9 years - 2	level. Of those 2 are approaching the overall maximum of 9 years.	selection. 2012 – 1 2013 – 1 2014 – 1 2015 – 1 2016 – 0		
Otolaryngology Head and Neck Surgery	10	0	1	0	0	4
Orthopaedic Surgery Au	8 6mth rotations	1 in 2017	2	2	0	4
Orthopaedic Surgery NZ	8	0	1	0	0	0 – 1 is going on interruption in June 2017
Paediatric Surgery	No minimum	2	1	0	0	4
Plastic and Reconstructive Surgery Au	10 (each of 6 months FTE clinical training time)	There are 16 trainees in this category.	If "**approaching maximum time of training**" is defined as "having less than 2 years remaining out of 9 years maximum training time", then there is one trainee in this category.	One in 2014	0	As at February 2017, two trainees are on interruption (one for parental leave and one for research) Does not include two deferred commencements dates and six SET 1 trainees commencing clinical training in Term 2, 2017.

Plastic and Reconstructive Surgery NZ						
Urology * interpreted to be the number of trainees who are undertaking extension of training.	5 x 12 month positions	6 *	0	0	0	4
Vascular Surgery	10	5	2	0	0	2

Please provide copies of end of term report forms and in-training assessment forms.		
	Yes/No	**Comments**
Cardiothoracic Surgery		Attached: http://www.surgeons.org/surgical-specialties/cardiothoracic/
General Surgery		Attached
Neurosurgery		There are two forms; the Professional Performance Assessment and the Neurosurgical Competency Assessment Report
Otolaryngology Head and Neck Surgery		Mid Term Assessment form, End of Term Assessment form, Mini-CEX Assessment form, DOPS Assessment form, Tympanoplasty Audit form, Temporal Bone Dissection Record
Orthopaedic Surgery Au		Quarterly Assessment Report attached
Orthopaedic Surgery NZ		Attached
Paediatric Surgery		New drafts being considered. See attached.
Plastic and Reconstructive Surgery Au		See attachment end of term report: • "2016 T2 PPA form.pdf" See attached in-training assessment forms: • "DOPS Form.pdf" • "Mini-CEX Form.pdf" • "Multi Source Feedback - Updated July 2016.pdf"
Plastic and Reconstructive Surgery NZ		
Urology		All assessment documentation can be found via the link below: http://www.usanz.org.au/regulations-and-forms/
Vascular Surgery		attached

ADDITIONAL INFORMATION REGARDING SPECIALTY TRAINING PROGRAMS

Does your specialty collect feedback on the training program from external stakeholders such as health administrators and health consumer groups? If Yes, how do you do this?		
	Yes/No	**Comments**
Cardiothoracic Surgery	No	The Board does not collect feedback on training program. However, issues that area raised with the Board by trainees or any external stakeholders is taken seriously by the Board. The Board will conduct an unscheduled inspection of the accredited hospital. Appropriate action will be taken with the full approval of the Board.
General Surgery	No	
Neurosurgery	No	
Otolaryngology Head and Neck Surgery	No	
Orthopaedic Surgery Au	Yes	Feedback was purposely sought from these groups in the development of the revised AOA Curriculum. AOA also has active and regular involvement with a number of key stakeholders with regard to workforce and training issues. Stakeholders include; Health Workforce Australia, Department of Immigration and Border Protection – Skills Australia, Australian Medical Association, Ministry of Health (NSW), Federal Department of Health, Minister for Health (Chief of Staff), Private Health Organisations, and Industry. A Jurisdictional Representative continues to sit on the AOA Federal Training Committee. This representative is a full, voting member of the committee. Jurisdictional Representative involvement is actively sought in training site accreditation inspections and SET selection interviews. Work is underway to further refine and define this role. In the interests of transparency, good governance and in order to safeguard trainees, AOA has implemented Accreditation Agreements with Training Sites which confirm acceptance of the AOA accreditation standards and the process by which those accreditation standards are to be applied.
Orthopaedic Surgery NZ	No	
Paediatric Surgery	Yes	Attempted with CF and Pullthru Network groups
Plastic and Reconstructive Surgery Au	Yes	During 2009 – 2012 a jurisdictional representative was member of the Training Board. The new Collaboration Agreement (signed in 2013 for years 2014 – 2019) the jurisdictional representatives withdrew their involvement. RACS performs the central role of advocacy and external stakeholder management. We intend to collect feedback on the revised curriculum.
Plastic and Reconstructive Surgery NZ		
Urology		Current feedback to members of the Board of Urology is via interaction with sectional members (other urologists who may be in the community, or be training supervisors themselves). Meetings are periodically held amongst urologists within each Section (Australian States and NZ), not just those who work in training

		posts. The relevant Training and Education Section Chair sits on the executive of the State Board and makes a report to the section regarding training. Feedback can be shared at this forum. Supervisors provide more frequent feedback via the Regional Training Committees. These Committees meet quarterly to discuss trainee progress reports. Other internal and external stakeholders have the opportunity to comment on the program and graduate outcomes during the inspection of training posts. The inspectors meet with hospital administrators where views on training in that post are shared. From this feedback, the Board has made modification most visibly on the selection criteria of new trainees awarding more merit on surgical experience and skills. It was thought that specialists produced by the training program had not started with the necessary skills to capitalise from the program. The limitation in making this change has been identifying the ideal standard of candidate, but also what is realistic within the medical post-graduate pool across Australia and New Zealand. Deliberate attempt was made not to change criteria too quickly as it may have resulted in excluding a large cohort of talented candidates, or alienated those who had devoted a great deal of time in preparation for their application. Unfortunately, there is limited control over the fundamental method of learning skills (exposure to Urological medicine within relatively varied Urology units). Background skills in other disciplines and basic competencies have to be built up elsewhere to allow steady learning in Urology. Some compensation can be made through academic studies, but there is often no simple substitute. Ongoing, the proposed survey of recently qualified fellows will be evaluated by the Education Sub-Committee and potential changes and recommendations discussed. The report and conclusions will be tabled to the Board of Urology, which has ultimate responsibility for changing policy for training.
Vascular Surgery	No	

ADDITIONAL INFORMATION REGARDING SPECIALTY TRAINING PROGRAMS

Please provide information on how selection panels are appointed in your specialty.	
Cardiothoracic Surgery	All Supervisor of Training and accredited hospital trainers who had done their SET SAT course are eligible to be in the selection panel The Board appoints the selection panel.
General Surgery	Aus – Appointed by invitation to Fellows and Hospital Administrators where available NZ – The entire NZ Training Board (subcommittee to Board in General Surgery) or their proxies, serve as the selection panel
Neurosurgery	Members of the SET Board of Neurosurgery who are responsible for the conduct and oversight of the SET Program are appointed as the selection panel. Where needed, these are supplemented by surgical supervisors. The members of the SET Board of Neurosurgery are elected by the general neurosurgical population subjection to jurisdiction limitations to ensure diversity (no more than 2 from any one jurisdiction).
Otolaryngology Head and Neck Surgery	Australian OHNS regional chairs ask supervisors of training to attend as interviewers. There is usually a mix of experienced ones and a few new ones each year. In 2016 there were 18 interviewers (22% women) required to form 3 groups of 3 panels. Each group asked the same questions for a different cohort of applicants. The process is similar in New Zealand
Orthopaedic Surgery Au	Regional Training Committee Chairs are responsible for formulating the interview panels. Directors of Training, and other members, act as interviewers on standardised interview stations. Jurisdictions are also invited to participate at the interview. Each interviewer is assigned to a specific station based on a particular competency area. All interviews attend a training session prior to participation each year.
Orthopaedic Surgery NZ	The Selection panel is made up of Members of the NZOA Education Committee. There are six interview panels consisting of 2 interviewers. Panels consist of a more experienced interviewer with a less experienced panel member. In addition there are at least 2 independent observers – one is the President Elect of NZOA and the NZOA CEO.
Paediatric Surgery	Comprised of Board Members, may be augmented by local Supervisors of SET if interview course completed.
Plastic and Reconstructive Surgery Au	ASPS staff members are appointed internally to review and score structure CVs. Selection interviewers are determined by expressions of interest (EOI). The process may vary slightly by state / region. Initial EOI are requested via regular ASPS communications or during regional subcommittee meetings. Where low response numbers are present, requests for EOIs are expanded from Surgical Supervisors to all active Surgical Trainers. Selection panels are appointed prior to interviews by the Regional Chair with knowledge of experience in mind. Selection applicants and interviewer pairs are randomly assigned by the ASPS office prior to the conducts of interviews. Interviewers are encouraged to participate in a standardised training sessions (RACS online course for interviewers and SATSET) prior to conducting interviews. They are provided with approved Interviewer Guidelines (reviewed by the Training Board annually).
Plastic and Reconstructive	

Surgery NZ	
Urology	Each year, the Board of Urology invites consultant urologists who are actively involved in the SET Program in Urology to participate on interview panels. There is normally a mix of experienced and new interviewers each year. The Board also makes concerted efforts to ensure interview panels comprise members from diverse backgrounds (i.e. females, younger fellows, different cultures etc).
Vascular Surgery	Board members, and then co-opted from RACS diversity plan (younger Fellows, IMGs, etc)

ADDITIONAL INFORMATION REGARDING SPECIALTY TRAINING PROGRAMS

Does your specialty currently have a trainee representative on the training board? If Yes, how does the board support and train the trainee representative for this role?		
	Yes/No	**Comments**
Cardiothoracic Surgery	Yes	The Trainee Representative is a full member of the Board and is included in all discussions. The trainee representative is well supported by the Board with equal voting rights. The trainee representative must have an appointment at an institution accredited for Surgical Education and Training.
General Surgery	Yes	In Australia there is admin support for each Trainee Rep across the Training Committees and the Board's Australian Rep. We provide support through facilitating discussion of issues across each state NZ – the NZ subcommittee has a Trainee Representative who is elected by the NZ trainees. The incumbent attends local and full Board in General Surgery meetings. Support is provided by the NZAGS office and the outgoing trainee representative hands over to their replacement
Neurosurgery		They are a full, funded member of the Board and participate in all discussions. They are elected by the SET Program trainees on an annual basis. There is no specific training for the role. For associated activities such as selection panels and hospital inspections they are paired with experienced Board members (the same process for new Board members).
Otolaryngology Head and Neck Surgery	Yes	1 x Australia, 1 x New Zealand. Support provided by SET Program Administrator ASOHNS
Orthopaedic Surgery Au	Yes	The President of the AOA Registrar Association (AORA) is a full voting member on both the Federal Training Committee and the AOA Board. As such, they receive a complete induction. AOA works with AORA to ensure transition arrangements are in place for changing between presidencies, including involvement of the vice-president in meetings prior to handover.
Orthopaedic Surgery NZ	Yes	The previous training representative takes primary responsibility for training the next representative. In addition the trainee representative is sent a pack with a number of documents relevant to the Board such as previous minutes and Board Charter.
Paediatric Surgery	Yes	Full membership of Board deliberations. Board deliberations clearly discussed/explained. Induction information provided. Handover from previous Board representatives.
Plastic and Reconstructive Surgery Au	Yes	Board members learn on the job skills which commence as members of a regional training subcommittee, then appointment as Regional Chair and, in some instances, to the role of Training Board Chair. There, experiences are conveyed to the Trainee Representative during their appointment. The Trainee Representative may initially observe the Board's conduct and then provides reports. The Board members support the Trainee Representative and provide leadership feedback and support. Where the Board's Trainee Representative is the same as the ASPS Council's Trainee Representative, there is complementary leadership training and support.
Plastic and Reconstructive Surgery NZ		

Urology	Yes	The Trainee Representative is commonly a member of the Board for at least 2 years. The Board provides ongoing guidance and mentoring to the Trainee Representative on all matters. The Trainee Representative regularly interacts with the Board in various forums and is an active participant in a range of training related meetings.
Vascular Surgery	Yes	RACSTA

ADDITIONAL INFORMATION REGARDING SPECIALTY TRAINING PROGRAMS

Does your specialty have a set ratio of trainees to supervisors? If Yes, what is the ratio of trainees to supervisors in your specialty?		
	Yes/No	**Comments**
Cardiothoracic Surgery		Each accredited post must have a ratio of trainers to trainees (2:1) plus a supervisor. Of the 31 hospitals with accredited posts, 25 have only one trainee. Cardiothoracic is a small specialty with maximum of 2 advanced trainees in each accredited unit. Therefore the ratio is usually one supervisor or at least two trainers to one trainee.
General Surgery	No	
Neurosurgery		The maximum posts possible at a single training unit is 3. As such the maximum ratio is 3 trainees to 1 training supervisor. The average is 2 trainees to 1 training ratio.
Otolaryngology Head and Neck Surgery	No	
Orthopaedic Surgery Au	Yes	1:1 is preferred, 2:1 at a maximum
Orthopaedic Surgery NZ	No	There is no minimum however in NZ there is a very good ratio of trainees to supervisors. Some departments are 1:1, some are 2:1 and the most there would ever be is 6:1
Paediatric Surgery	No	
Plastic and Reconstructive Surgery Au	No	There is no set ratio. Supervisors are appointed on a one to one ratio per hospital/training location. The accreditation process determines if a training position has the required number of consultants to offer support to the trainees. For instance, the roles are Head of Unit/Department and Surgical Supervisor are usually always held by different people. An exception may be approved for remote training positions.
Plastic and Reconstructive Surgery NZ		
Urology		There is no set ratio of trainees to supervisors. All accredited training posts must have a supervisor. However, some hospitals have more than one training post. In this situation, one supervisor is responsible for all trainees. There is also no ratio of trainers to trainees. However, one of the criteria for accreditation of a SET Urology training post is as follows: *3.1 The hospital employs two or more urologists with appropriate College recognised qualifications per trainee, each actively involved in trainee education. At least one urologist, actively involved in supervision and training, must possess the FRACS (Urol) from the Royal Australasian College of Surgeons.*
Vascular Surgery	Yes	1 appointed surgical supervisor and at least 2 FRACS in unit